Counselor Gender Self-Confidence and Social Influence In Counseling: Counselor Perceptions of the Therapeutic Alliance

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ABSTRACT

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Counselor Gender Self-Confidence and Social Influence In Counseling: Counselor Perceptions of the Therapeutic Alliance (200 pp.)

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The purpose of this study was to investigate how a counselor's biological sex, gender self-confidence (which includes gender self-definition and gender self-acceptance) and the counselor's use of social influence (which includes soft and harsh power bases) within the counseling relationship explains the working alliance between the counselor and client. The sample of 161 participants were surveyed on the working alliance with clients (Horvath & Greenburg, 1989), use of social influence in the counseling session (Raven, Schwarzwald & Koslowsky, 1998), and gender self-definition/self-acceptance (Hoffman et al., 2000). A demographics questionnaire provided participant data on the biological sex, age, race, and number of years working as a practicing licensed counselor. This questionnaire also provided information on the counselor setting within which the participants work. The degree of socially desirable answers was evaluated (Crowne & Marlowe, 1960).

Multiple regression analysis was used to analyze the data. Results revealed that harsh and soft power bases, gender self-definition, gender self-acceptance, and biological sex combined to significantly predict the quality of the working alliance, explaining 11.8% of the variance. Harsh power base was the strongest significant predictor in the equation. Results indicated that as harsh power base scores increased, the quality of the

working alliance decreased. As gender self-definition scores increased, the quality of the working alliance decreased. As soft power base and gender self-acceptance scores increased, the quality of the working alliance increased.

Supplemental analysis revealed (a) statistically significant correlation between harsh and soft power bases, and (b) statistically significant correlation between gender self-definition and gender self-acceptance. Findings support the importance of counselor characteristics regarding use of social influence in the counseling session and the degree of gender self-definition/self-acceptance to build a quality working alliance between the counselor and client. The research provides demographic data on the participants. A discussion of the pilot study results, survey instruments, multiple regression analysis, supplemental analysis, implications/recommendations of the study and directions for future research are presented.

Approved: _____

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CHAPTER I: INTRODUCTION

Counselors strive to establish a strong working alliance with their clients consistent with literature demonstrating since a strong relationship between the quality of the working alliance and positive treatment outcomes. A working alliance focuses on the collaborative relationship between the client and the counselor, as well as the ability of both to negotiate treatment goals and tasks that are appropriate to the relationship (Bordin, 1979; Horvath & Greenberg, 1989; Horvath & Symonds, 1991; Luborsky, 1976; Marmar, Weiss, & Gaston, 1989; Marziali, 1984; Strupp & Hadley, 1979). This alliance in the counseling setting is seen as an active agent in the change process (Borders, 1979, 1994; Safran & Muran, 2000).

Counseling has also been described as involving social influence, where each counselor develops an individualized method of exerting influence within the counseling setting. Typically, this method is developed through a trial and error process. The counselors' preferences affect their choices regarding the use of social influence. But counselors are not immune to the effects of learned stereotypic social roles on power structures within a counseling setting, and one major stereotypic role is gender identity (Robyak, 1981). Male and female differences in access to personal power have been identified (Carli, 1999), but there has also been an inconsistency and variability in the degree of differences.

Previous research has frequently studied the impact of gender identity based upon biological sex, yet it has been proposed (Kaschak, 1992; Levant, 1996) that it is not one's physical sex that determines gender identity. Rather, it is the way in which one has

learned what it means to be male and female. Gender identity is seen as socially rather than biologically constructed. It is this gender identity that influences one's choices regarding attitudes and opinion (Bem, 1996).

Research indicates that gender identity influences one's choices. In a 2006 study, Seem and Clark replicated the work of Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970). They found that counselors-in-training continue to hold different standards of mental health for women, men, and healthy adults. Hinkleman and Granello (2003) found that gender role adherence predicted the level of tolerance for mental illness. Gold and Hawley (2001) found that counselors-in-training displayed a lack of flexibility for nontraditional gender roles.

Therefore, a counselor's choice regarding the use of social influence in the counseling setting becomes more a question of that counselor's gender identity rather than of biological sex. And, since clients rate collaborative techniques highly, the type of influence chosen by the counselor influences the quality of the treatment relationship (Busseri & Tyler, 2003; Hinkleman & Granello, 2003).

Background of the Study

Examination of a counselor's gender identity and how that identity impacts the use of power within the counseling session could assist in the development of a strong working alliance with clients. Research indicates that female counselors seem better able to form therapeutic bonds than male counselors (Werner-Wilson, Michaels, Thomas, & Theisen, 2003). But this difference could be due to gender identity in the area of male independence versus female interrelatedness (Benetti-McQuoid & Bursik, 2005; Pollack,

1992; Werner-Wilson et al.) and the resulting impact on the use of social influence within the counseling setting. Working alliance, the counselor's use of social influence, and the gender identity of the counselor will be explored more fully.

Working Alliance

The counseling relationship is an element that counseling theories endorse as being of primary importance (Hall, 2004; Lambert & Cattani-Thompson, 1996). It is one of the most intimate relationships that an individual may have, with significant amounts of emotion and facts being shared. Qualities of caring, such as warmth, support, understanding, and acceptance have been emphasized. Bordin (1979) was one of the first researchers to use the term "working alliance" in the field's efforts to explore this relationship.

A strong working alliance has been found to be one of the key predictors of positive outcomes in treatment (Bordin, 1979; Horvath & Symonds, 1991; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Krupnick, Stoksy, Simmens, Moyer, Elkin, Watkins, & Pilkonis, 1996) and of client change. Bordin (1979) describes this working alliance as one between a person seeking to make changes in his or her life and the person offering to be a change agent. He contends that this alliance can occur within many types of relationships (i.e., teacher and student, leader and group) and consists of three distinct parts – goals, tasks, and bonds – where treatment is going, how the client and counselor will get there, and the level of warmth and understanding that they share. The mutual agreement and collaboration between the client and counselor within these three parts is important.

In fact, the strength of this collaboration seems more important than the particular counselor's method of treatment (Bordin, 1979; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). In a 1991 meta-analysis, Horvath and Symonds found therapy outcomes were positively related to the quality of the working alliance. More recently Martin et al. (2000) conducted a meta-analysis, and the results continued to demonstrate a positive relationship between working alliance and outcomes.

The quality of the "bond" aspect of working alliance has been identified as very important for clients (Fitpatrick, Iwakabe, Stalikas, 2005; Mallinckrodt, Gantt, & Coble, 1995). However, much less attention has been given to how this bond is achieved, and which counselor factors contribute to and maintain a good working alliance. Research has shown that counselors who are perceived as empathetic, nonjudgmental and congruent are more likely to be open and responsive. This openness and responsiveness allows the counselors to fit their treatment approaches to the needs of the client (Lietaer, 1992; Safran & Segal, 1990; Stiles, Honos-Webb, & Suko, 1998; Watson & Gellar, 2005; Watson & Greenburg, 1994).

These same qualities of empathy, acceptance and congruence have been positively related to treatment outcomes (Asay & Lambert, 2001; Bohart, Elliott, Greenberg, & Watson, 2002; Orlinsky, Grawe, & Parks, 1994). Clients report strong therapeutic alliances with counselors using collaborative qualities (Evans, Kincade, Marbley, & Seem, 2005; Fitzpatrick et al., 2005). They rate collaborative dimensions such as insight, increased awareness of feelings and experiences, and the progress made on the presenting problem highly.

Use of Social Influence in the Counseling Relationship

Foucault (1980, 1982) states that power cannot be separated from the social context. Therefore, power is tied to the counseling relationship. The counselor, by virtue of having the skills needed and the ability to provide help to the client, is in a position of power. The counseling takes place on the counselor's territory and the client has to conform to the procedures in that territory. If the client is struggling with a sense of powerlessness, the power choices of the counselor becomes critical.

French and Raven (1959) developed a typology of social power that described different power bases through which social influence is employed. According to this model, the extent to which a person, P, is influenced by another person or group of people, O, depends upon the relationship and how P perceives O. The model describes five power bases: reward, coercive, expert, legitimate and referent. Therefore, when the counselor is seen as possessing reward power, the client recognizes the counselor has the ability to give rewards. If the counselor uses coercive power, the client links the counselor with the potential to give out punishment. Expert power refers to the level of expertise that clients believe the counselor possesses. Legitimate power occurs when clients believe that the counselor has the right to exert power over them. Finally, referent power describes the likeability of the counselor (Carli, 1999).

Counselors' intention in their use of power is to influence their client in a positive way. The difficulty lies in the reality that many of the clients seeking the services of a counselor may already feel so stripped of power within their own lives that they see the exercise of power as being one-way. The need for approval from the counselor can also

affect the choices and behaviors of the client. Although the original intent of the power bases of reward and coercive power were in terms of tangible rewards and physical threats, the fear of rejection or disapproval can serve as a powerful coercive force in a client's life (Raven, 1992).

Another aspect of social influence is the motivation of the counselor (or influencing agent.) Are they attempting to satisfy a personal need? Does the counselor seek higher self esteem or independence? Take for example the setting of the counseling, typically the office of the counselor. Diplomas and licenses are displayed upon the walls. The arrangement of the desk and chairs that place the counselor behind a desk, and the counselor's professional attire all speak silently to his/her position as expert (Raven, 1992). The motives of the influencing agent will, in part, determine the type of power used.

Gender Identity and the Quality of the Working Alliance

It has been proposed that men and women use power differently (Johnson, 1976). Research has demonstrated that women tend to utilize more indirect forms of power (i.e., referent) and men gravitate towards the direct forms of power (i.e., expert and legitimate) (Carli, 1999; Johnson, 1976). This has partly been explained as a difference in an access to social and interpersonal power, with men possessing greater access than women (Depret & Fiske, 1993; Johnson, 1976; Kanter, 1977; Lips, 1991; Lorber, 1998).

Yet research has produced mixed findings in the area of counselor effectiveness and gender. The inconsistency of the results may have to do with gender identity, rather than with biological sex. In counselor preference research, participants are given an a

priori set of attributes upon which to base their preference decisions (i.e., African American or white, female or male, old or young), therefore limiting the options of preference (Speight & Vera, 2005).

In a 2005 archival study of 881 university counseling center clients, Speight and Vera asked their participants to describe their preference of counselor characteristics. Only 38.9% of the clients expressed any preference, and out of this percentage, preferences for male or female counselors were expressed most frequently. Women were preferred as counselors over men, and if the client presented with emotionally-laden issues, they were more likely to state a preference.

Hinkleman and Granello (2003) studied the tolerance of mental illness by biologic sex and by gender role orientation. They found that biologic sex was not a significant predictor of tolerance, but gender role orientation did predict tolerance for mental illness. This study demonstrates an apparent over-reliance on biologic sex as a variable in research (Bem, 1996; Hinkleman & Granello, 2003).

Are these client preferences an indication of male and female stereotypes? Are clients' perceptions of women as nurturing and caretaking influencing clients' beliefs about the effectiveness of female counselors? In another field-based study, researchers found that when given an opportunity to choose, clients chose counselors that they liked better and felt were more helpful. The decision was based on the "bond" that was formed between the client and counselor rather than the gender (Alexander, Barber, Luborsky, Crits-Christoph, and Auerbach, 1993; Speight & Vera, 2005).

Statement of the Problem

Research has explored the affect of biologic sex, gender identity, and the counselor's use of social influence on the quality of the counseling relationship. However, little is understood about how these variables combine to increase or decrease the working alliance between the counselor and client. Research has demonstrated that males and females use power differently (Carli, 1999; Johnson, 1976). Research has also shown that clients report strong working alliances with counselors using collaborative qualities (Evans et al., 2005; Fitzpatrick et al., 2005). How does gender identity, combined with the use of power in the counseling session, affect the working alliance?

The purpose of this study was to investigate how a counselor's biological sex, gender self-confidence (which includes gender self-definition and gender self-acceptance) and the counselor's use of social influence (which includes soft and harsh power bases) within the counseling relationship enhances or detracts from the working alliance between the counselor and the client. This was achieved by using the responses of practicing counselors. Therefore, the focus of this study written as research question was: How well do the counselor's biological sex, gender self-definition, gender self-acceptance and the counselor's use of social influence (both soft and harsh power bases) in the counseling setting explain the quality of the working alliance? This study explored the relationship between the counselor's biological sex, gender self-definition, gender self-acceptance, and the counselor's use of soft and harsh power bases within the counseling session, and the quality of the working alliance between the counselor and client.

Research Hypotheses

This study addressed the following hypothesis:

Hypothesis:

The counselor's biological sex, gender self-acceptance, gender self-definition, soft power base and harsh power base within the counseling relationship explains the quality of the working alliance between the counselor and client.

Null Hypothesis:

There is no relationship between the counselor's biological sex, gender self-acceptance, gender self-definition, soft power base and harsh power bases in the counseling session and the quality of the working alliance. The null hypothesis is represented by the equation H_0: $R^2 = Ø$.

Significance

This study is significant to clients, counselors, and counselor educators because of the theoretical and practical implications. Research that expands the understanding of what promotes effective counseling will benefit the field. A quality working alliance has been shown to have a consistent relationship with treatment outcomes (Horvath & Symonds, 1991) therefore increasing the field's understanding of how such a working alliance can be enhanced promotes successful treatment outcomes.

Additionally, this researcher has found limited research examining the correlation of gender self-concept, social influence and working alliance. Increased understanding of the relationship gender self-concept and social influence to the working alliance will

demonstrate the importance of self-awareness to educators and practitioners. The counselor's choices regarding the use of social influence can become more purposeful.

Limitations and Delimitations of the Study

The delimitations of this study include the boundary of studying practicing counselors in the state of Ohio who have attained the PCC (Professional Clinical Counselor) licensure. Participants who do not meet these requirements were not included in the study. Since Ohio was the only state from which data was gathered, a further delimitation was the possibility of a geographic influence on the study.

Also, this study utilized self-report tools, establishing some limitations. First, there was a possibility that the counselors would choose socially desirable responses for the questions. In order to address the possibility of this limitation, the researcher will include the Marlowe-Crown Social Desirability Scale (Crowne & Marlowe, 1969; Zook & Sipps, 1985) in the survey sent out to potential participants, Secondly, due to the nature of the tools, there was little opportunity to examine the answers on these tools in any great detail. And finally, the work settings of the participating counselors varied, which had a potential impact on some of the responses on these tools.

Additionally, the study accessed responses from practicing counselors of at least two years in the field. The information gained from this research may not generalize well to providers of counseling that have been trained in other philosophies.

Definitions of Terms

The terms used in this study are defined as follows:

Working alliance: Conceptualized as containing three components: goals, task, and bond. Goals are the agreed upon outcomes of treatment, tasks are the behaviors and changes in cognition that occur throughout the treatment process, and the bond is the liking and attachment between the counselor and the client (Bordin 1979; 1994; Fitzpatrick et al., 2005; Werner-Wilson et al, 2003). This bond, and the agreement upon goals and tasks defines therapeutic alliance (Luborsky et al., 1997; Horvath & Symonds, 1991; Krupnick et al., 1996; Martin et al., 2000; Watson & Geller, 2005)

Social influence: A change in the beliefs, attitudes and behavior of a person as a result of the actions or presence of another person or group of people (French & Raven, 1959; Raven, 1992).

Social power: The potential for social influence (French & Raven, 1959; Raven, 1992).

Gender role identity: The degree to which a person adheres to a social, but not necessarily a personal construction of masculinity and femininity based upon the situational context in which they live their lives (Basow, 1992; Bem, 1996; Hinkleman & Granello, 2003; Kaschak, 1992; Levant, 1996; Mintz & O'Neil, 1990).

Gender self-concept: Perception of oneself as a man or woman, whether or not there is a secure conviction of maleness and femaleness; broader than gender identity (Hoffman, Borders, & Hattie, 2000).

Gender identity: A person's concept and secure conviction of his or her maleness or femaleness (Golombok & Fivush, 1994; Hoffman et al., 2000; Money, 1994).

Gender self-confidence: the intensity of one's belief that she/he meets her/his personal standards for femininity/masculinity (Hoffman et al., 2000).

Gender self definition: how strong a part of an one's identity he/she believes his/her self-defined sense of masculinity or femininity to be (Hoffman et al., 2000).

Gender self-acceptance: how comfortable an individual is with his/her gender (Hoffman et al., 2000).

CHAPTER II: REVIEW OF THE LITERATURE

Researchers have identified the importance of a working alliance between a counselor and client. The quality of this alliance has been found to have a relationship with the outcome of treatment (Horvath & Symonds, 1991; Martin et al., 2000). However, there are many moderating variables involved in the development of this alliance. Among these variables are the gender identity of the counselor and the choices the counselor makes regarding the use of power within the counseling relationship. These variables are important to address in the effort to more fully understand the development of a working alliance.

Working Alliance

The concept of a working alliance is first found in psychoanalytic literature. Sigmund Freud (1912; 1994) was the first to use the term collaborator to describe the patient role with the doctor. He argued that the doctor needed to ally with the patient and viewed the treatment situation as a pact focused on giving control of mental life back to the patient. Freud saw positive transference as the vehicle of success for treatment, but did not discuss alliance.

The term therapeutic alliance was introduced by Zetzel (1956), beginning the distinction between transference and alliance. She suggested that it was a form of positive transference and necessary as a prerequisite for successful analysis. Anna Freud (1954) stated that there needed to be a space left within the concept of transference for the relationship between analyst and patient. Sterba (1934) emphasized the importance of the contract between the rational ego of the patient and the analyst, stating that the analyst

used the term “we” to encourage a partnership between the analyst and that part of the patient’s ego that was in touch with reality. Menninger (1958) described the significance of the therapeutic contract. In this treatment contract it was not just the reactions of the patient that were important. The analyst was also a person and was reacting, even if the primary reaction seen by the patient was one of quiet listening.

Greenson (1967) was the first to use the term ‘working alliance’. He stated that the patient had the capability to work consciously and purposefully on treatment goals, continuing the differentiation from the psychoanalytic concept of transference. He argued that this working alliance was the real relationship in the treatment setting, and not that of transference. He described how these two concepts (working alliance and transference) were interconnected but very different aspects of treatment. He went on to define three concepts of this alliance: transference, working alliance, and the real relationship. He described this alliance as one that could utilize either transference or the real aspects of the relationship to further the work of analysis.

The concept of alliance in the current study is based on the work of Edward Bordin. Bordin (1979, 1994) defined a working alliance as a pantheoretical conceptualization of the “alliance between the client seeking change and the therapist offering to act as a change agent” (Bordin, 1994, p. 13). Working alliance was described as the major ingredient that allowed a patient to accept and work within the treatment relationship. This alliance incorporated a mutual understanding and agreement on the goals, an assignment of tasks that were needed to move towards these goals and the development of bonds between the client seeking change and the change agent. He

emphasized negotiation regarding goals and tasks as a crucial step in building alliance between the client and counselor.

Bordin (1979, 1994) asserted that the counselor conducts a thoughtful search with the client for the treatment goal that seems to cover the most important aspects of the client's struggles. The client may be eager to work on this goal, or the goal may be more than the client can handle. The negotiation between the client and the counselor results in the selection of a treatment goal that the client feels capable of pursuing. The client must understand the importance of treatment activities, but it is the counselor who selects the activities (Bordin, 1994).

The therapeutic bonding between the client and counselor occurs as a result of "their experience of association in a shared activity" (Bordin, 1994, p. 16). It is expressed "in terms of liking, trusting, respect for each other, and a sense of common commitment and shared understanding in the activity" (p. 16). When the negotiation of goals and tasks are based upon bonds of mutuality, there can be enough strength in the therapeutic relationship to withstand the strains involved in the process of change.

The counselor must pay attention to the client's presentation of the problem in order to achieve this mutual goal. The counselor's efforts are directed towards identifying a goal that is in keeping with what the client is presenting, and then obtaining agreement from the client that this is the correct goal. Even though this process is a mutual one, the counselor has the "greater knowledge and experience" and "these differences, when there, are to be expected…they represent an asset of knowledge of the terrain over which a journey will pass" (Bordin, 1994, p. 22).

Bordin describes this concept of working alliance as one that focuses primarily on the mutual collaboration of the change seeker and the change agent, and less on the expectations. A client's readiness to collaborate on goals and tasks may be a result not only of the struggle leading the client to treatment, but also of environmental pressures and supports. Bordin suggests that these sets of experiences for both the client and the counselor be discussed openly in order to establish a strong alliance (Bordin, 1979, 1994; Strong, 1968).

Bordin's concept of working alliance diverges from Rogers' (1957) emphasis on the therapist's ability to be empathetic, congruent and unconditionally positive. Rogers' emphasis is on the therapist's actions rather than on the collaboration between the therapist and client. Bordin also differs from Strong's (1968) emphasis on the interpersonal influence of the counselor. Instead, Bordin emphasizes the interdependence between client and counselor. His concept is one that focuses primarily on the process of reaching an agreement on the goals and tasks of treatment. The concepts of goals, tasks, and bond involve collaboration and joint purpose. It is the vehicle that facilitates effective treatment (Bordin, 1979; Freud, 1912/1994).

Bordin's conceptualization of alliance has been recognized in research as one that has contributed greatly to the understanding of alliance (Horvath & Symonds, 1991; Martin et al., 2000). Several measurement scales have been developed which have built partly upon Bordin's work. These include the Vanderbilt Psychotherapy Process Scale (Gomes-Schwartz, 1978; Hartley & Strupp, 1983), the Therapeutic Alliance Rating Scale (Marziali, Marmar, & Krupnick, 1981), and the California Psychotherapy Alliance Scales

(Marmar, Gaston, Gallagher, & Thompson, 1989). One measurement scale, The Working Alliance Inventory (Horvath & Greenburg, 1986, 1989), was developed to directly measure Bordin's three aspects of alliance (goal, task, and bond).

Research Into the Construct of Alliance

Horvath and Symonds (1991) conducted a meta-analysis on the quality of the working alliance to treatment outcome. Horvath and Symonds searched the major data bases and completed a manual search of the prior 12 months of published articles. Horvath and Symonds uncovered 24 studies that investigated the relationship construct of a working alliance. These studies had a quantifiable measure between alliance and outcome, and had at least five participants who were involved in individualized treatment. The product moment correlation coefficient between the alliance and the outcome was the measure. They found a "moderate but reliable association" (estimated effect size of .26) between good working alliance and positive treatment outcome (Horvath & Symonds, 1991, p. 139). The client's and observer's ratings of working alliance were most predictive of treatment outcomes.

In another meta-analysis Martin et al. (2000) identified 58 published and 21 unpublished studies relating alliance to outcome. This analysis used the same inclusion criteria as the Horvath and Symonds (1991) meta-analysis. Martin et al described a "moderate but consistent" relationship between working alliance and outcome with an estimated effect size of .22 (Martin et al, p. 438). These findings were consistent despite the presence of confounding third variables that had been thought to influence the therapeutic relationship. Although counselor ratings of working alliance were slightly

less predictive of outcome, they were still within the acceptable range. Clients tended to rate the alliance more consistently than therapists or observers, indicating that clients viewed alliance as more stable.

Tyron, Blackwell, and Hammil (2007) conducted the most recent meta-analysis of working alliance, focusing on the correlation and mean difference between counselor and client alliance ratings. They used 53 studies published between 1985 and 2006, and included studies based on criteria used in the Horvath and Symonds 1991 meta-analysis. They found a moderate correlation (.36) between counselor and client ratings of alliance, with client ratings higher (.63) than that of counselors.

Moderating Variables of Alliance

Research has shown a strong relationship between alliance and outcomes, but criticisms have been directed towards the failure of these studies to control for possible moderating variables. These moderating variables include early improvement in treatment (between the baseline condition for the client and the time when the first measurement of alliance is given), length and type of treatment, counselor experience, counselor use of clinical techniques, client factors (such as client disturbance and biological sex), and counselor personality and interpersonal style (Crits-Christoph & Gibbons, 2003; Horvath & Symonds, 1991; Martin et al, 2000; Tyron et al, 2007).

Rochlen, Rude, and Baron (2005) found that a client's readiness for change and perceptions of the relationship with the counselor powerfully predicted the outcome of short-term therapy in a sample of college students seeking treatment. Likewise, Darchuk (2007) found that treatment readiness in adolescent substance abusers and their ratings of

the alliance predicted positive treatment outcomes. Tyron et al. (2007) found that clients with mild disturbances and substance abuse had the greatest amount of discrepancy between client and counselor ratings of alliance. They hypothesized that this might be due to the fact that substance abuse counseling was often offered free of charge to clients, and that the mildly disturbed clients were often volunteers. Ratings for substance abuse clients and mildly disturbed clients accounted for most of the residual variance in the data, based on counselor experience, length and type of treatment, client disturbance and alliance measures (Rochlen et al.). Goldman (2005) found that the more comfortable a client was with closeness and intimacy, the higher the client rated the working alliance.

The Martin et al. (2000) meta-analysis conducted a test of homogeneity on the 79 studies included in the analysis. This test indicated that the overall weighted alliance-outcome correlation was .23 (n = 67, SD = .10) with an estimated population variance of zero. Even when this overall alliance-outcome correlation was disaggregated by the various moderator variables, the model failed to account for additional variance. Only when the overall correlation was disaggregated by the alliance scale used could the additional variance be accounted for (Crits-Christoph & Gibbons, 2003; Martin et al.). Likewise, the Horvath and Symonds 1991 meta-analysis examined homogeneity among the studies included. Similar to the Martin et al. study, there was no single variable that systematically biased the results. These meta-analyses (Crits-Christoph & Gibbons; Horvath & Symonds, 1991; Martin et al.) could not identify a specific aspect of working alliance that better accounted for the correlation of alliance and treatment outcome. One group of moderating variables involves counselor characteristics. One of these counselor

characteristics is gender and it is the characteristic of gender that is of particular importance to this study.

Alliance and Gender

Gender (biological sex) and its relationship to alliance has been the subject of some research. Werner-Wilson (1997) found that female clients rated working alliance in marital therapy higher than in family therapy and male clients rated working alliance in family therapy higher than in marital therapy. These results were based on a self-report alliance measure and the author was not able to identify specific factors behind this difference. Delany (2006) found that female clients in marital therapy rated working alliance higher than male clients (female clients, $F(5,37) = 15.55$, $p < .001$; for male clients, $F(5,37) = 5.45$, $p = .001$). In a 2005 study, Thomas, Werner-Wilson and Murphy utilized taped initial session between 112 student and master level therapists and their clients (one adult male and one adult female in a romantic relationship). Using the Working Alliance Inventory (WAI; Horvath & Greenburg, 1989) and a coding system (performed by four graduate level students unaware of the purpose of the study) Thomas et al. found that male clients in marital therapy rated working alliance more highly when the counselor challenged them and offered advice (for goal subscale, $B = .69$; for task subscale, $B = .77$; for bond subscale, $B = .30$). Male clients rated the alliance lower for counselors who did not provide some type of protection from negative statements made by their romantic partner (for goal subscale, $B = -.23$; for task subscale, $B = -.21$; for bond subscale, $B = -.36$). Female clients also rated working alliance more highly when the counselor challenged them (for goal subscale, $B = .10$; for task subscale, $B = .53$; for

bond subscale, $B = .19$), but their ratings of alliance did not change when their romantic partners made negative statements. Women did, however, rate working alliance more negatively when their partners challenged them in session (for goal subscale, $B = -.40$; for task subscale, $B = -.55$; for bond subscale, $B = -.48$). In 2004, Symonds and Horvath found that when male clients in couples therapy rated the alliance highly, or when male clients' ratings of alliance improved, the correlations between alliance and outcome were the strongest, ranging from $r = 0.35$ ($p = .13$) to $r = 0.60$ ($p = .01$). Bourgeois, Sabourin, and Wright (1990) studied 63 marital couples involved in skills training and found that male clients' ratings of alliance had a more consistent connection to outcome than their female partners (Dyadic Adjustment Scale = 7%, Marital Happiness Scale = 5%, Potential Problem Checklist = 8%). In their 1995 research, Courchaine and Loucka (1995) found a significant interaction between gender and the discrepancy between the counselor/client interpretations, $F(1, 136) = 3.18$, $p < 0.08$. Females rated working alliance more highly when the counselor's interpretations more closely matched their own, while males rated alliance more highly when there was a moderate discrepancy between their interpretations and the counselor's interpretations.

Alliance and Social Influence

In a 1995 study, Courchaine and Loucka studied working alliance, clients' reactance (oppositional behaviors), and the counselor's interpretation and social influence. Low reactant participants viewed tentative counselor interpretations more highly, while highly reactant participants viewed absolute counselor interpretations more highly. Chris-Christoph, Barber, and Kurcias (1993) evaluated working alliance and

counselor interpretations, finding that counselor accuracy in interpretation significantly predicted the development of alliance.

There have been remarkably few studies exploring the relationship between gender (biological sex) and working alliance (Blanton & Vandergriff-Avery, 2001; Bourgeois et al., 1990). Many alliance studies contain heterogeneous samples of clients, but fail to break down the alliance-outcome correlation by biological sex (Martin et al., 2000). Additionally, the relationship between gender identity and alliance remains unexplored.

Working alliance is defined for this study according to Bordin (1994). It is defined as the "alliance between the client seeking change and the therapist offering to act as a change agent" (Bordin, 1994, p. 13). Working alliance includes three components: goals, task, and bond. It incorporates a mutual understanding and agreement on treatment goals, an assignment of tasks that are needed to move towards the goals and the development of bonds between the client seeking change and the therapist. This study will conduct an investigation into the variables of gender identity and the counselor's choice of social influence within the counseling session in the formation of alliance. Gender identity is a concept separate from gender (or biological sex) as it has been historically measured in alliance research.

Gender Identity

Gender role orientation refers to the social construction of gender identity based upon the situational context in which an individual lives his/her life (Bem, 1996; Hinkleman & Granello, 2003; Kaschak, 1992; Levant, 1996). It is the way through

which an individual perceives whether personal choices are appropriate for the culture's idea of being male and female.

Historically, this definition of gender role orientation has been a basic organizing principle of human culture (Barry, Bacon, & Child, 1957; Bem, 1981; Meade, 1949). Even though societies differ, all assigned roles were based upon the biological sex of the adult. For example, males tended to be assigned the roles of hunter and warrior due to their greater physical strength. In 1957 Barry et al. conducted an ethnographic study of one hundred and ten non-literate cultures. These cultures were chosen based upon an adequate collection of ethnographic reports on socialization practices. Information regarding the socialization of infants and children was included and separate ratings for male and female children were conducted when possible. The sex differences in child socialization pressure for nurturance, obedience, responsibility, achievement, and self-reliance were explored. Pressure for female children to be nurturing was found in 82 percent of the cultures, but was not evident in the socialization of male children at all. Male children were socialized toward achievement in 87 percent of the cultures. Only 3 percent of cultures pressured female children towards the same achievement. Male children were also encouraged to be self-reliant in 85 percent of the cultures and there was no evidence of the same pressure for female children.

The socialization patterns were similar in many of the cultural settings studied by Barry et al. (1957). These patterns derived from different roles (both biological and socio-economic). Males were more frequently assigned the task of leaving home and engaging in activities such as hunting and acting as protectors/warriors. Emphasizing

achievement and self-reliance would prepare the male children for these activities. Females were more likely to be assigned roles nearer to home, such as childbirth (due to biological assignment) and caring for others. Emphasizing nurturance in female children would prepare them for these biological/economic roles. Differences in socialization based upon biological sex were a widespread adaptation of culture to the biology of human beings (Barry et al., 1957; Block, 1973).

While the Barry et al. study (1957) did show strong tendencies in the socialization of children, these tendencies were not completely uniform. Large sex differences in socialization were found in cultures where the economy emphasized superior physical strength and motor skills characterized by the males. Large sex differences in socialization were also found in cultures where there were large family groups, such as with polygamy and strong extended families. When a nuclear family was relatively isolated, both the male and female had to be prepared to take over the other's role in the event of incapacitation. Strong sex differentiation could not be too great in this situation. But in a large family system sex differentiation was not a handicap, since the female or male role could temporarily be taken over by another male or female.

Block (1973) studied six Western, technological countries and their gender role stereotypes. These countries included Norway, Sweden, Denmark, Finland, England, and the United States. She utilized adjectives describing the kind of person the participants would most like to be (ideal self). University students of these six countries were compared across sexes and across countries, and the study found a strong cross-cultural stability in masculine-feminine ideals. Adjectives that males emphasized included

ambitious, independent, assertive and competitive. Females tended to endorse adjectives such as generous, sympathetic, loving, sensitive and artistic.

Block's 1973 study also found differences in how these countries emphasized the stereotypes surrounding masculine and feminine ideals. The United States had the strongest emphasis for males on the adjectives incorporating the impersonal individualistic ideal. Bakan (1966) described the relationship of this ideal to capitalism, stating that capitalism required the exaggeration of these characteristics. Two of the countries, Sweden and Denmark, had long histories of commitment to social welfare. They demonstrated the least difference between males and females, bringing further reinforcement to the possibility that there could be differences in the definition of masculine and feminine.

Development of Gender Role Orientation

Children learn masculine and feminine traits within the family and society (Brewer, 2001). Mead (1949) stated:

> Children's experiences in a world in which the adults already have a way of life become in turn the stuff out of which they, as adults, are able either to conform to use, or to rebel against and change, their ways of life. In following the steps by which the infant learns his civilization, we are tracing a process of transmission, not one of creation. (p. 61)

The child gradually develops concepts of masculinity and femininity and then attempts to match behaviors to these concepts. The transmission of the concept of masculinity and femininity is organized from a wide variety of sources (Maccoby & Jacklin, 1975).

These lessons begin with the example set by parental influences, sibling relationships and teachings. Children actively search for ways to make sense of the world around them and use gender cues to help them understand what they see and hear (Martin & Ruble, 2004). They observe their parents' relationship and the division of labor between their mother and father. They observe the differences in treatment between their brothers and sisters. They observe the ways in which their parents make decisions, pay attention to the attitudes and values their parents display, and watch the extended family interactions. They make social comparisons from what they observe in their environment, and then make decisions about what is expected from males and females (McHale, Crouter, & Whiteman, 2003).

Even children from nontraditional family settings display conventional gendered behaviors. Boys raised in single parent, mother headed households tended to be less stereotypical in their behaviors, but the difference tended to be small. Russell and Ellis (1991) found a significantly higher percentage of individuals raised in single parent homes were androgynous (a mixture of masculine and feminine traits) than were individuals raised in two-parent families (57% of single-parent participants versus 36% of two-parent participants). Stevenson and Black (1988) conducted a meta-analysis of every study they could find comparing father-present and father-absent children on a measure of sex typing. The final sample included 67 studies with 222 effect sizes. They found few generalizable differences in father-present and father-absent females. Father-absent females were slightly less feminine than the father-present females. Male children seemed to be more effected by the differences in family structure, with a weighted

estimator of effect size that was significantly different from zero. Roberts, Green, Williams, and Goodman (1987) found that a father's presence in the home was positively related to the development of masculine behaviors in male children. Research conducted with children of lesbian mothers found that girls were less stereotypically feminine than girls from heterosexual parents (Green, Mandel, Hovedt, Gray, & Smith, 1986). Again the difference was small. Children from nontraditional families tended to fall within stereotypical gendered behaviors. The development of gender role orientation came about from more than just family structure. Children observed the nature and division of housework (such as who washes the dishes or does the laundry), paid work (going to a job) and child care (putting the children to bed or playing tag). They observed the patterns of decision making (i.e., who is in charge), as well as the values and attitudes of their parents.

Gender role orientation continues to develop through ongoing social exchanges (Hoffman, Hattie, & Borders, 2005). These social exchanges tend to define femininity and masculinity in stereotypical ways. The American Heritage Dictionary (1992) defines stereotype as "a conventional, formulaic, and oversimplified conception, opinion, or image" (p. 1762). Society exerts pressure to conform to these stereotypes and to minimize the importance of individual differences (Hoffman et al., 2000). These social expectations or rules regarding gender are "understood" by the members of society and provide a foundation to the development of gender identity (Mahalik, Morray, Coonerty-Femiano, Ludlow, Slattery, & Smiler, 2005).

Hoffman et al. (2005) found that men and women typically viewed themselves in stereotypical ways. Participants in their study included 273 female and 98 male undergraduate students from a moderately sized university in the southeastern region of the United States. The researchers asked the question "What do you mean by femininity (masculinity)?" which yielded 14 categories or themes. Women strongly endorsed biologic sex (31.4%), expressive/relational (29.5%), societal standards as in displaying characteristics that are in keeping with the socially constructed norm (21.4%), and gender self-confidence (20.5%). Men responded the most significantly to being forceful/aggressive (35%), followed by biological sex (31.3%), and societal standards (22.5%).

Gender role orientation has an influence on perceptions of appropriate emotional responses. For example, grief is often categorized in terms of "feminine" (e.g., open expression of emotion, asking for support) and "masculine" (e.g., cognitive, problem-solving) responses. Society historically has given more sympathy to individuals who stereotypically cope with grief (Versalle & McDowell, 2005). For example, Kubitz, Thornton, and Robertson (1989) studied the grief reactions of college age males and females. They found that males who experienced grief with low intensity symptoms (such as feeling slightly sad and having a tightness in the stomach) were viewed as being interpersonally more attractive than males who expressed their grief with high intensity symptoms (such as feeling very sad and sitting alone and crying). Mendelsohn and Sewell (2004) found that male victims of traumatic events received less social approval than female victims. Women given a scenario-based measure tended to experience more

guilt-proneness and shame-proneness (a pattern of responses to certain situations) than men (Benetti-McQuoid & Bursik, 2005).

Crawford (2003) studied humor (a form of discourse that accepts ambiguity, paradox and multiple interpretations of what is real) as a social strategy. Women typically use humor in social situations to build intimacy and a sense of connectedness. Instead of being the center of attention, and building up to the punch line in a linear style, women tend to share the main point and then encourage participation from others while they tell the rest of the story. There is a collaborative quality containing laughter, joking and teasing. Wetherell and Edley (1999) identify three patterns in how males use humor in social situations to establish their masculinity and position themselves socially as males. Constructing masculinity through a heroic ideal (accepting the stereotype of masculinity), being an average guy, or being a rebel (rejecting the social expectations of masculinity) are all argued by Wetherell and Edley as ways males reproduce power.

Gender role orientation teaches men and women which behaviors and attitudes are considered appropriate. Girls are taught to defer to others, make amends when possible and to take care of others (Benetti-McQuoid & Bursik, 2005). They are raised to value the relational attachment to others. Boys, on the other hand, are not taught strong connections to others, but are given validation for independence (Pollack, 1992).

Gender Role Orientation and Personality Theory

This dichotomous way of thinking about gender has been perpetuated by various theorists. In 1965, Gutmann described masculine as impersonal, unpredictable and allocentric (centered on an object for itself rather than its relevance to oneself). He

described feminine as interpersonal, constant, and autocentric (centered on the self). Guttman's formulation parallels Erikson's (1968) observation that girls are more concerned with inner space and boys are more focused on the external world. Bakan (1966) introduced "agency" and "communion." Bakan defined agency as being concerned with the self as an individual and expressing that concern through self-protection, self-expansion, and self-assertion. Communion was defined as the self as it existed within a larger group of which the self was a part and was expressed through being at one with the others in the group. Spence and Helmreich (1978) put forward "instrumentality" (stereotypical masculine traits such as independence and self-confidence) and "expressiveness" (stereotypical feminine traits such as tactfulness and awareness of other's feelings) as descriptions of masculine and feminine characteristics.

Feminist theorists such as Nancy Chodorow (1989) and Carol Gilligan (1983, 1991) emphasized the differences between males and females. Chodorow (1989) looked at the differentiation of the self in the context of object relations theory. She stated that differentiation involved a relational component. Where the formation of the core identity is conflicted for boys it is not conflicted for girls. Girls begin life in connection to the mother and are recognized as similar to the mother. Separation from the mother is not necessary for a girl to form her core identity. However, a boy is recognized as different from the mother and has to separate from the mother in order to ensure formation of his core identity. Gilligan (1983, 1991) challenges that male and female experiences of development are different and that these differences must be acknowledged and addressed. Gilligan views females as relational and males as rational and instrumental.

She states that a woman's development is based on connections and relationships with others, as well as on an ethic of care.

Test developers continued this dichotomous way of viewing masculine and feminine. Terman and Miles developed the Attitude Interest Analysis Survey (AIAS; Terman & Miles, 1936) which identified masculinity and femininity as a pair of opposite traits. Their work became a foundation for researchers in the field (Lewin, 1984). The masculine/feminine scales of the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1941), the California Psychological Inventory (CPI; Gough, 1952), and the Strong Vocational Interest Blank (SVIB; Strong, 1927) followed this dichotomous pattern.

Debate over Gender Role Stereotypes

Debate has occurred that has challenged the adequacy of this bipolar perception. In 1973, Constantinople explored the possibility that the terms masculinity and femininity should be dropped from psychology's vocabulary due to the wide variation in definitions. The definitions of masculine and feminine for most test developers contain the assumptions of unidimensionality and bipolarity, and Constantinople challenged that neither of these assumptions had been tested for applicability to the masculine-feminine construct. In masculine-feminine test construction, the assumption of bipolarity was evident in three ways: the dependence on biologic sex as the criterion for relevance of item selection, the implication that the opposite of a feminine response indicated masculinity, and the use of a single algebraic score that placed the individual on a single

bipolar dimension. She proposed that if the concept of masculinity and femininity could not be measured satisfactorily, then perhaps these concepts did not exist.

Hare-Mustin and Marecek (1988) continue the exploration of viewing masculine and feminine as possessing opposite and mutually exclusive traits. Whether the differences between male and female are emphasized or minimized, male behavior is the standard that all behaviors are measured against. In order to maintain the illusion that a dichotomy exists, the complexities of the human experience must be overlooked. Block (1973) proposes the final goal of sexual identity development is not to become masculine or feminine as these concepts are socially constructed. Instead, Block states the hope that sexual identity will mean "the earning of a sense of self in which there is a recognition of gender secure enough to permit the individual to manifest human qualities our society, until now, has labeled as unmanly or unwomanly" (Block, 1973, p. 512).

Miriam Lewin (1984) called "psychologists' attempts to understand and measure femininity and masculinity a chronicle of failure" (p. 156). She believed the failure to find a valid measure for femininity and masculinity was due to inadequate conceptualization, leading to errors in methodology. She stated that the biggest failure was in the assumption that femininity and masculinity consisted of a set of traits based on sex difference statistics. She listed eight erroneous assumptions that interfered with attempts to measure the masculine-feminine construct. First, none of the tests were validated to measure the differences between more or less masculine men (or more or less feminine women). Second, any appealing item that might measure sex differences was included as a measure of feminine and masculine. Third, masculinity and femininity were

assumed to be opposites (Deaux, 1984; Hare-Mustin & Marecek, 1988). Fourth, masculinity and femininity were thought of as static and unchanging (Deaux, 1984). Fifth, the responses of homosexual men were treated as identical to feminine women. In a critique of the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1943), Lewin (1984) writes "It is rather staggering to realize that the femininity dimension of this popular test was validated on a criterion group of 13 male homosexuals" (Lewin, 1984, p. 181). Sixth, some test users had the assumption that large proportions of the general population had "an unconscious other-sex gender identity" (Lewin, 1984, p. 168). Seventh, the intimate link of the masculine-feminine construct to changing economic, political, and social conditions was ignored, along with the test users' position in the social hierarchy (Hare-Mustin & Marecek, 1988). And finally, the masculine-feminine construct was viewed as a set of personality traits and not as a facet of self-concept (Lewin, 1984).

In the 1970s the concept of psychological androgyny was introduced. Bem (1977) defined psychological androgyny as the possibility for an individual to be both feminine and masculine, assertive and compassionate, or instrumental and expressive, depending on the situation. Block (1973) found that individuals with an androgynous outlook possessed a greater moral maturity. Constantinople (1973) proposed that the concept of androgyny was a byproduct of the bipolar perception connected to the masculine-feminine construct. Within this perception, bisexuality or androgyny became almost necessary in order to explain the complexities of human beings. Deaux (1984) documented a backlash to androgyny in the 1980s, stating that androgyny continued to

rely on the traditional ideas of masculinity and femininity. She asserted the concept of androgyny had not been fully investigated. Before counselors make androgyny a goal of treatment for their clients, they need to identify what an individual living free of the stereotypical masculine/feminine roles looks like. To do this, counselors need to look beyond the concept of androgyny (Cook, 1985).

Gender Role Orientation and Assessment Measures

The dichotomy of masculinity and femininity has also been supported in the tools developed to measure masculine and feminine traits. One of the best known tools is the Bem Sex Role Inventory (BSRI; Bem, 1977, 1981). She based her tool on a gender schema theory. A schema is a network of associations that organize and guide a person's perceptions. The perceptions and actions of the person would reflect the biases that his or her personal schema recognized as acceptable (such as males being assertive and females accommodating). Gender schema theory proposed that the person processes information through sex-linked associations learned throughout the socialization process. This schema becomes a standard or guide, and the person regulates individual behaviors so that it conforms to the definitions of masculine and feminine that has been incorporated into the person's schema. The BSRI contains a masculinity scale of 20 items and a femininity scale of 20 items. There are also 20 items that are considered gender-neutral and are used as a way to assess social desirability in responses. These items are personality characteristics judged to be desirable in American society. They are worded in a positive way (e.g., independent, affectionate) and the test taker rates how each characteristic fits him/her on a 7-point scale. The degree of stereotyping is the person's self-concept. The

BSRI uses a median-split to form four groups: feminine, masculine, androgynous, and undifferentiated. If the person scores much more highly on the masculinity scale than on the femininity scale the person has a masculine gender role. If the person scores much more highly on the feminine scale than the masculine scale the person has a feminine gender role. If the person scores highly on both the masculine and feminine scale the person is androgynous, and if the person has low scores on both scales the person is undifferentiated. Since the median-split method is relatively easy for researchers to score, it may explain the wide use of the BSRI in the research community (Hoffman & Borders, 2001).

In 1990, Beere identified 795 articles and 167 ERIC documents that used this tool. Bem wrote in 1998 that she was shocked at how popular her tool had become. Although Sandra Bem designed the BSRI to allow for the blending of masculine and feminine traits, studies using this tool tended to emphasize the bipolarity of masculine and feminine. This inadvertently reinforced the very stereotypes that the tool was supposed to challenge (Bem, 1981; Deaux, 1984; Hoffman et al., 2000).

There have been many critiques of the BSRI, and Hoffman and Borders (2001) conducted a thorough examination of these concerns through a literature review. They reported investigations on the BSRI's theoretical basis, along with the validity, reliability, item selection, scoring, interpretation, and factor analysis/dimensionality. According to their findings, Bem seemed to indicate that human beings were passive recipients of their gender schema, rather than being capable of complexity. Bem did not recognize a people's ability to participate in their own development process. The validity of the tool

was questioned due to the inconsistencies in the definitions of masculinity and femininity, and an incomplete description of the validity studies that was included in the manual. There seemed to be much less critique of the reliability of the tool, but Hoffman and Borders state "reliability without validity is of questionable value" (p. 47). In regards to item selection, there was continued concern over Bem's inconsistent use of masculinity and femininity, and a lack of explanation of how many items met the selection criteria and how she narrowed the selection down to the chosen items. Bem recommended the median-split technique of scoring and in spite of critiques that this type of scoring could lead to distortion of the data, she did not revise her scoring procedures (Hoffman & Borders, 2001).

The Personal Attributes Questionnaire (PAQ; Spence, Helmreich, & Stapp, 1974) is another well known tool used to measure masculine and feminine traits, second in popularity to the BSRI. Beere (1990) identifies 238 articles and 49 ERIC documents using the PAQ. This 55 bipolar item self-report tool is based upon Spence et al. (1974) definition of instrumentality (prescriptive stereotypes) and expressiveness (descriptive stereotypes). The items are broken down into three subscales: two self-rated classifications (female-valued and male-valued), along with the stereotype rating sex-specific subscale. Test takers are asked to rate each item as it applies to them using a 5-point rating scale. A short version (with 8 items per subscale) is often used. Males tend to score significantly higher on the instrumentality scale and significantly lower on the expressiveness scale than females. Again, the bipolarity of the instrumentality and

expressiveness scale emphasizes stereotypes (Hoffman & Borders, 2001: Spence & Helmreich, 1974, 1975).

Interestingly, the creators of both of these popular tools have voiced their own concerns regarding the use of these tools. Spence stated that the findings from the PAQ could not be generalized to gender role behaviors, limiting the interpretations to those involving instrumentality and expressiveness. She stated that the dimensions of instrumentality and expressiveness needed to be separated out from concepts of masculinity, femininity, and androgyny (Spence & Helmreich, 1980). Bem stated that an individual's behavior should not be viewed as gendered, and that the concept of androgyny contained contradictions that would cause its own destruction (Bem, 1979).

Development of a New Tool and a Paradigm Shift

A paradigm shift has been recommended by Hoffman, Borders, and Hattie in 2000. They propose moving away from the stereotypical conception of femininity and masculinity. They suggest a conception of femininity and masculinity that respects the diverse ways in which individuals perceive femininity and masculinity.

Since early 1970, researchers have been exploring the complexity of the concepts of masculinity and femininity (Block, 1973; Constantinople, 1973; Deaux, 1984; Hare-Mustin & Maracek, 1988; Lewin, 1984). Concerns have been raised by these authors regarding the dichotomy of masculinity/femininity that existed in the field. There did not seem to be an acceptable way to measure the reality of masculinity and femininity in the natural environment. There did not seem to be recognition that males and females made

behavioral choices reflecting both masculine and feminine behaviors within the same person.

Block (1973) studied the differences in gender stereotypes across cultures and argued for the abandonment of narrow definitions of gender roles held over from less civilized times. She called for an integration of masculine and feminine in order to enrich and more truly honor the human experience. Deaux (1984) called for a "conceptual shift" in how gender was viewed. She offered that theories should view gender as "a process that is influenced by individual choices, molded by situational pressures, and ultimately understandable only in the context of social interaction" (p. 115). In 1988 Hare-Mustin and Marecek also challenged the social construction of gender, stating "constructing gender is a process, not an answer…we open the possibility of theorizing gender in heretofore unimagined ways" (p. 462).

Lewin (1984) stated that tests assessing masculinity and femininity should assess gender self-confidence. She wrote:

> the test should measure individuals' beliefs that they are, or are not, living up to various aspects of their personal gender-relevant self-concepts. Do they feel competent as members of their own sex? Are they meeting their own standards of femininity or masculinity? (p. 200)

Although research tools had been developed to measure the concepts of masculinity and femininity (i.e., BSRI; Bem, 1977, 1981; PAQ; Spence et al., 1974), they ended up reinforcing the dichotomy of masculinity/femininity. In spite of the fact that these measures did allow for the blending of masculine and feminine stereotyped

qualities within the same individual, researchers did not emphasize this aspect. Criticisms had also been raised against these measures due to the fact that they had been based upon stereotypes. Hoffman (2001) stated:

> A critical point of agreement in the literature, however, is that both women and men are displeased with and unfulfilled by traditional gender-related restrictions. Restrictive definitions of femininity and masculinity allow only limited expression of both women's and men's humanity. (p. 481)

In 2000, Hoffman, Borders, and Hattie introduced the Hoffman Gender Scale and proposed a paradigm shift in the conception and measurement of femininity and masculinity. Instead of describing femininity and masculinity in stereotypical terms, this tool measures the individual's gender self-confidence as one part of gender identity. Gender self-confidence is defined as the intensity of an individual's belief that he or she meet his or her personal standards for femininity and masculinity (Hoffman et al., 2000; Lewin, 1984). Gender self-confidence allows the individual to decide what masculine and feminine means to them, regardless of whether or not their decisions fit within the stereotypical definitions of their society. Hoffman et al. (2000) created a visual depiction of gender self-confidence. *Figure 1* below is their representation of this conception.

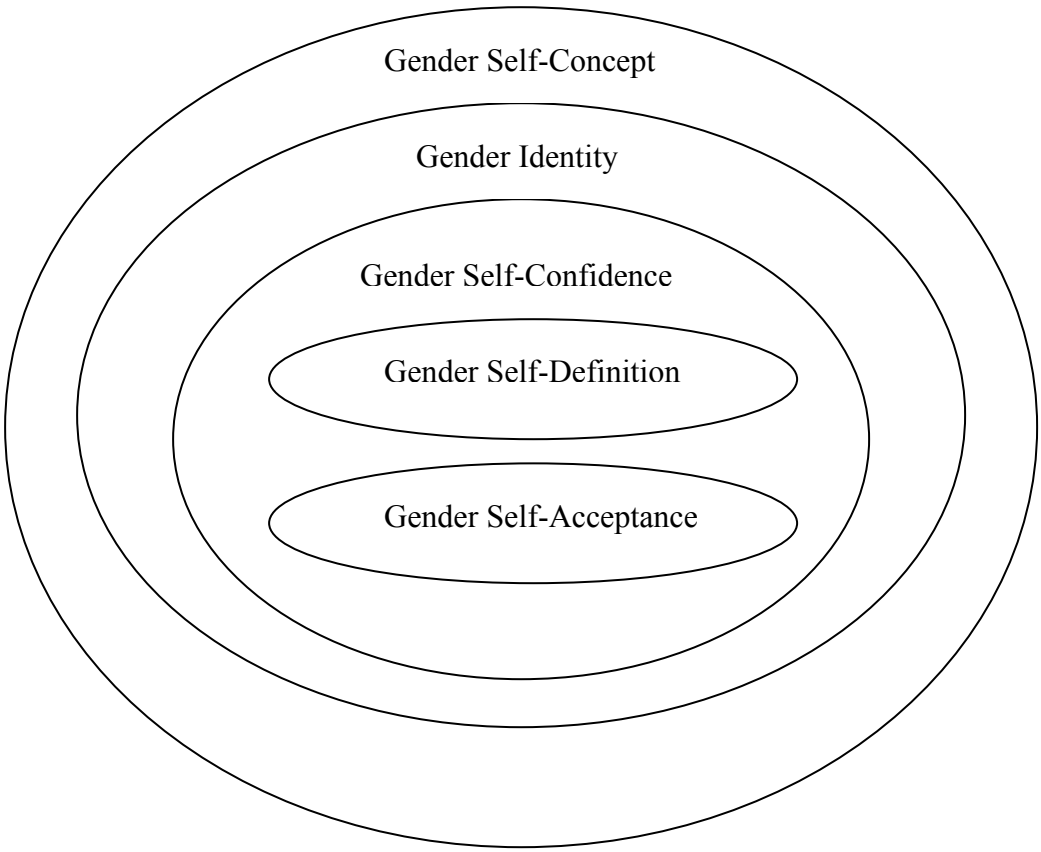

Figure 1. Model of Gender Self-Confidence.
From "Reconceptualizing Masculinity and Femininity: From Gender Roles to Gender Self-Confidence," by R. M. Hoffman, L. D. Borders, and J. A. Hattie, 2000, *Journal of Social Behavior and Personality, 15,* p. 494. Reproduced with permission of the author.

concept (Hoffman et al., 2000). This is a multifaceted concept, and is defined as the perception of oneself as a man or woman, whether or not there is a secure conviction of maleness and femaleness. It reflects what the individual considers personally relevant about being male or female. It asks questions such as what does it mean to a particular

male or female to be masculine or feminine. Is it important to him/her? Does the individual conceive masculinity or femininity in stereotypical or unique ways? Does the individual have a positive self-image as a male or female?

Gender identity is one aspect of gender self-concept and is defined as a person's secure conviction of maleness or femaleness (Golombok & Fivush, 1994; Hoffman et al., 2000; Money, 1994). This definition of gender identity allows individuals to vary in the specific personal content of their self-image, without implying uncertainty. It describes the personal definition of masculinity and femininity, not the social definition. As one aspect of gender self-concept, an individual's gender identity may or may not be strong (Hoffman et al., 2000).

Gender role identity, as it has been measured in the past, is a narrower concept than gender identity. Gender role identity is defined as the degree to which a person adheres to a social, but not necessarily a personal construction of masculinity and femininity based upon the situational context in which they live their lives (Basow, 1992; Bem, 1996; Hinkleman & Granello, 2003; Kaschak, 1992; Levant, 1996; Mintz & O'Neil, 1990). This concept is what tools like the Bem Sex Role Inventory and the Personal Attributes Questionnaire measure.

Gender self-confidence is "the intensity of one's belief that she/he meets her/his personal standards for femininity/masculinity" (Hoffman et al., 2000, p. 481). Gender self-confidence is one aspect of gender identity and may or may not contain much self-confidence. It is gender self-confidence that the HGS is designed to measure (Hoffman et al., 2000).

As a result of the development process of the HGS, the single factor of gender self-confidence was recognized as being a continuum between gender self-acceptance and gender self-definition. Self-definition is defined as how strong a part of one's identity the individual believes his/her self-defined sense of masculinity or femininity is. If the individual believes that his/her masculinity or femininity is very important, a strong gender self-definition is established. Gender self-acceptance is defined as how comfortable an individual is with his/her gender. An individual with a strong self-acceptance will possess a positive view of himself/herself as a male or female, but they may or may not feel that their gender is that important to their identity (Hoffman et al., 2000).

In 2001, Hoffman, Hattie, and Borders furthered the exploration of the HGS subscale scores (gender self-definition and gender self-acceptance) by comparing participants' HGS subscores to the ratings of the BSRI items. The participants were undergraduate students (n = 244) from a mid-size university in southwestern United States. The participants were first asked to rate the items on the BSRI as feminine, masculine, or neutral. Then the participants were asked to complete the HGS. The researchers found that strong gender self-definition was negatively correlated with the BSRI items that the participants had rated masculine or feminine (for females, r = -.18, df= 270, p < .00; for males, r = -.28, df = 95,p< .001. There was no correlation between the participants' ratings of the BSRI items and the gender self-acceptance subscale. The results suggest that the higher the gender self-definition subscale score (or the importance the individual defines the self in regards to masculinity/femininity), the more likely that

individual will perceive basic human traits as masculine or feminine (and not as neutral). One of the possible explanations proposed by the authors is that these participants were responding to the BSRI in socially stereotypical ways, rather than a person perception of masculine/feminine. The lack of a correlation between gender self-acceptance and the ratings of the BSRI items seems to suggest that the acceptance of one's femininity/masculinity is much less influenced by perceptions of what constitutes femininity or masculinity.

In 2006, Hoffman explored the relationship of gender self-definition and gender self-acceptance with feminist, womanist, and ethnic identity. Participants were 361 women from a large California university. They completed the HGS, as well as instruments designed to measure feminist, womanist, and ethnic identities. The Feminist Identity Scale (FIDS; Bargad & Hyde, 1991), the Womanist Identity Attitudes Scale (WIAS; Ossana, Helms, & Leonard, 1992), and the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992).

Hoffman (2006) found a positive significant correlation between gender self-definition and some of the FIDS/WAIS subscales (.20 through .32, with a low-to-medium to medium effect size of 2.0 through 3.2), suggesting that gender self-definition has a relationship with the female identity developmental statuses related to the struggle build a positive female identity and the commitment to an antisexist society. The low positive correlations between gender self-acceptance and the FIDS/WAIS subscales (ranging from .16 through .22, with somewhat low to low-tomedium effect sizes of 1.6 through 2.2)

likely indicates the discomfort females experience in regards to their femininity as they are actively engaged in their search for identity.

The significant positive correlation between gender self-acceptance and ethnic identity (.23, with a medium effect size of 2.3) suggests that the development of both gender and ethnic identity may occur in a parallel fashion. Hoffman (2006) also found a significant positive correlation between gender self-definition and ethnic identity (.30, with a medium effect size of 3.0), further supporting the possible parallel development of a parallel developmental process between gender and ethnic identity. She proposes that a female who has achieved a satisfactory level of ethnic identity may find it easier to move through the gender identity developmental process.

As a result of these studies (Hoffman, 2006; Hoffman et al, 2005), the psychometric properties of the HGS are further strengthened. Both studies supported the structure of the two factors (or subscales) and their internal consistency. The correlation of the two subscales (r = .49) in the Hoffman (2006) study indicated strong internal consistency with the correlation reported by Hoffman et al. in 2000 (r = .43). The test-retest reliability was explored by asking 49 respondents from the 2006 study to complete the HGS four weeks after the initial administration. The correlation for self-definition was .53 and for self-acceptance was .49 (with both correlations being significant at the .01 level). Therefore, test-retest reliability was found to be adequate.

Gender Role Orientation and Counselors

Counselors are members of cultural groups, such as gender, race, ethnicity and social class. These cultures are lenses through which counselors base their perceptions and values. Each counselor comes to the session with a set of cultural expectations for what it means to be a “good” woman and a “good” man for themselves and for their clients (Erickson, 2005). When counselors are unaware of their own gender development they increase the risk of imposing their expectations on their clients (Stadler, Suh, Cobia, Middleton, & Carney, 2006).

In 1970 and 1972, Broverman and colleagues studied clinicians’ judgments of mentally healthy males and females (Broverman et al., 1970; Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972). In the 1970 Broverman et al. study 79 clinicians were asked to respond to a 122 item Stereotype Questionnaire with one of three sets of instructions. Ten females and 17 males were given the male instructions which stated “think of normal, adult men and then indicate on each item the pole to which a mature, healthy, socially competent adult man would be closer". Twelve females and 14 males were given the female instructions which asked them to describe a "mature, healthy, socially competent adult woman" (Broverman et al., 1970, p. 2). Finally, 11 females and 15 males were given the adult instructions which asked the participants to “describe a healthy, mature, socially competent adult person (sex unspecified). Responses to these adult instructions may be considered indicative of ideal health patterns, without respect to sex” (Broverman et al., 1970, p. 2). The hypothesis regarding the existence of a double standard of health for males and females was supported, meaning that the general

standard applied to males only (male and adult concepts did not differ significantly (t = 1.38, $p > .10$). Females were perceived as significantly less healthy than the adult standard ($t = 3.33$, $p < .10$).

The Broverman et al. (1970, 1972) studies found that clinicians' judgments of adult healthy males and healthy adults, sex unspecified, did not significantly differ. However, the clinicians' judgments of adult healthy females did differ from healthy adults, sex unspecified. These differences corresponded with the cultural stereotypes of men and women held during that time.

In 1985, O'Malley and Richardson repeated the 1970 Broverman et al. study using 249 psychologists, counselors, and social workers. Each participant was given one of the three sets of instructions used in the Broverman et al. study (male, female, and adult). The data was analyzed using a four-way analysis of variance (sex of participant, time of professional training, set of instructions, and male-valued/female-valued score). There was no difference in how males and females responded to the questionnaire items. Likewise, there was no difference found in the time of the participants' professional training. However, there was a significant interaction between the set of instructions (male, female, and adult) and the scores. Participants given female instructions scored items differently than the participants given male instructions. The mean of the female valued scores ($M = 4.36$) of the participants given female instructions was significantly higher than that of participants given the male instructions ($M = 3.74$). The mean of the male valued scores of the participants given female instructions did not equal that of participants given the male instructions and the adult instructions. The results of this

study indicated that females continued to be perceived differently than males and healthy adults. One difference between the O'Malley and Richardson study and the 1972 Broverman et al. study was that the healthy adult now contained some feminine characteristics. Therefore it was possible for a female to behave as an adult without being considered unhealthy. However, clinicians' judgments for a healthy adult female continued to be different from a healthy adult male and healthy adult, sex unspecified.

Seem and Clark (2006) evaluated the current gender role stereotypes held by counselors-in-training. They used the same categories utilized in the Broverman et al. (1970, 1972) studies (adult male, adult female, and adult, sex unspecified). They found that the judgments of clinicians had not changed much since the early 1970s. The participants were 121 master's level students in two northeastern counseling programs. They were given the Stereotype Questionnaire with different instructions. The instructions were:

> Imagine that you are going to meet a person for the first time and the only thing you know in advance is that the person is a woman (man/adult). On the following questionnaire, think of a normal man (woman/adult), and then indicate on each item the pole to which a mature, healthy, socially competent woman (man/adult) would be closer. (p. 250)

A repeated measures MANOVA was used to compare the total gender stereotypic scores, and biologic sex was a between subject factor. A significant effect for the total gender stereotypic scores was found, F (1, 86) = 30.81, p 0.0001. Paired t-tests were performed to evaluate the main effect of the total gender stereotypic scores. The

participating clinicians continued to view a healthy adult female and a healthy adult differently ($t = -5.72$, $df = 92$, p 0.0001), and continued to view a healthy adult female and a healthy adult male differently ($t = -5.22$, $df = 89$, p 0.0001). There was not a significant difference between a healthy adult man and a healthy adult ($t = 0.51$, $df = 93$, p 0.61). These results indicate that counselors-in-training hold two standards for mental health. One standard exists for a healthy adult female, and a second standard exists for a healthy adult male and a healthy adult, sex unspecified. These standards continue to be in keeping with traditional gender stereotypes.

The healthy adult male continued to be described in stereotypical masculine ways. The perception of the healthy adult male contained 15 stereotypic items and all of the items came from the traditionally masculine set. The results for the healthy adult female contained 21 stereotypic items from the traditionally feminine set, as well as three items from the traditionally masculine set of items ("strong," "independent," and "enjoys a challenge"). Seem and Clark (2006) indicated that while the stereotype for a healthy female was changing, the stereotype for a healthy male showed little change from the 1970s. An important finding in the 2006 Seem and Clark study was that a healthy adult female continued to be significantly different from a healthy adult, sex unspecified.

There has been the suggestion that the biological sex (male and female) of the counselor plays a role in the social interaction of the counseling process itself. Female counselors seem to develop a therapeutic bond with their clients better than male counselors (Werner-Wilson et al., 2003). Wintersteen, Mensinger and Diamond (2005)

found that when clients were matched with their counselors based on biological sex, higher therapeutic alliances were reported, and the alliances occurred more quickly.

Vogel, Epting, and Wester (2003) studied 59 case histories and found that although the counselors' descriptions of their male and female clients were similar, there were differences in emphasis for certain areas of female versus male clients. They used grounded theory to explore how counselors perceived male and female clients. Themes of vulnerability and how much the client asserted him/herself were emphasized more for the female clients. Male clients had the theme of being stuck and of how much they connected with others.

Female counselors tended to point out more positives in their clients than male counselors. Female counselors emphasized empowerment and assertiveness, especially with female clients (Vogel et al., 2003). They emphasized the theme of difficulty more with their male clients, as well as the emotional expression and connectedness of their male clients. Male counselors were more likely to emphasize gender stereotyped themes in their clients' histories, but the emphasis was different for male clients and female clients. They provided help for the "vulnerable" female client by providing "pacing" and "stability" in the counseling setting. For male clients experiencing problems with connection, the male counselor was more likely to be directive and give options (Vogel et al., 2003).

It has also been suggested that biologic sex plays a role in the diagnostic decisions of counselors. Flanagan and Blashfield (2005) studied the diagnostic decisions of 99 psychiatrists and psychologists by showing the participants cases of either a male or a

female demonstrating some of the criteria for histrionic and antisocial personality disorders. The researchers found that the clinicians in their study tended to make different diagnostic decisions dependent upon whether the client in the case study was male or female. Tomlinson-Clarke and Camilli (1995) found that female counselors tended to rate the severity of their client's current condition more severely than male counselors.

The inclusion of gender identity into the field of research has made understanding the influence of biological sex more difficult. Hinkleman and Granello (2003) found that when their results were examined based on biological sex, females were more likely to be intolerant towards mental illness than males. When gender role adherence was controlled for there were no differences between the attitudes of males and females. They determined that it was a strict adherence to gender roles, and not biological sex, which accounted for intolerance towards mental illness.

Studies have demonstrated that counselors hold the same gender role stereotypes as the general population. Gold and Hawley (2001) found that students entering the counseling profession were not more egalitarian in their gender descriptions and gender role orientations than the general population. The participants of this study consistently chose stereotypical adjectives to describe males and females. Simon, Gaul, Friedlander, and Heatherington (1992) found that counselors equated treatment success with their clients' adherence to traditional gender roles (regardless of biological sex). Counselors also hold the same gender role stereotyping for the expression of emotions, describing females as hyperemotional (Broverman et al., 1972; Hare-Mustin, 1983) and males as

hypoemotional (Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, & Goodholm, Jr., 1999).

These gender role stereotypes have the potential to limit the ability of counselors to treat individuals who may not fit within the traditional categories of male and female. When this limitation is coupled with the role of the counselor as an influencing agent, the risk is that the gender role biases of the counselor may impact the counseling relationship (Gold & Hawley, 2001). A counselor has the potential to be a significant change agent in the life of a client. Who that counselor is as an individual (including the personal beliefs of the counselor) will have an impact on the client and on the client's journey of change. Who that counselor is as an individual will also have an impact on the counselor's ideas about influence within the counseling setting (Spong, 2007).

Social Influence

Social influence is defined as a change in the beliefs, attitudes and behaviors of a person as a result of the actions or presence of another person or group of people (French & Raven, 1959; Raven, 1992, 1993). Usually social influence occurs as a result of an intentional act of one person or group upon another. However, influence could also occur as a result of the passive presence of a person or group on another person or group. There may be no evidence of speech or obvious movement. For example, the presence of a highway patrol vehicle on the highway could be considered a passive social influence over a speeding motorist.

Social power is defined as the potential for such a social influence (French & Raven, 1959; Raven 1992, 1993). Power, in and of itself, does not exist. "It exists only

when it is put into action" (Focault, 1982, p. 219). French historian and philosopher Michael Foucault (1982) suggested that power is a generative, productive force. It is a part of the social fabric, acting through the individual and able to guide that individual. Although individuals may believe that it is their own will that is steering them, they can never totally control their own choices. Focault wrote:

> What defines a relationship of power is a mode of action which does not act directly and immediately on others. Instead it acts upon their action: an action upon an action, on existing actions or on those which may arise in the present or the future. (p. 220)

Social power in not visible, but when power has been exercised some type of change occurs. It is the change which is visible, and it is the change which is labeled as social influence. In the example of the state patrol vehicle parked along a highway, it is not the power of the vehicle that others can see, but the braking and the slower speed of the passing motorists. This change is the evidence of social power. It is social influence.

A relationship of power is not a relationship of violence, which is an action upon a body or things (Focault, 1982). A relationship of violence forces, breaks, or closes the door on all possibilities. It is not a relationship of passiveness. A relationship of passiveness can only seek to minimize any resistance it comes up against. A relationship of power contains two elements. The person or group over whom the power is being exercised exists to the very end as a person or group that acts. Secondly, when the person or group is faced with a relationship of power a variety of responses, reactions and possibilities open up. The exercise of power is an action upon an acting person or group.

It is a set of actions upon actions. When a motorist gets behind the wheel of a car, the motorist has a variety of choices regarding how the car will be operated. There is recognition of the relationship of power between this motorist and the highway patrolman, but the motorist still can make choices about individual actions in the car. The power of the patrolman does not prevent the motorist from making any of the possible choices. The motorist exists as a person that acts and chooses, no matter what decisions the motorist makes (i.e., whether or not to speed while driving).

French and Raven's Social Power Model

French and Raven (1959) described five types of social power: reward, coercive, legitimate, referent, and expert. This list was expanded by Raven in 1965 to add informational power, and again expanded in 1992 and 1993. The new set resulted in 14 power bases. These include reward (personal, impersonal), coercive (personal, impersonal), expert (positive, negative), legitimate (position, reciprocity, equity, dependence), referent power (positive, negative), and informational power (direct, indirect).

Reward and coercive power represent the ability of the influencing agent (person or group) to give rewards/approval and threats/disapproval (French & Raven, 1959; Raven, 1992). A personal reward power base involves target (person being influenced) compliance because the target believes he/she will gain the approval and/or will be liked by the agent. An impersonal reward power base means the target complies due to the belief that the agent can give a tangible reward, such as a promotion or money. Personal coercive power is exercised by the target recognizing that the agent may disapprove or

dislike him/her for noncompliance. Impersonal coercive power is exercised when the target complies based on the belief that the agent can tangibly punish him/her for not complying.

Positive expert power occurs when the target perceives that the agent is an expert in a certain field and therefore does what the agent says (French & Raven, 1959; Raven, 1992). Negative expert power occurs when the target thinks the agent is acting in his/her own best interests and therefore does the exact opposite that the agent says. Legitimate power is based on a structural relationship between the target and the agent. The formal legitimate power base of position occurs when a superior influences a subordinate. The agent occupies a position of authority over the target and the target feels obligated to comply. The legitimate power base of reciprocity involves the give-and-take mindset. The target feels obligated to comply because the agent has done something positive for the target. The legitimate power base of equity involves the idea that the agent has somehow worked hard or suffered. Therefore the agent has earned the right to ask something of the target. The target feels obligated to comply in order to make up for the agent's hard work. The legitimate power base of dependence occurs when the target feels the need to comply because the agent cannot accomplish a certain goal without the help of the target (Erchul, Raven, & Wilson, 2004; French & Raven, 1959; Raven, 1992).

Positive referent power occurs because the target wants to be associated with or similar to the agent and therefore complies. Negative referent power occurs when the target does the opposite of what the agent wants because the target does not want to be associated with or be similar to the agent. Informational power is based on information or

a logical argument that the agent gives to the target. Informational power is direct when the agent gives the information directly to the target. Informational power is indirect when the target overhears or gets the information from the agent through a third party (Erchul et al., 2004; French & Raven, 1959; Raven, 1992).

In 1998, Raven, Schwarzwald and Koslowsky refined the understanding of these eleven power bases into two groups of power bases – soft and harsh power bases. By examining the mean scores of the eleven power bases they found two clusters of power bases. The softer (or weaker) power bases were identified as positive expert, positive referent, direct information, formal legitimacy, and legitimacy of dependence. The harsher (or stronger) power bases were identified as personal and impersonal coercion, personal and impersonal reward, legitimacy of equity, and legitimacy of reciprocity. They found greater compliance to the soft power bases was related to a higher level of job satisfaction. Harsh power bases did not relate to job satisfaction.

Foucault (1980) further defines a power relationship as being one where resistance is always possible, stating that resistance is "formed right at the point where relations of power might be exercised (p. 142). Resistance is visible, while the use of power often remains hidden from view. As a result of this resistance, the type of influence used by the influencing individual can change. Every power relationship implies a struggle between two forces that do not become confused or superimposed (Foucault, 1982; Guilfoyle, 2002, 2005).

Counseling and Social Influence

Strong (1968) stated that counseling was an interpersonal influence process, and that the counselors' attempts to change their client's behaviors would result in dissonance (a psychological tension that has a drive characteristic). Out of the various ways the client might resolve this dissonance, one choice would be to change an opinion to match that of the counselor. Strong proposed that counselors could increase the likelihood that their clients would choose to advocate their counselor's position.

In order to achieve this, he described a two-stage model of counseling. The first stage could be accomplished by the counselor enhancing his/her image as expert, trustworthy, and attractive. In the second stage, the counselor would use influence to bring about change in the client (Corrigan, Dell, Lewis, & Schmidt, 1980; Heppner & Claiborn, 1989; Strong, 1968).

In Strong's (1968) first stage, counselors demonstrate their expertness by providing "(a) objective evidence of specialized training such as diplomas, certificates, and titles, (b) behavioral evidence of expertness such as rational and knowledgeable arguments and confidence in presentation, and (c) reputation as an expert" (Strong, 1968, p. 216). French and Raven (1959) state that the strength of expert power the individual attributes to the counselor varies according to the extent of the knowledge the individual believes the counselor has. The counseling profession provides counselors with many pieces of expertness: diplomas, licenses, professional memberships, titles, and credentials. The expectations of the counseling setting also provide evidence of expertise. The counselor establishes the structure of the intake interview, defines the process of

counseling, and delineates roles. As the client experiences this structuring, belief in the expertness of the counselor is enhanced (French & Raven, 1959; Raven, 1992, 1993; Strong, 1968).

Corrigan et al. (1980) reviewed 17 studies for clients' reactions to their counselors' expertness, trustworthiness, and attractiveness. They found that visible evidence of the counselor's training and knowledge, information about the reputation of the counselor, and the nonverbal communications of the counselor all enhanced the client's perceptions of counselor expertise. Heppner and Claiborn (1988) reviewed 57 studies from 1981 through mid-1988. They found that 27 of the 57 studies explored the expertness of counselors. Their findings were consistent with Corrigan et al.'s. Evidence of training, prestige, and other counselor behaviors (both verbal and nonverbal) consistently enhanced the client's perceptions of expertness.

Strong (1968) defined his second stage as the part where counselors use their influence to bring about change in their clients. Counseling can be seen as a process of various influence strategies designed to break through client resistance and persuade the client to agree with the opinion of the counselor. Through this process the social power of the counselor is increased, the client's resistance is decreased, and the treatment goal is achieved. Studies found that expert and referent counselors were found to exert a stronger and similar influence than other types of counselor styles (Dell, 1973; Merluzzi, Merluzzi, & Kaul, 1977).

Interestingly, the majority of the studies Heppner and Claiborn (1989) reviewed focused on the first stage of Strong's two-stage model of counseling. Research was

occurring regarding how to enhance the trustworthiness, attractiveness, and expertise of the counselor. Less research, however, was focusing on the concept of the counselor's use of influence. The reviewers had to construe use of influence by the means of indirect measures (such as change in attitude or symptoms). Using this method, Heppner and Claiborn were able to determine that 31 studies (54% of the original 57 studies) examined influence. These studies were grouped into three variables: counselor variables, client and messenger variables, and field variables. Fifteen studies examined counselor variables that clients perceived positively, such as not using profanity, having a positive reputation, and being congruent in using positive verbal and nonverbal behaviors. However, due to the fact that these perceptions were based on short vignettes and viewers' initial reactions, the generalizability of many of the studies is not clear. Three studies found moderate to strong relationships between client satisfaction and the client's perception of the counselor's expertness, trustworthiness, and attractiveness (Heppner & Heesacker, 1983; McNeill, May, & Lee, 1987; Zamostny, Corrigan, & Eggert, 1981). Two other studies examined favorable counseling outcomes with perceived counselor expertness, trustworthiness, and attractiveness (Dorn & Day, 1985; LaCrosse, 1980). LaCrosse (1980) found that counselor expertness explained 31% of the variance in predicting favorable counseling outcomes.

Regarding the ability of the counselor to influence the client, Corrigan et al. (1980) found two commonalities among the studies. For most of the studies, the data was based on one interview only. Another commonality was that the studies demonstrated the counselor's ability to influence client attitudes but not behavior change. Demonstrating

behavior change outside of the session was more difficult for research to demonstrate. Heppner and Claiborn (1989) found only 15 of the original 57 studies explored the influence process. Twelve of these studies successfully demonstrated the effects of influence. Since the clients were given hypothetical decisions, Heppner and Claiborn state the studies have given a weak test of influence.

In 1998 Houser, Feldman, Williams, and Fierstien researched the use of social influence by counselors. They found no significant difference effects for theoretical orientation or experience. A repeated measures analysis of variance on 15 influence tactics yielded significant differences. The most frequently used tactic was that of metaphors. The second most used influence tactic was pointing out the negative consequences to actions, followed by noting positive rewards, use of reasoning, asking the client to compare perceptions of real self to ideal self, and use of modeling.

Counseling and the Use of Social Influence In Session

Just as Focault (1982) argues that power is interwoven in the social fabric of all social relationships, Guilfoyle (2002) proposes that the use of counselor power in therapy is structured into the therapy process. Focault also makes a distinction between power and domination. In a relationship of power, resistance is possible and the role of the influencing person or group can shift. However, in a relationship of domination, resistance is futile and the role of the influencing person or group is fixed. This distinction plays a role in therapeutic approaches, leading Foote and Frank (1999) to say that counselors have no choice but to play games with power while domination should be avoided. The difficulty is that power is often hidden and domination is not. Guilfoyle

(2002) states that the problem with power in counseling is that it is structured into the counseling setting and cannot be resolved with the development of new techniques.

Efforts have been made to address the power imbalance in the counseling setting. Larner (1999) stated that to understand and cope with power, the counselor can both question and preserve the institution of therapy. Therefore, many theorists have addressed power at the discursive level (the level of talk). Some counselors attempt to equalize the power between the counselor and the client by describing their particular style of therapy (Kazan, 1994). Others utilize the process of feedback and a sense of partnership with the client in order to minimize the power imbalance (Carpenter, 1994). In another strategy, Totten (2000) suggested counselors talk openly about the struggle over power.

But the power imbalance in the counseling setting cannot be equalized by addressing the discursive level only. The imbalance of power also exists in the material factors (such as hospitals, clinics, structures) of the counseling relationship. These material factors cannot be ignored. Addressing the use of power at the discursive level only serves to conceal how material factors can limit the counseling relationship. Focault (1982) describes a reinforcing circular relationship between material factors and the type of talking and speaking that happens within these structures. He states the existence of the material factors/structures (i.e., a mental health clinic) encourages talk about the people within them (i.e., counselors, clients), and the reason the people are there (i.e., illness, mental health problems). This reinforces the need for the material factors/structures and the experts within them. The discursive and material factors of

power repeat and reproduce each other (Burr, 2000; Focault, 1982; Guilfoyle, 2002; Kendall & Wickham, 1999; Rose, 1989).

Social power has been defined as an invisible force with a potential to bring about change (Focault, 1982; French & Raven, 1959). Social influence is the evidence of social power being utilized. It is the change or the resistance to change that is visible. Counselors enhance the relationship of power with evidence of their expertness (such as their diplomas displayed on the office wall), through material factors (such as the buildings constructed for the purpose of treatment), and in the role that counselors play within that relationship. In 2002, Guilfoyle writes the following:

> what we say and do - are the means and tools with which we exercise power. Our applications of knowledge (i.e., offering interpretations, or deciding on which questions are the most relevant) extend and reproduce power, thus constitute the strategies of power. (p. 86)

This knowledge is the vehicle of power. Knowledge organizes and enables power to operate. Counselors use this knowledge to reach into the client's experiences and encourage change, through client self-reflection and self-examination (Focault, 1982, 1999; Guilfoyle, 2002; Rose, 1989).

There have been claims that counseling is a much more democratic relationship, and that power can be kept out of the counseling setting (Anderson, 1997, 2001; Bird, 1994; Carpenter, 1994; Guilfoyle, 2003; Hoffman, 1988, 1992; Proctor, 2002). However, in a truly democratic relationship, the counselor and client would experience a fluid relationship. They would be able to easily change between the person doing the

influencing to the person being influenced. Instead, the counseling setting is one where the counselor and client are positioned in their roles by virtue of the setting itself. The counselor inherits entitlements not given to the client (Guilfoyle, 2005).

Counseling is not a democratic relationship. It is the counselor who explains the counseling process, defines the limits of confidentiality, and determines how the standards of the counseling process are met within the session. It is the counselor who determines which questions are the most important to ask. The counselor and client maintain their roles. They behave, say and do what is expected of their positions within the power relationship (Guilfoyle, 2003).

But the client and counselor are not passive participants in the counseling relationship. As in all social relationships, the client may resist change. Focault (1982) states that while power is often hidden, resistance is more visible because it is a response to power tactics. In general, counselors tend to view resistance as an internal conflict within the client, rather than an indicator of the use of power (Guilfoyle, 2005). This allows the use of power within the counseling relationship to remain hidden and obscure. Additionally, since the counselor is in the position of the influencing agent, the client's resistance is a relatively weak force. When outside of the counseling setting, the counselor's interpretations and suggestions can much more easily be dismissed by the person the counselor is attempting to influence. The counselors' knowledge has become disconnected from the counseling setting. While the client's resistance is respected by some counselors, it is important to remember that it is the counselor who determines if this resistance will be respected, not the client.

Within the counseling setting, the counselors' knowledge and power combine to be productive. The counselor is the expert and the client is the problem to be figured out. Counselors cope with their clients' resistance by legitimizing their use of power within the counseling relationship (through actions such as challenging, ignoring, and other strategies meant to push beyond resistance). This treatment is made reasonable by the imbalance of power between the counselor and the client. The imbalance establishes the counselor as an individual who knows what is best (Focault, 1982; Guilfoyle, 2002).

But which set of counselor actions promote the most effective treatment? Carl Rogers (1957) defined empathy, unconditional positive regard and congruence as the hallmark actions of a counselor. Strong (1968) emphasized the client's perceptions of the counselor's expertise, trustworthiness and attractiveness. Freud (1895, 1966) described neurotic and friendly feelings of the patient for the analyst. In each of these theories, attention is focused on the client being an active participant in the change process.

Gender Identity and Social Influence

Robyak (1981) describes the conceptualization of change in the counseling setting as a process of social influence. Counseling as a social influence process is not exempt from the presence and effect of stereotypic roles. Gender identity creates expectations in the counseling setting, just as it does in other social settings.

Everything that a counselor says and does in session can influence the client. Spong (2007) describes the influence of the counselor on the client:

> not only from her interventions, but also from her presence, her beliefs, values, actions, the place where she chooses to work and the whole range of aspects of herself that can be perceived and responded to at some level by the client. (p. 332)

Counselors attempt to help their clients attain some type of change in their behaviors, attitudes and views of the world. These attempts can be viewed as influence, whether or not the counselor is intentionally directive in a chosen treatment style (Corrigan et al., 1980; Spong, 2007). Therefore the counselor's choice regarding social influence within the counseling session is related to gender identity (Robyak, 1981).

Definitions of social influence presume that the power of one individual or group over another comes from structural and cultural advantages. Johnson (1976) predicted that males would exert more coercive and reward power due to possessing more tangible resources with which to reward or punish. Males were also predicted to use more legitimate power due to males having more authority than females. Females, however, were predicted to prefer referent power due to the fact that this form of power emphasized the maintenance of relationships.

Research has shown that people do have gender role stereotypes (Broverman et al., 1970, 1972; Gold & Hawley, 2001; Seem & Johnson, 1998). Research has also examined differences in social influence between males and females, suggesting that males have more access to social power than females (Depre & Fiske, 1993; Johnson, 1976; Lorber, 1998). Social power has been defined as the potential to influence or to have power over another person or group (Focault, 1982; French & Raven, 1959). Given the differences in stereotypes between healthy adult males, healthy adult, sex unspecified,

and healthy adult females, differences in the use of social power seem likely (Carli, 1999; Johnson, 1976).

In 1981, Roybak investigated the effect of gender on counselors' choice regarding their method of social influence when attempting to influence the client's behaviors. He found that the method of social influence did vary according to the biological sex of the counselor and of the client. Female counselors endorsed the legitimate method of social influence more than male counselors. Both male and female counselors rated expert methods of social influence as being more likely when treating clients of the same biological sex. The results of this study seem to reflect the presence of gender role stereotyping.

In order for this social influence to be successful the client and counselor need to form an effective relationship or alliance (Horvath & Symonds, 1991; Martin et al., 2000). This alliance takes in both the client and the counselor's behaviors and choices within the relationship. Therefore the choices a counselor makes regarding the use of power in the session have a direct impact on the success of treatment (Corrigan et al., 1980; Horvath & Symonds, 1991; Martin et al., 2000).

Conclusion

Despite the literature on the working alliance between the client and counselor, there is a lack of research in the area of the counselor's use of social influence in the session and the resulting impact on alliance (Heppner & Claiborn, 1989). The focus of research tends to be on the impact of counselor trustworthiness, expertness, and attractiveness. Also, when studies on alliance explored gender as a variable the focus was

on biological sex (as in male and female) and not gender identity. Yet how the client views the counselor is only the first of Strong's two-stage model of counseling. The second stage is the counselor's use of influence (Strong, 1968). This lack of research indicates the need for further work.

Additionally, research in the area of gender identity has tended to focus on biological sex (as in male and female) and gender role orientation (Bem, 1996; Hinkleman & Granello, 2003; Kaschak, 1992; Levant, 1996; Spence & Helmreich, 1978). A new shift in conceptualizing gender identity has been proposed by Hoffman et al. (2000). Instead of defining gender identity by the adherence to stereotypes, gender identity is instead defined by the degree to which the individual feels personally confident and satisfied with his or her sense of masculinity or femininity. The introduction of this conceptual shift and a new tool to measure the new concept opens up new research possibilities.

This study explored the ability of gender self-definition, gender self-acceptance, soft and harsh power bases, and biological sex to enhance or detract from the working alliance between a counselor and client. A deeper understanding of how to build an effective working alliance promotes successful treatment outcomes. Further understanding of how these variables relate to each other enables the field to recognize the importance of counselor gender self-awareness and the importance of making purposeful decisions regarding use of power in the session

To address the limitations of prior research and literature, this study utilized methodology designed to explore and study the gender self-confidence of the counselor

(as defined by Hoffman et al., 2000), the counselor's use of social influence, and the quality of the working alliance. Chapter 3 discusses the methodology used to explore these concepts, including the research question/hypothesis, sample selection, instrumentation, reliability/validity analysis, and descriptive statistics.

CHAPTER III: METHODOLOGY

This study utilized a quantitative analysis to explore the ability of the counselor's biological sex, gender self-confidence (including self-acceptance and self-definition), the use of social influence (including soft and harsh power bases) in the counseling session to explain the working alliance between the counselor and client. This chapter describes the procedure for conducting the current study, including the research design, sampling plan, population, instrumentation, pilot study results, data collection, and analysis of the results.

Research Design

The research design for this study utilized multiple regression to analyze the percentage of variance the independent variables could explain. The purpose of this study was to investigate the relationship between a counselor's gender self-confidence (which includes gender self-definition and gender self-acceptance), the counselor's use of social influence (which includes soft and harsh power bases) within the counseling session, the counselor's biological sex and the development of the therapeutic working alliance between the counselor and client.

The hypothesis:

> The counselor's biological sex, gender self-acceptance, gender self-definition, soft power base and harsh power base within the counseling relationship explains the quality of the therapeutic alliance between the counselor and client. The first hypothesis will be represented by the equation H_1: $R^2 \neq Ø$.

The null hypothesis:

There is no relationship between the counselor's biological sex, gender self-acceptance, gender self-definition, soft power base and harsh power base in the counseling session and the quality of the therapeutic alliance. The null hypothesis is represented by the equation H_0: $R^2 = Ø$.

The researcher mailed the surveys to randomly selected licensed Professional Clinical Counselors (PCCs) from the state of Ohio via the U.S. Postal Service. The survey contained four separate instruments. Two of the instruments measured the independent variables of the counselor's gender self-confidence (including self-acceptance and self-definition) and preference for use of social influence (including soft and harsh power bases) in the treatment session. The third instrument was used for measuring the dependent variable of the quality of the working alliance between the counselor and client. The fourth instrument measured the degree to which the respondents answered in a socially desirable way. The survey, along with some demographic questions, a cover letter and a self-addressed, stamped envelope were mailed to selected professionals. The researcher used the following statistical methods in this study: descriptive statistics, correlations, ANOVA, multiple regression analysis, and post-hoc tests. Since one of the instruments for this study was reworded, a pilot study was conducted to test the new wording of the instrument. A second instrument was included in the pilot study, in order to gather preliminary data.

Operational Definition of the Variables

There were five independent variables in this study: biological sex (male/female), gender self-definition, gender self-acceptance, "soft" power bases, and "harsh" power

bases. The dependent variable was the quality of the working alliance between the counselor and client.

Identification of the Population

The population of interest was licensed Professional Clinical Counselors (PCC) from the state of Ohio. Ohio grants licenses to counselors consistent with the national standards for counselor preparation of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001). The rationale behind the choice of this population was the high level of professional preparation and at least two years of post-master's experience (to meet the state requirements required to earn the PCC licensure level). Currently, the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board licenses 3,963 PCC level counselors.

Sampling Plan

Participants for this study were selected from a list of licensed Professional Clinical Counselors obtained from the Ohio Data Network. The Ohio Data Network is Ohio's centralized data center and serves multiple state entities. This list of entities includes the professional licensing organization, The Ohio Counselor, Social Worker, Marriage and Family Therapist Board. A random selection method was utilized in order to obtain the final selection of names.

The sample size for this study was based on the work of Cohen (1988). For a five-predictor study, with a medium effect size and a power of .80, a sample size of 120 was required. Due to the possibility of low response rates in survey research, ranging from 21 to 83% (Dillman, 2000; Erwin & Wheelright, 2002), a conservative rate of return was

estimated. In order to achieve the desired number of participants, 500 surveys were mailed.

Instrumentation

There were four instruments used in the current study, as well as a demographic questionnaire. The instruments included the Hoffman Gender Scale (HGS) by Hoffman, Borders, and Hattie (2000), the Interpersonal Power Inventory (IPI) by Raven, Schwarzwald, and Koslowsky (1998), the Working Alliance Inventory (WAI) by Horvath and Greenburg (1989), and the 13-item Marlowe-Crowne Social Desirability Scale (M-C SDS) by Reynolds (1982).

The Hoffman Gender Scale

The Hoffman Gender Scale (HGS; Hoffman et al., 2000) was developed by Hoffman, Borders, and Hattie in 2000. Hoffman et al. proposed a paradigm shift in the conception and measurement of femininity and masculinity. Instead of measuring masculinity and femininity in stereotypical terms, this tool measures the individual's gender self-confidence as one part of gender identity. Gender self-confidence is defined as the intensity of an individual's belief that personal standards for femininity and masculinity are met (Hoffman et al., 2000; Lewin, 1984).

Development of the HGS began with an initial set of items that various individuals provided. These individuals were asked what they felt represented self-confidence in themselves as individuals. Graduate students in a class for test development gathered this information and then sorted and assessed these items into categories resulting in 20 statements. Undergraduate students (N = 146) were then asked to rate

these items using a Likert-type scale from 1 (strongly disagree) through 6 (strongly agree). Internal consistency of the first version of HGS was assessed, resulting in a coefficient alpha of .94 for female participants and .94 for male participants with no overall mean differences between the male and female participants (Hoffman et al., 2000).

As a result of the HGS development process, three modifications were made. First, the Likert-type scale was modified to increase the difference between the rating levels. Second, some items were eliminated in order to further strengthen what appeared to be two separate factors that the items were measuring. This decision allowed the authors to further investigate these two factors. Finally, two items were added to one factor in order to strengthen this factor and to allow there to be an equal number of items for both factors (Hoffman et al., 2000).

The revised HGS contains two subscales (representing the two factors identified in the development process of the HGS). These subscales measure self-definition and self-confidence. Self-definition is defined as how strong a part of one's identity a personal sense of masculinity or femininity is. An example of an item measuring self-definition is "My identity is strongly tied to my femininity" (Hoffman et al, 2000, p. 502) and "My identity is strongly tied to my masculinity" (p. 503). Gender self-acceptance is defined as how comfortable an individual is with his/her gender. An example of an item measuring self-acceptance is "I am secure in my femininity" (p. 502) and "I am secure in my masculinity" (p. 503).

Hoffman et al. (2000) conducted further research on the revised HGS to assess the measurement of the two factors identified in the development process, as well as validating the revised HGS with the Bem Sex Role Inventory (BSRI; Bem, 1981). The BSRI is one of the most widely used instruments to measure masculinity and femininity (Beere, 1990; Hoffman et al.). Undergraduate students (N = 371) completed both instruments. The authors used exploratory factor analysis to assess the presence of the two factors (gender self-definition and gender self-acceptance). These two factors accounted for 62% of the variance for the male and female participants, supporting the two-factor structure of the HGS (Hoffman et al., 2000).

HGS reliability was calculated separately for males and females. The coefficient alphas for females were .88 for the Gender Self-definition subscale and .90 for the Gender Self-acceptance subscale. The coefficient alphas for males were .93 for Gender Self-definition and .80 for Gender Self-acceptance. Using a MANCOVA, there were no overall differences between males and females within the 14 items that form the two subscales, $F(2,368) = 1.72$, $p = .181$ (Hoffman et al., 2000).

The relationship between the HGS and the BSRI (Bem, 1981) was examined using MANOVA (Hoffman et al., 2000). Discriminant validity was supported, with a low correlation between the HGS self-definition subscale and the BSRI (-.07 for the masculine BSRI scale and -.03 for the feminine BSRI scale) and a low correlation between the HGS self-acceptance subscale and BSRI (-.22 for the masculine BSRI scale and -.16 for the feminine BSRI scale).

The HGS was further validated by Hoffman in 2006. Using a maximum likelihood factor analysis, the author found that the instrument items included in the two factors loaded as expected (ranging from .52 through .92, with one item loading at the cutoff of .35). The correlation of the two subscales (r = .49) indicated strong internal consistency with the correlation reported by Hoffman et al. in 2000 (r = .43). The coefficient alpha for gender self-definition was .90 and for gender self-acceptance was .87. In order to assess test-retest reliability, 49 respondents completed the HGS four weeks after the initial administration. The correlation for self-definition was .53 and for self-acceptance was .49 (with both correlations being significant at the .01 level). Test-retest reliability was found to be adequate (Hoffman, 2006).

The final revised HGS contains 14 items, with respondents using a Likert-type scale to rate each item from 1 (strongly disagree) through 6 (strongly agree). There are separate forms for males and females (Form A for female respondents and Form B for male respondents). The forms are identical except for being worded for males or females. For example, item number two reads "I am confident in my femininity" from Form A (Hoffman et al., 2000, p. 502) and "I am confident in my masculinity" from Form B (Hoffman et al, p. 503). A separate mean score is calculated for each of the subscores of the HGS. The mean score can range from 1 to 6. A higher score indicates a stronger level of self-definition and/or self-confidence.

At the beginning of the HGS the respondents are asked the question "What do *you* mean by femininity?" for females (Hoffman et al., 2000, p. 502) and "What do *you* mean by masculinity?" for males (Hoffman et al, p. 503). This is placed at the beginning of the

instrument in order to assist the respondents in focusing on their own personal definitions of masculinity/femininity.

The Interpersonal Power Inventory

The Interpersonal Power Inventory (IPI; Raven, Schwarzwald & Koslowsky, 1998) consists of 44 items that measure 11 social power bases (4 items per power base). Six of these power bases originated with French and Raven (1959) and Raven (1965), including reward, coercion, legitimate, expert, referent, and information. Three of these power bases were further defined by Raven et al. in 1998 to include reward (personal, impersonal), coercion (personal, impersonal), and legitimate (position, reciprocity, equity, and dependence). There are 2 forms of the instrument: one form for the supervisor and one form for the subordinate. The respondent is asked to rate each item in terms of how likely the item might influence a subordinate to comply with the request that the supervisor has made of him/her. The rating uses a Likert-type scale ranging from 1 (much less likely to comply) through 7 (much more likely to comply). For example, item 3 measures expert power and states "He/she probably feels I know the best way to handle the situation" (Erchul et al., 2001, p. 21). To test the validity of the instrument, Raven et al. (1998) analyzed the mean scores of the 11 power bases and found a two-factor solution. Factor 1 was labeled "soft" power bases including expert, referent, informational legitimate dependence, and legitimate position. Factor 2 was labeled "harsh" power bases including personal/impersonal coercive, personal/impersonal reward, legitimate reciprocity, and legitimate equity. Factor 1 explained 34.6% of the variance and Factor 2 explained 24.7% of the variance. Construct validity was verified by

similar conceptualizations of power bases between individuals from different cultures, with alpha coefficients ranging from .67 to .86 in Study 1 to .62 to .83 in Study 2 (Raven et al., 1998). Concurrent validity was provided by correlation of the "soft" power bases with the higher levels of job satisfaction, $F(1,99) = 7.51$, $p < .01$ (Raven et al, 1998).

The current study uses a modified version of the IPI (titled Form CN for the current study). Modification to the IPI involved changing the wording of some items to reflect the counselor/client dyad and an alteration of the instructions for completion (see Appendix B for the personal communication between this researcher and the authors of the IPI). The IPI has been similarly modified to reflect the university professor/student dyad (Elias, 2007) and the psychologist/teacher dyad (Erchul et al.,2001). Validity for the university professor/student version of the IPI has been studied resulting in coefficient alphas ranging from .45 to .80 (Elias). Validity for the consultant/teacher modification has also been studied, with coefficient alphas ranging from .79 to .83, with a mean of .81 (Erchul, Raven, & Whichard, 2001). Construct validity for the modified psychologist/teacher dyad has been compared to other studies utilizing the original IPI version and findings demonstrate consistency between the versions. Spearman rho correlations were computed between the modified psychologist/teacher IPI version and four other studies using the original IPI version including Raven et al., Studies 1 and 2 (1998) Koslowsky, Schwarzwald, and Ashuri (1998) and a university professor/student modification (Elias). Erchul et al. (2001) found that the psychologist/teacher version of the IPI was more similar to the university professor/student version of the IPI, $r_s(9) = .66$, $p < .05$ than the supervisor/subordinate version, all r_ss, $p > .05$. There was a lower

rank in the psychologist/teacher version of the IPI for the use of legitimate power (11 vs. 2-5) and a higher rank for both referent (4 vs. 9) and impersonal reward power (3 vs. 8-10).

The Working Alliance Inventory

The Working Alliance Inventory (WAI; Horvath & Greenburg, 1989) is an instrument that measures the quality of the relationship between the helper and the helpee. The instrument is available in a short form (WAI-S), with 12 items (Tracy & Kokotovic, 1989) and the original long version of 36 items (Horvath & Greenburg, 1989). It has three subscales: Goals, Tasks, and Bonds, which are based upon the work of Bordin's (1979) theory of working alliance. The Goals subscale measures the agreement between the client and counselor regarding the successful outcome of treatment. The Tasks subscale measures how well the client and counselor agree on the behaviors and actions that will occur during the counseling session. The Bond subscale measures the amount of mutual trust and acceptance that the client and counselor have (Horvath & Greenburg, 1989). Each of the subscales is rated with a Likert-type scale ranging from 1 (never) to 7 (always). There are 12 overlapping items. The subscale scores can be totaled individually or added together for an overall score. The WAI subscale scores range from 12 to 84 and the total scores range from 36 to 252 (Horvath & Greenburg, 1989). The WAI-S subscale scores range from 4 to 28 and the total scores range from 12 to 84 (Tracy & Kokotovic, 1989). Higher ratings reflect a stronger alliance. There are three versions to the WAI: a client, counselor, and observer version. Horvath and Greenburg (1989) analyzed the internal consistency of the three subscales and estimated a range of

.85 to .92 for the client version and a range of .68 to .87 for the counselor version. The internal consistency estimates for the overall score of the client and counselor version was .93 and .87 respectively (Horvath & Greenburg, 1989). Two versions of the WAI-S exist: a client and a counselor version. Tracy and Kokotovic (1989) analyzed the internal consistency of the three subscales and estimated a range of .90 to .92 for the client version and a range of .83 to .91 for the counselor version. The internal consistency estimates for the overall score of the client and counselor version was .98 and .96 respectively (Tracy & Kokotovic, 1989). Hanson, Curry, and Bandalos (2002) conducted a review of twenty-five studies from 1989 to 2002 to assess the reliability of the WAI and the WAI-S. Hanson et al. found that the subscales from both the WAI and the WAI-S were highly reliable, with means ranging from .79 to .97. They also determined that the reliability estimates remained stable across the studies, with a standard deviation of only .02 to .12 (Hanson et al., 2002). Horvath and Symonds (1991) and Martin et al. (2000) reported similar statistics with validity across the subscales ranging from .73 to .92. This study will utilize the original WAI long form.

Marlowe-Crowne Social Desirability Scale

The Marlowe-Crowne Social Desirability Scale (M-C SDS; Crowne & Marlowe, 1960) was developed to measure the level of need for cultural approval present in the responses of participants in research. In order for items to be included in the scale, ten judges (faculty members and graduate students from the Department of Psychology of the Ohio State University) had to unanimously agree that ratings given to an item were the result of a need for cultural sanction and approval rather than an indicator of pathology or

abnormality. A set of 50 items was gathered from behaviors that could result from a need for cultural sanction and approval, but were also not likely (i.e., I am always courteous, even to people who are disagreeable.). Out of this set of 50 items the 10 judges unanimously agreed on 36 items and had a 96 percent agreement on 11 other items. This preliminary scale was administered to 76 undergraduate students, resulting in 33 items (18 true and 15 false items) that discriminated at the .05 level or higher. Internal consistency, analyzed using the Kuder-Richardson formula 20, was .88 (the Kuder-Richardson formula 20 is equivalent to Cronbaugh's alpha). The test-retest correlation was .89.

Due to the fact that a 33-item social desirability scale might be considered too long for some researchers, a 13-item short form of the MC-SDS was developed by Reynolds in 1982. Reynolds reported a Kuder-Richardson-20 of .76, which is comparable to the original scale. Zook and Sipps (1985) sought to further validate the Reynolds short-form version of the scale, finding an overall KR-20 coefficient of .74. Zook and Sipps found a mean item to total scale correlation of .49, which is comparable to Reynold's finding of .38. This study utilized the 13-item version of the MC-SDS developed by Reynolds.

Pilot Study

A pilot study was conducted in order to gather preliminary data regarding the modified version of the IPI (Raven et al., 1998) and the relatively new HGS (Hoffman et al., 2000). A convenience sample of 28 master's level counselors-in-training from a Midwestern university was invited to participate in the pilot study. The survey took about

20 minutes to complete, and the researcher received 25 completed surveys for analysis (three students were not available at the time of the pilot study). Participants included five males and twenty females. No other demographic information was gathered for this study.

Results of the pilot study indicated that the participants viewed the power bases of the IPI similarly to the results in Erchul et al., 2001. Four of the top five power bases found in the Erchul et al. study (2001) were found in the top five power bases in this pilot study (Impersonal Reward, Positive Expert, Positive Referent, and Direct Informational). Five of the six lowest rated power bases in the Erchul et al. (2001) study were found in the pilot study's six lowest rated power bases (Legitimate Reciprocity, Legitimate Equity, Personal Coercion, Impersonal Coercion, and Formal Legitimacy). Three of the five soft power bases were in the top five. Using the 7-point scale, the mean for the soft power bases was 2.84 (SD = .34); for the harsh power bases the mean was 3.04 (SD = .38). Validity for this counselor/client modified version of the IPI resulted in alphas coefficients ranging from .52 to .78, which is comparable to the coefficient alphas for the professor/student version, ranging from .45 to .80 (Elias, 2007). The consultant/teacher modification the coefficient alphas ranged from .79 to .83 (Erchul, Raven, & Whichard, 2001). Impersonal Reward represents a harsh power base and in both the pilot study and the Erchul et al. study (2001), this power base was present in the top five power bases. Unlike the Erchul et al. study(2001), Personal Reward was also present in the top five power bases of the pilot study. Four of the six lowest rated power bases in the pilot study were harsh. These were the same four harsh power bases found in the six lowest power

bases of the Erchul et al. study (2001). In both studies, Formal Legitimacy (a soft power base) was the lowest rated power base.

The HGS portion of the pilot study demonstrates a moderate correlation between the two pilot study HGS subscales (r = .55). This correlation is similar to the correlation reported in Hoffman, 2006 (r = .49). The Self-Acceptance subscale had a mean of 5.41 (SD = .61) and the Self-Definition subscale had a mean of 3.85 (SD = 1.01).

Participants were asked to give feedback about the survey, including things they found helpful and recommendations for improvement. Of the 19 participants who chose to respond to this request, 4 stated that the presence of the rating scale on each page was helpful for them to remain clear about the scale descriptors. Two participants thought the questions in the IPI were repetitive and two participants stated their recognition that this repetition likely increased the validity of the tool. Five participants felt the questions in the IPI were ambiguous and three openly admitted that they felt bothered by some of the questions. Two participants recommended that the IPI be given to more experienced counselors, due to their recognition that there would likely be a difference in how these more experienced counselors rated the IPI items. Six participants stated they liked the opportunity to define a personal definition for masculine/feminine and that this encouraged them to think of masculinity and femininity differently as they answered the following questions.

The results of the pilot study indicate that the reworded IPI has honored the original intent of the instrument. The ranking of the 11 power bases compares positively to the ranking of the power bases in Erchul et al, 2001. Comments from the participants

seemed to indicate a level of discomfort with some of the questions regarding use of power and recommendations were made to utilize this tool with more experienced counselors. This reinforces the decision to choose experienced clinicians for the study. By choosing Professional Clinical Counselors (PCC), this researcher will ensure the participants will have at least two years of practical post-master's experience (the minimum experience requirement to qualify for PCC licensure). Participants also found the reprinting of the rating scale on each new page helpful. The reminder kept the meanings for each of the ratings clear for the participants.

Additionally, participants reported the helpfulness of being asked to think about their personal definitions for masculine and feminine at the beginning of the HGS. Hoffman, et al. (2000) initially put this question at the end of the HGS, but during the development process found that the question was more effective at the beginning of the tool, helping to focus the participants' responses to the questions on their personal definitions of masculine/feminine.

As an additional effort to evaluate the rewording of the IPI, this researcher asked five practicing PCCs (three females and two males) in the state of Ohio to review the tool. All found the wording clear and the rating reminders helpful. Even with the minimum of two years of experience, some the the PCCs found the questions about the use of power in the counseling session uncomfortable to examine. One PCC recommended adding a demographic question regarding the counseling setting of the client that the respondent was thinking about when rating the items. This researcher added this question to the demographic sheet.

Data Collection Procedures

A random sample of approximately 500 Ohio licensed Professional Clinical Counselors (PCCs) were obtained from the Ohio Data Network list. The Ohio Data Network is Ohio's centralized data center and serves multiple state entities, including the Ohio Counselor, Social Worker, Marriage and Family Therapist Board.

Established research protocols to protect human subjects were followed throughout this study. Research participants were fully informed of the purpose of the study, their role within the study as participants, and the fact that their participation was voluntary. The researcher utilized a numbering system to code surveys that the participants will complete. This was done in order to identify which participants will need to be contacted a second time regarding taking part in the survey. The researcher kept the names of the participants and their corresponding codes in a locked confidential location in order to protect the personal information of the participants. The decision to participate and complete the survey was considered consent to participate. This consent was obtained through the use of a cover letter sent to the participants through the U.S. Postal Service. Since this study used a survey and presented a low level of risk to the participants, the researcher submitted a request for an exempt review from the Ohio University Office of Research Compliance (see Appendix A) of the Institutional Review Board (IRB).

Using the U.S. Postal Service, participants were sent a cover letter, survey, and a self-addressed stamped envelope. The cover letter was personalized to each participant, and originated from Ohio University (both strategies increase response rates, according to

Edwards, Roberts, Clarke, DiGuiseppi, Pratap, Wentx, and Kwan, 2002). As an added incentive to respond to the request to participate, the participant were informed of the opportunity to receive one of five $20 gift certificates if he/she returned a completed survey. This strategy has also been found to increase response rates (Edwards et al., 2002; Erwin & Wheelright, 2002). After two weeks a postcard was sent to non-respondents reminding them of the survey and requesting that they consider completing and returning the survey. After one week, a second mailing (which included the complete packet of cover letter, survey, and self-addressed stamped envelope) was sent to all non-responders (Dillman, 2000), to again invite them to participate in the research.

Data Analysis Procedures

Upon completion of the data collection, the researcher used descriptive statistics to compute all independent and dependent variables, such as mean, standard deviation, frequency and range. The relationship between the dependent variable and the independent variables was assumed to be linear and was analyzed using various graphical methods, such as a bivariate scatterplot and boxplots. Data for the variables was assumed to be normally distributed. The data was examined for extreme or missing values, and for kurtosis and skewness. Tests were used such as the Kologorov-Smirnov test of normality and scatterplots to assess for homoscedasticity and linearity. The researcher used the following statistical methods in this study:

1. Descriptive statistics were utilized to explain the data. Significance of the various tests of assumptions and of the regression model used $\alpha = .05$. Beta (β) assisted in interpreting the ability of the variables to predict the dependent

variable. In order to understand the amount of change that each variable added to the part/partial correlation, the *R* square change (R^2_C) statistic was used.

2. Inferential statistics included the use of *z* and *t* statistics to assist in analyzing the data, testing the assumptions and obtaining the standardized coefficients (beta). *F* change statistics assisted in establishing the importance of the model.
3. Graphical methods included histograms, boxplots, scatterplots, normal Q-Q plots, and partial regression plots.

Chapter Summary

This chapter provided information regarding the methodology that was used to investigate the ability of the counselor's biological sex, gender self-definition, gender self-acceptance and use of soft and harsh power bases in the counseling session to explain the working alliance between the counselor and client. This chapter also included a discussion of the pilot study results. The procedures for the proposed study were outlined including a discussion of the research design, research questions/hypotheses, identification of the population, sampling plan, instrumentation, data collection procedures, data analysis procedures. The following chapter presents an analysis of the procedures and the results of the hypotheses.

CHAPTER IV: RESULTS

The purpose of this study was to investigate the relationship between a counselor's biological sex, gender self-confidence (which includes gender self-definition and gender self-acceptance), the counselor's use of social influence (which includes soft and harsh power bases) within the counseling session, and the development of a therapeutic working alliance between the counselor and client. Additionally, the researcher examined the perceptions of counselors' use of power and counselors' gender self-confidence in greater detail.

This chapter presents an analysis of the data collected for this research, as described in Chapter Three. First, the research participants are described, and then descriptive data and reliability analyses used to test the research hypothesis are provided. Next is a presentation of supplemental analyses and results of the social desirability scale. Then qualitative data from the counselors' gender self-confidence will be examined.

Participants in this study were licensed Professional Clinical Counselors (PCC) from the state of Ohio. Each participant was asked to complete a demographic questionnaire and four additional instruments: the Hoffman Gender Scale (HGS) by Hoffman et al. (2000), the Interpersonal Power Inventory (IPI) by Raven et al. (1998), the Working Alliance Inventory (WAI) by Horvath and Greenburg (1989), and the 13-item Marlowe-Crowne Social Desirability Scale (M-C SDS) by Reynolds (1982).

Mailing Response Rate

A list of 3,963 licensed Professional Clinical Counselors (PCCs) was obtained from the Ohio Counselor, Social Worker, Marriage and Family Therapist Board. In the

first mailing, 500 surveys were mailed to randomly selected PCCs from the list obtained. A total of 115 surveys (a 23% response rate) were returned in the first mailing. Five counselors declined participation due to retirement/having left the field and four counselors declined due to having no time or feeling that their situation was inappropriate for the research subject. Three surveys were returned to the researcher as undeliverable. Two weeks after the first mailing, a reminder post card was sent, resulting in 26 more returned surveys (increasing the response rate by 5.2%). One letter was received indicating the death of the prospective participant and four more counselors declined participation (due to no longer working in the field, lack of time, or not being comfortable with part of the survey). One week after the reminder post card, a second set of surveys were mailed, resulting in 48 additional surveys (adding 9.6% to the response rate) and five more counselors declining to participate (due to retirement/no longer working in the field, or discomfort with the survey). The total number of returned surveys was 187, resulting in a response rate of 37.4%. Due to sections of the surveys being incomplete, a total of 25 surveys (5%) were not usable to test the research hypothesis. The number of participants desired for the study was 120 (24%). A total of 162 usable surveys were available to test the research hypothesis, with a final 32.4 % response rate.

Demographic Characteristics

A total of 187 counselors completed a survey. However, due to sections of the surveys being incomplete and one survey containing some extreme values (very different responses given in the HGS from the rest of the respondents), a total of 161 surveys were available for the multiple regression. Due to this fact, the following demographic data is

based on the 161 usable surveys. All were licensed by the Ohio Counselor, Social Worker, Marriage and Family Therapist Board as Professional Clinical Counselors. A demographic questionnaire collected information about their biological sex, race, age, number of years practiced as a licensed counselor and information about the setting in which they work. Biological sex included 120 females (74.5%) and 41 males (25.5%). One hundred fifty four (95.7%) of the respondents were Caucasian/White, 4 (2.5%) were Black/African American, 1 (0.6%) was Asian or Pacific American, and 2 (1.2%) reported themselves as Other Minority (one respondent reported being "Appalachian/Native American/Caucasian") (see Table 1). Based upon other literature conducted in the counseling field, these percentages appear to be representative of counselors in the field.

Table 1

Demographics of Sample Counselors

Demographic	Number	Percentage
Biological Sex		
Female	138	73.8
Male	49	26.2
Race		
Caucasian/White	175	93.6
Black/African American	6	3.2
Asian or Pacific American	3	1.6
Other Minority	3	1.6

The age of the respondents ranged from 27 to 73, with a mean age of 47.65 and a median age of 49.00. The number of years practiced as licensed counselors ranged from 2 to 35, with a mean of 13.61 and a median of 12.0 (see Table 2).

Table 2

Age and Years of Licensed Experience of Sample Counselors

Demographic	Range	Mean	*SD*	Median
Age (in years)				
Female	27 – 73	46.48	11.56	47.50
Male	27 – 71	52.27	11.48	56.00
Total*	27 – 73	48.01	11.79	50.00
Licensed Experience (in years)				
Female	2 – 35	12.79	7.40	11.00
Male	2.5 – 35	16.02	8.90	15.00
Total**	2 – 35	13.61	7.91	12.00

*Note: $N = 182$. Five counselor's data for this item were coded as missing

**Note: $N = 185$. Two counselor's data for this item were coded as missing

Information gathered about the setting in which these respondents worked included whether they practiced: 1) in an inpatient/acute setting, an outpatient setting, or a residential setting, 2) in a community mental health setting (serving Medicaid and/or uninsured individuals) or a private practice setting, and 3) whether they worked primarily with voluntary or involuntary clients. Respondents reported 141 (88.7%) worked in an outpatient setting, 13 (8.2%) in a residential setting, and 5 (3.1%) in an inpatient/acute setting. Respondents reported 85 (61.6%) worked in a community mental health setting

(serving individuals with Medicaid or no insurance) and 53 (38.4%) worked in a private practice setting. Finally, respondents reported 126 (79.7%) worked primarily with voluntary clients and 32 (20.3%) primarily with involuntary clients. Respondents left some of the setting sections blank due to feeling their setting did not fit within the forced choices. Some respondents gave reasons for this, identifying their settings. Some worked in correctional facilities, juvenile detention centers/residencies, and colleges/universities (see Table 3).

Table 3

Settings for Sample Counselors

Setting	Number	Percentage
Setting #1*		
Inpatient/Acute	5	3.1
Outpatient	141	88.7
Residential	13	8.2
Setting #2**		
Community Agency (Medicaid/Free Services)	85	61.6
Private Practice	53	38.4
Setting #3***		
Voluntary	126	79.7
Involuntary	32	20.3

*Note: $N = 159$. Two counselors' data for this item were coded as missing

** Note: $N = 138$. Twenty-three counselors' data for this item were coded as missing

*** Note: $N = 158$. Three counselors' data for this item were coded as missing

Reliability Analysis on Research Instruments

Working Alliance Inventory

The Working Alliance Inventory (Horvath & Greenburg, 1989) demonstrated adequate reliability. Cronbaugh's alpha coefficient was utilized to show the internal

consistency of the WAI. Alpha coefficient was α = .88, which indicated a high level of reliability for the instrument. The reliability coefficient was comparable to the alpha coefficient (.93) reported by Horvath and Greenburg (1989). Reliability coefficients for the individual subscales also reflected the reliability estimates given by Horvath and Greenburg. Alpha coefficient for the Task subscale was α = .81 (.81 to .87 in Horvath & Greenburg). The reliability coefficient for the Bond subscale was α = .70, slightly less than the .85 to .92 reported by Horvath and Greenburg. The Goal subscale reliability coefficient was α = .85 (.82 to .87 in Horvath & Greenburg). Correlations between the three subscales and the total score ranged from α = .64 to α = .85. These results suggest that the Working Alliance Inventory provided reliable results for the current study.

Interpersonal Power Inventory

The counselor/client Interpersonal Power Inventory (Raven et al., 1998) demonstrated adequate reliability. Alpha coefficients for the counselor/client modification ranged from α = .51 to α = .78, which is in keeping with the alpha coefficients in the pilot study (.52 to .78). The results of the current study also resemble the coefficient alphas for the professor/student version of this tool, ranging from .45 to .80 (Elias, 2007). In the consultant/teacher modification of the IPI, the coefficient alphas ranged from .79 to .83 (Erchul, Raven, & Whichard, 2001). Correlations between the five power base subscales and the IPI Soft score range from α = .64 to α = .75, and correlations between the six power base subscales and the IPI Harsh score ranged from α = .66 to α = .86. These results, in addition to the results of the pilot study, suggest that the counselor/client modification of the IPI provided reliable results for the current study.

Hoffman Gender Scale

The Hoffman Gender Scale (Hoffman et al., 2000) demonstrated adequate reliability. Alpha coefficient for Self-Definition was α = .91, with the individual items correlating to HGS Self-Definition in a range from .66 to .89. Alpha coefficient for Self-Acceptance was α = .90, with individual items correlating to HGS Self-Acceptance ranging from .73 to .85. The authors of the scale established alpha coefficients for males and females separately. In the current study, the alpha coefficient for males was α = .94 for Self-Definition and α = .86 for Self-Acceptance. The alpha coefficient for females was α = .92 for Self-Definition and α = .94 for Self-Acceptance. The results are similar to the reliability scores established by Hoffman et al. (for females, .88 for Self-Definition and .90 for Self-Acceptance; for males, .93 for Self-Definition and .80 for Gender Self-Acceptance). These results suggest that the Hoffman Gender Scale provided reliable results for the current study.

Statistical Analysis to Test the Null Hypothesis

Statistical analyses were conducted using the Statistical Package for Social Sciences (SPSS) for Windows, version 14.0. Descriptive statistics were used to test for assumptions, regression analysis, and supplemental analyses.

Testing Assumptions for Multiple Regression Analysis

The dependent and independent variable scores were examined for normality using kurtosis, skewness, Kolmogorov-Smirnov tests, histograms, bar charts, and the normal Q-Q Plot. Kurtosis scores were evaluated and found that the confidence interval for the HGS Self-Definition variable contained zero, indicating a normal distribution.

However, the kurtosis scores for the IPI Soft, IPI Harsh, and the HGS Self-Acceptance variables suggested that these distributions were not normal. The variables were evaluated for both a positive or negative skew, and again the skewness scores seemed to indicate that the distributions for IPI Soft, IPI Harsh, and the HGS Self-Acceptance variables were not normal. However, review of the Kolmogorov-Smirnov test for normality indicated that all variables except for the HGS Self-Acceptance were distributed normally.

Histograms, boxplots and normal Q – Q Plots were reviewed. The variables HGS Self-Definition, IPI Soft, and IPI Harsh appeared normally distributed. The scores of each variable were standardized and for both the IPI Soft and IPI Harsh variables there was one extreme case. Analyses were conducted after removal of these extreme scores, however, new cases became outliers and extreme. Since these variables had already been established as normally distributed, the multiple regression was conducted with all cases included in the IPI Soft and IPI Harsh variables.

HGS Self-Acceptance was reviewed utilizing histograms and boxplots (see *Figures 2* and *3)*. According to the initial histogram and boxplot of this variable, there was one extreme score more than 3 standard deviations from the mean (Case 85, z = -6.37). When reviewing the data in this case, it appeared that the respondent conceptualized the HGS differently from the other respondents (did not use any 5 or 6 rating for any of the items). This score was removed. In a second examination 3 outlying scores now had scores more than 3 standard deviations from the mean (Cases 89, 142, and 46). These scores were also removed from the variable and further analyses were

conducted. The new histogram and boxplot displayed no outlying or extreme scores, however removal of these scores did not alter the significant result in the Kolmogorov-Smirnov test of normality. Therefore, the only score that was removed from the HGS Self-Acceptance variable was Case 85, due the extreme difference of this score from the rest of the HGS Self-Acceptance scores.

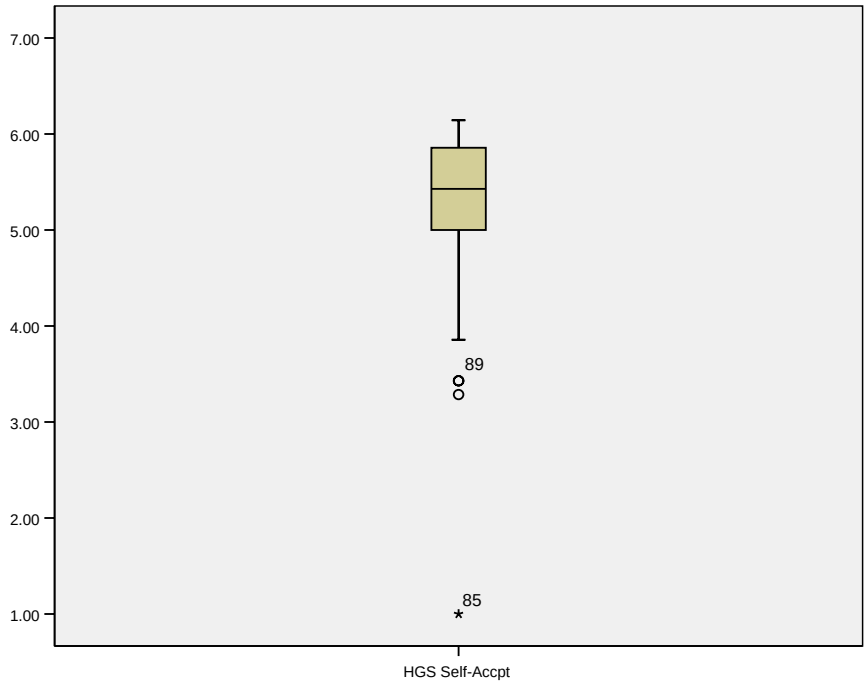

Figure 2. HGS Self-Acceptance Boxplot.

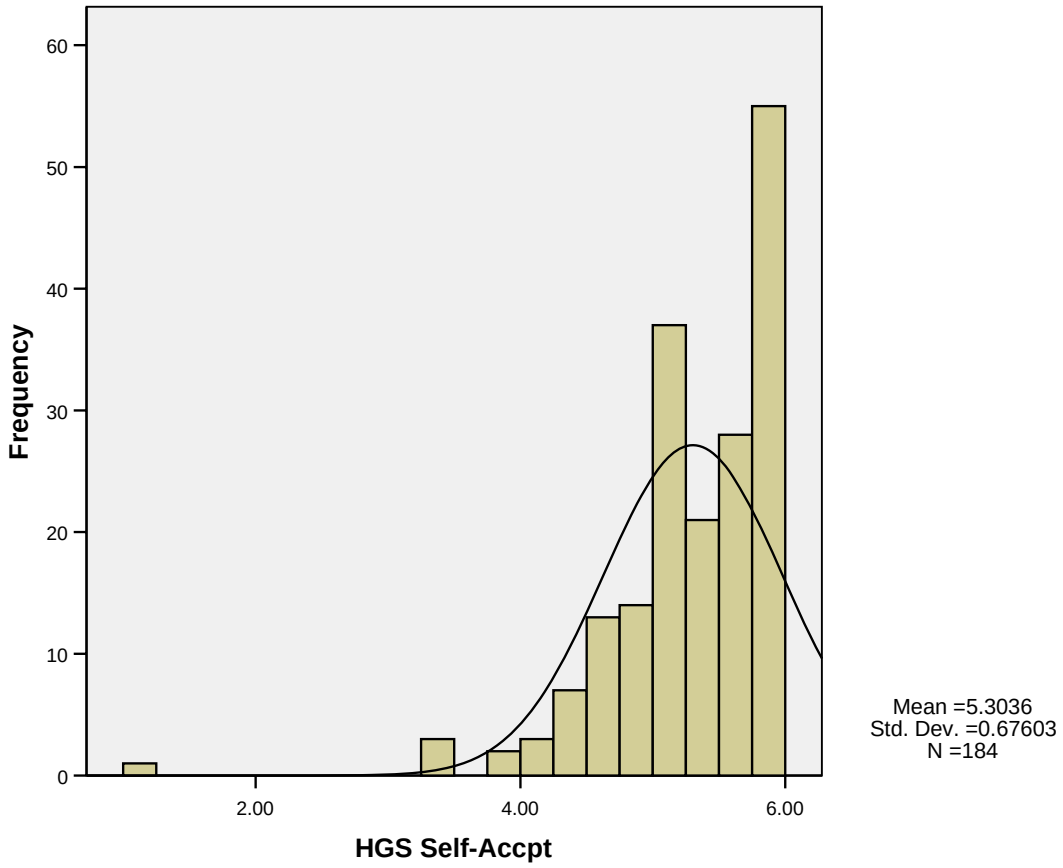

Figure 3. HGS Self-Acceptance Histogram.

Correlations between the independent and dependent variables were examined, along with tolerance scores in order to check for problems with multicollinearity (see Table 8). Collinearity diagnostics calculated the tolerance of the Working Alliance Inventory scale for biological sex (.96), IPI Soft (.56), IPI Harsh (.56), HGS Self-Acceptance (.86), and HGS Self-Definition (.83). These values were not near zero and did not appear to violate the assumption of multicollinearity.

Multiple Regression Analysis

A multiple regression analysis was conducted to see how well a counselor's biological sex, gender self-confidence (which includes gender self-definition and gender self-acceptance), and the counselor's use of social influence (which includes soft and harsh power bases) within the counseling session predicted the quality of the working alliance between the counselor and client.

In order to answer the research question "How well do the counselors' biological sex, gender self-definition, gender self-acceptance and the counselors' use of social influence (both soft and harsh power bases) in the counseling setting explain the quality of the working alliance?" the following null hypothesis was tested:

Null Hypothesis: There is no relationship between the counselor's biological sex, gender self-acceptance, gender self-definition, soft power bases and harsh power bases in the counseling session and the quality of the working alliance.

The findings of the multiple regression analysis indicated a rejection of the null hypothesis. There was a significant relationship ($F = 5.29$, $p = .000$) between the IPI Soft, IPI Harsh, HGS Self-Definition, HGS Self-Acceptance, and the Working Alliance Inventory.

Using the "Enter" method for the analysis, Table 4 shows that all of the variables except for biological sex had a statistically significant beta weight, explaining approximately 11.8% of the variance in the Working Alliance Inventory. The IPI Harsh and HGS Self-Definition variables were negatively correlated to the Working Alliance Inventory.

Table 4

Results of Coefficients with Five Predictors of the Working Alliance

	Unstandardized Coefficients		Standardized Coefficients		
Variables	*B*	*SE*	β	*t*	*p*
Model 1					
IPI Soft	9.66	3.37	.28	2.87	.005
IPI Harsh	-8.49	2.77	-.30	-3.06	.003
HGS Self-Definition	-4.41	1.45	-.25	-3.04	.003
HGS Self-Acceptance	8.00	2.63	.24	3.05	.003
Biological Sex	5.14	3.26	.12	1.57	.118

Note: IPI Soft and Harsh = Interpersonal Power Inventory – Soft and Harsh Power Bases; HGS Self-Definition and HGS Self-Acceptance = Hoffman Gender Scale – Self-Definition and Self-Acceptance.

Ad Hoc Analysis

The survey utilized in the study consisted of three instruments: Working Alliance Inventory (Horvath & Greenburg, 1989), Interpersonal Power Inventory (Raven et al., 1998), and the Hoffman Gender Scale (Hoffman et al., 2000). Means, standard deviations, and range for the predictor and criterion variables are summarized in Table 5.

Table 5

Means, Standard Deviations, and Range for Survey Instrument

Scale	*N*	*M*	*SD*	*Range*
Working Alliance Inventory	158	202.91	18.74	134 - 239
IPI Soft	160	4.70	.56	2.15 – 6.30
IPI Harsh	158	4.38	.68	1.79 – 5.83
HGS Self-Definition	160	3.89	1.06	1.0 – 6.0
HGS Self-Acceptance	160	5.34	.58	3.43 – 6.0
Biological Sex	161	.75	.44	0 – 1

Responses to the Working Alliance Inventory range from (1) Never to (7) Always, with higher scores indicating a stronger level of agreement. In the current study, scores on the WAI were M = 202.91, SD = 18.74. The three subscales of the WAI Task, Bond, and Goal were explored. The mean for the Task subscale was (M = 66.50, SD = 6.72), for the Bond subscale (M = 70.44, SD = 6.46) and for the Goal subscale (M = 65.83, SD = 6.46). The highest mean was for the Bond subscale.

The Hoffman Gender Scale consists of items rated from (1) Strongly disagree to (6) Strongly agree. The fourteen items combine to form two subscales, the Self-Definition and Self-Acceptance subscales (two of the independent variables for this study. HGS Self-Definition was M = 3.83, SD = 1.06 and the HGS Self-Acceptance was (M = 5.33, SD = .597). Breaking down the results into male and female, HGS Self-

Definition for male was (M = 3.46, SD = 1.13) and female (M = 3.95, SD = 1.01). HGS Self-Acceptance for male was (M = 5.34, SD = .51) and female (M = 5.32, SD = .63).

Scores for the Interpersonal Power Inventory in the current study range from (1) Much less likely to comply to (7) Much more likely to comply, with the higher scores indicating that the respondent strongly believes the other person in the dyad would be likely to comply with a request.

The results of this inventory result in eleven power bases. These power bases are then grouped into two different subscales, the Soft and Harsh power bases (two of the independent variables in this study). IPI Soft was M = 4.70, SD = .56 and the IPI Harsh was (M = 4.38, SD = .70).

Table 6 compares the means for these power bases in the current study and the pilot study. Positive Expert (current, M = 5.21; pilot, M = 3.88), Positive Referent (current, M = 5.06; pilot, M = 3.87), and Personal Reward (current, M = 4.99; pilot, M = 3.82) were identically ranked at positions 2, 3, and 4 respectively for both the current study and the pilot study. The number one ranking for the current study was Direct Informational (M= 5.53) and this power base was in last place for the Pilot Study (M = 1.80). Two of the lowest rankings for both studies were Impersonal Coercion (current, M = 3.99; pilot, M = 3.05) and Formal Legitimacy (current, M = 3.51; pilot, M = 2.52).

Table 6

Means, Standard Deviations, and Rankings for IPI Power Bases in the Current Study, Pilot Study, and the Erchul et al., 2001 Study

IPI Power Bases	*Current Study*		*Pilot Study*		*Erchul et al., 2001*	
	M(SD)	*Rank*	*M(SD)*	*Rank*	*M(SD)*	*Rank*
Direct Informational	5.53(.66)	1	1.80(.43)	11	2.48(.73)	1
Positive Expert	5.21(.69)	2	3.88(.51)	2	2.86(.73)	2
Positive Referent	5.06(.69)	3	3.87(.56)	3	3.03(.67)	4
Personal Reward	4.99(.69)	4	3.82(.48)	4	3.09(.60)	6
Impersonal Reward	4.96(.87)	5	4.14(.70)	1	2.91(1.42)	3
Legitimacy of Reciprocity	4.25(.79)	6	3.59(.41)	5	3.28(.70)	7
Legitimacy of Dependence	4.16(.80)	7	3.10(.61)	8	3.05(.67)	5
Legitimacy of Equity	4.11(.91)	8	3.35(.51)	7	3.89(.72)	9
Personal Coercion	4.03(.93)	9	3.39(.68)	6	4.11(.84)	10
Impersonal Coercion	3.99(.96)	10	3.05(.99)	9	3.71(1.52)	8
Formal Legitimacy	3.51(1.01)	11	2.52(.84)	10	4.15(1.03)	11

The rankings of power bases in this study are comparable to the rankings in other dyads utilizing this instrument. In Erchul et al. (2001), the highest ranked power base was

also Direct Informational. Four of the five highest ranked power bases (Direct Informational, Positive Expert, Positive Referent, and Impersonal Reward) in Erchul et al. are found in the five highest ranked power bases in this study. The same four power bases (Legitimacy of Equity, Impersonal Coercion, Personal Coercion, and Formal Legitimacy) are found at the lowest rankings for both this study and the Erchul et al. study.

It has also been proposed that males and females utilize power differently (Carli, 1999; Depre & Fiske, 1993; Johnson, 1976; Lorber, 1998; Roybak, 1981). In an effort to examine the element of biological sex in this instrument, the means for the variables IPI Soft and IPI Harsh were calculated separately for females and males. The means for females were IPI Soft M = 4.67 and IPI Harsh M = 4.33. For males, the means were IPI Soft M = 4.67 and IPI Harsh M = 4.34. There were no apparent differences between females and males. To investigate the results of the IPI more deeply, the 11 power bases were calculated separately for females and males (see Table 7).

Table 7

Female and Male Means, Standard Deviations, and Rankings for IPI Power Bases

IPI Power Bases	*Females*		*Males*	
	M(SD)	*Rank*	*M(SD)*	*Rank*
Direct Information	5.52(.62)	1	5.55(.75)	1
Positive Expert	5.24(.71)	2	5.11(.66)	2
Positive Referent	5.08(.73)	3	5.05(.55)	3
Personal Reward	4.95(.73)	5	5.02(.52)	4
Impersonal Reward	4.97(.86)	4	4.87(.87)	5
Legitimacy of Reciprocity	4.25(.82)	7	4.16(.74)	6
Legitimacy of Dependence	4.16(.84)	6	4.15(.58)	7
Legitimacy of Equity	4.09(.95)	8	4.09(.84)	8
Personal Coercion	3.98(.94)	9	4.06(.90)	9
Impersonal Coercion	3.97(.91)	10	3.78(1.07)	10
Formal Legitimacy	3.49(1.03)	11	3.45(1.01)	11

Again, the results were similar. The order of the power bases were identical except for two sets of power bases that were reversed. The order of the fourth and fifth ranked power base for females was Impersonal Reward and Personal Reward. For males the order was Personal and then Impersonal Reward. For the sixth and seventh power base, females rated Legitimate Dependence sixth and Legitimate Reciprocity as seventh.

Once again, males reversed the order. Means of the 11 power bases for females and males ranged from being identical (for Legitimate Equity) to a difference of .23 (for Positive Expert). In spite of the belief that females and males use power differently, this study did not demonstrate that.

Supplemental Analyses

Correlations and *t* test analyses were utilized to further explore the dependent and independent variables. Three significant relationships were demonstrated. The correlation between IPI Soft and IPI Harsh was statistically significant ($r = .66$, $p < .01$), as was the statistically positive correlation between HGS Self-Definition and HGS Acceptance ($r = .34$, $p < .01$) and between HGS Self-Acceptance and WAI ($r = .19$, $p < .05$). Some relationships were expected due to the fact that the IPI and HGS have subscales that share some similarities with each other (see Table 8).

Table 8

Correlations among the Predictor Variables for Working Alliance Inventory

Variable	1	2	3	4	5	6
Working Alliance Inventory	___					
IPI Soft	.11	___				
IPI Harsh	-.11	.66**	___			
HGS Self-Definition	-.12	-.02	.05	___		
HGS Self-Acceptance	.19*	.02	.03	.34**	___	
Biological Sex	.04	.01	.03	.20**	-.01	

Note: IPI Soft and Harsh = Interpersonal Power Inventory – Soft and Harsh Power Bases; HGS Self-Definition and HGS Self-Acceptance = Hoffman Gender Scale – Self-Definition and Self-Acceptance.

**$p < .01$

*$p < .05$

Independent sample *t* tests were conducted to further explore the data. An independent-sample *t* test was conducted to evaluate the difference between PCCs on the independent and dependent measures based on biological sex. Significant differences were observed for HGS Self-Definition (t = -2.25, df = 158, $d = .40$, $p < .05$). Females felt their femininity was more important to their definition of self (M = 4.00, SD = 1.03) than their male counterparts (M = 3.57, SD = 1.11) (see Table 9).

Table 9

Males and Females t Test

	Males			Females		
	N	M	SD	N	M	SD
Working Alliance Inventory	40	200.83	15.57	118	203.61	19.70
IPI Soft	41	4.71	.49	119	4.69	.58
IPI Harsh	41	4.36	.58	117	4.39	.71
HGS Self-Definition	41	3.57	1.11	119	4.00	1.03
HGS Self-Acceptance	41	5.37	.50	119	5.32	.61

Note: IPI Soft and Harsh = Interpersonal Power Inventory – Soft and Harsh Power Bases; HGS Self-Definition and HGS Self-Acceptance = Hoffman Gender Scale – Self-Definition and Self-Acceptance.

An independent sample *t* test was conducted to explore the difference between the PCCs on the independent and dependent measures based on whether the PCCs worked with involuntary clients versus voluntary clients. There were no significant differences.

Social Desirability Scale

A social desirability scale was included in this study in order to evaluate the level of need for cultural approval present in the responses of participants in research. Higher scores equal a higher need for cultural approval. The distribution was reviewed for the assumption of normality utilizing histograms, boxplots, skewness, kurtosis, and the

Kolmogorov-Smirnov test for normality. The distribution appeared to be normal, skewness and kurtosis had zero in the confidence interval and were not a problem, and the Kolmogorov-Smirnov test was not significant at the $p = .01$ level. There were no values over 3 standard deviations from the mean. This scale was also analyzed to see if it was significantly correlated with any of the variables in this study. No significant correlations were found. Therefore this distribution appeared to be normal, indicating that the respondents responded with a normally distributed need for cultural approval.

Hoffman Gender Scale Qualitative Data

The HGS began with a question that asked "What do *you* mean by femininity (or masculinity)?" Through a review of the responses, 37 respondents chose to leave this question unanswered. In the remaining 150 surveys, many included more than one component in their answer. Therefore, responses from 150 respondents resulted in 226 entries from females and 72 entries from males.

Responses were organized into categories based upon the entries and reflecting the categories established by Hoffman et al. (2005), where possible. These categories include 1) attractiveness, 2) androgyny, 3) biological sex, 4) forceful/assertive, 5) expressive/relational, 6) gender self-acceptance, 7) gender self-confidence, 8) gender self-definition, 9) not based on stereotypes, 10) opposite sex, 11) personal feeling/a "sense", 12) sexual orientation, 13) self reliance, and 14) societal standards. In order to adequately describe the entries given in this study, four additional categories were added. These include 1) protective/influential, 2) intelligence/abilities, 3) insights/spirituality, and 4) open-minded/accepting (see Table 10).

Table 10

Categories, Examples of Responses, and Entries of Females and Males Who Responded to Each Category

Category and Example	Percentage of reponses	
	Female	Male
N =	226	72
Attractiveness	11.06	0
Wearing dresses, heels, lace, frills (F)		
Androgyny	3.10	0
Characteristics held by both male and female (F)		
Biological Sex	0	8.33
Physical power, nothing more than a description of genitalia (M)		
Forceful/Assertive	8.41	20.83
Unafraid to take risks (M)		
Expressive/Relational	36.73	8.33
Helping, supporting others (F)		
Gender Self-Acceptance	2.66	5.56
Aware of who you are (F)		
Gender Self-Confidence	6.64	2.78
Being comfortable with oneself as a man (M)		
Gender Self-Definition	7.08	11.11
Embracing and exhibiting womanhood (F)		
Protective/influential*	.44	6.94
Guide, guard, exert influence (M)		
Intelligence/abilities*	.88	6.94
Rational, doing what you say you will (M)		

Table 10: continued

Insights/spirituality*	6.64	0
Dreams, intuitive (F)		
Not based on stereotypes	1.32	4.17
Doesn't adhere to stereotypes, healthier, congruent (F)		
Open minded/accepting*	1.77	2.78
Willing to admit you are wrong (M)		
Opposite sex	2.66	1.39
Less involved in other people's business inappropriately (M)		
Personal feeling/a "sense"	2.21	0
Sense of being distinctively female		
Sexual orientation	.44	0
Sexual orientation (F)		
Self-reliance	.88	5.56
Proactive, self-sufficient (M)		
Societal standards	7.08	15.28
Becoming what a man was intended to be (M)		

Note: The designation in the parentheses indicates whether the respondent is male (M) or female (F)

*Indicates categories created in this study to adequately describe the entries

Summary

This chapter presents the results of the study. Results indicate a rejection of the null hypothesis and acceptance of the hypothesis that the counselors' biological sex, gender self-definition, gender self-acceptance, and use of soft and harsh power bases within the counseling session significantly predict the quality of the working alliance.

Supplemental analyses were conducted to further explore the relationship between the variables including the counselor's gender self-definition, gender self-acceptance, soft and harsh power bases, and biological sex. The following chapter provides a discussion about the sample, null hypothesis, supplemental analyses, limitations, implications for practice and training, and recommendations for future research.

CHAPTER V: DISCUSSION

The purpose of this study was to investigate the relationship between the counselor's biological sex, gender self-confidence (including gender self-definition and gender self-acceptance), the counselor's use of social influence in the counseling session (including soft and harsh power bases) and the quality of the working alliance between the counselor and client. In this chapter, characteristics of the sample are discussed, as well as the results of the null hypothesis and supplemental analyses. Next, an in depth examination of the counselor's gender self-confidence (including self-definition and self-acceptance) and use of social influence (including soft and harsh power bases) is presented. Implications are explored, limitations of this study are discussed, and recommendations for the future are given.

Sample Characteristics

Response Rate

The response rate for this study was higher than projected (25%, or n = 125). The total response rate was 37.4% (187 returned surveys), and the final response rate of usable surveys (due to some sections of the surveys being incomplete and one survey excluded due to extreme scores) was 32.2%, or 161 surveys. This rate of response falls above the cutoff of the 25% minimum response rate described in Granello (2007) and suggests that the respondents are representative of the sample (Dillman, 2000).

Some possible reasons for the higher response rate could be the accuracy of the list, the underutilization of practicing counseling professionals in research efforts, the use of the U. S. Postal Service rather than email, efforts to personalize the communications

with each potential participant, the use of official letterhead for the cover letter, and a promised incentive.

The list of 3,963 licensed Professional Clinical Counselors (PCC) was obtained through the state of Ohio's professional counseling licensing body, the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board. These professionals would have a vested interest in keeping their licensing body updated on their current address and contact information. There is an opportunity to do so every two years when their license is up for renewal. Only three of the initial mailings came back to the researcher as undeliverable.

In much of Counselor Education research, the participants are frequently undergraduate or graduate students (Ametrano & Pappas,1996; Trepal, Wester, & Schuler, 2008)). The presence of these students in groups allows for simple access for researchers in search of participants for their studies. Unfortunately this limits the generalizability of the results to the population at large. Licensed counselors, practicing in the field, hold valuable information regarding the realities of performing treatment. Yet, there are no clear direct lines of communication to these individuals. Not all of these counselors belong to the professional memberships of their field (such as the Ohio Counseling Association or the American Counseling Association). The only apparent unifying thread is the license they hold, and who they must be in communication with to retain it. Therefore, practicing counselors are unlikely to be overwhelmed with requests to participate in research. This possibility may have promoted a willingness to respond to the current study.

Another possibility for the higher response rate may be due to the use of the U. S. Postal Service rather than email. When an advertisement or spam appears in the email inbox, it is simple to delete it unopened. Often individuals will do so if they do not know the sender. Literature indicates that response rates for internet surveys continues to be lower than for mailed surveys (Dillman, 2000; Leece, Bhandari, Sprague, Swiontkowski, Schemitsch, Tornetta, Devereaux, & Guyatt, 2004; Ritter, Lorig, Laurent, & Matthews, 2004). Studies using the internet have oversampled in order to get the number of responses needed to achieve the desired power level (Austin, 2004; Sebera, 2005), but often deal with low response rates. However, it is a much different experience to get a piece of mail, which is a tangible object held in the recipient's hands. If it is not clear what the purpose of this piece of mail is, most recipients are likely to open the mail and quickly review it. At that point the decision will be made whether to keep the mail or throw it away.

Additionally, and in connection to the possibility of the traditional mail service increasing the response rates, efforts were made to personalize each recipient's packet. This researcher followed four of the five elements recommended by Dillman (2000) when sending out the surveys. Two of these elements include the use of return envelopes with real first-class stamps and personalization of the communication. Each envelope was personally addressed by hand and real first-class stamps were used (rather than the machine stamping service offered by the post office). Each cover letter was personalized by the use of their first name in the greeting, and there was a stamped (real first-class) envelope included in each packet.

Another effort to increase the response rate was through the use of Ohio University letterhead for the cover letter, along with original signatures of this researcher and her dissertation advisor/chair. This let the recipients know that the survey was coming from a legitimate source, as well as recognizing that the signatures at the bottom of their letter were original (a further personalization). These efforts have been proven to increase response rates (Dillman, 2000).

Finally, a promised incentive was described in the cover letter. Although a promised incentive has been shown to have a smaller impact on the response rate than a "token" incentive (Dillman, 2000), the cost of a token incentive was prohibitive. Therefore a promised incentive of five $20 gift certificates was chosen and described for the recipients. In this way the study's response rate could receive the smaller benefit of the promised incentive.

Biological Sex Ratio

Participants in this study were 74.5% female and 25.5% male. This researcher did not attempt to control the percentage of female and male recipients of the survey in the belief that the random sample would replicate the percentage of female and male counselors practicing in the field. Unfortunately information regarding biological sex is not recorded by the database of the Ohio Counselor, Social Worker, Marriage and Family Therapist Board. However, this percentage resembles those found in Ametrano and Pappas (1996) where counselors-in-training from ten universities were participants of research regarding the effects of gender role orientation and biological sex. Their sample was comprised of 70% females and 30% males. Another recent study of counselors-in-

training comprised 72% females and 28% males from one Midwestern university (Trepal et al., 2008). Therefore these percentages appear to reflect the ratio of females to males in related counseling research.

Race

One hundred fifty four (95.7%) of the respondents were Caucasian/White, 4 (2.5%) were Black/African Americans, 1 (0.6%) was Asian or Pacific American, and 2 (1.2%) reported themselves as Other Minority (with one respondent identifying himself as "Appalachian/Native American/Caucasian"). These percentages are again reflected in the related literature. In Trepal et al. (2008), the sample consisted of 86% Caucasian/White, 10% Black/African American, and 4% Asian American participants. In the Seem and Clark (2006) study, the sample was made up of 92.6% Caucasian/White, 5% Black/African American, and 2.4% Asian participants. These percentages reflect those gathered in this study, indicating that the sample is similar to the samplings of other studies conducted with counselors-in-training.

Age and Years Practiced as Licensed Counselors

The age of the respondents ranged from 27 to 73, with a mean age of 47.65 and a median age of 49.00. The number of years practiced as licensed counselors ranged from 2 to 35, with a mean of 13.61 and a median of 12.0. These numbers reflect a group of counselors that are generally older and have experience in the field. It was the opinions and thoughts of this maturity and experience that this study was hoping to explore.

Counseling Setting

The survey gathered information about the setting in which these respondents worked. This information included whether they practiced: 1) in an inpatient/acute setting, an outpatient setting, or a residential setting, 2) in a community mental health setting (serving Medicaid and/or uninsured individuals) or a private practice setting, and 3) whether they worked primarily with voluntary or involuntary clients. Respondents reported 88.7% worked in an outpatient setting, 8.2% in a residential setting, and 3.1% in an inpatient/acute setting. Respondents reported 61.6% worked in a community mental health setting (serving individuals with Medicaid or no insurance) and 38.4% worked in a private practice setting. Finally, respondents reported 79.7% worked primarily with voluntary clients and 20.3% primarily with involuntary clients. Some respondents experienced difficulty answering the forced choice questions about their counseling setting due to feeling their setting did not fit within the choices. These settings included correctional facilities, juvenile detention centers/residencies and colleges/universities.

Discussion of Analysis to Test the Null Hypothesis

The multiple regression analysis rejected the null hypothesis that there was no relationship between the counselor's biological sex, gender self-acceptance, gender self-definition, soft and harsh power bases in the counseling session and the quality of the working alliance. The results indicate that there was a significant relationship between the dependent variable (the working alliance) and four of the five independent variables. Gender self- definition and harsh power bases had a significant negative relationship with the working alliance. Gender self-acceptance and soft power bases had a significant

positive relationship with the working alliance. Interestingly, biological sex was the only variable to have a nonsignificant relationship with the dependent variable of working alliance.

Increasing the understanding of how to effectively build a strong working alliance between the counselor and client is vital, since research consistently connects the quality of the working alliance to positive treatment outcomes. The current study demonstrates the importance of counselor characteristics to this working alliance. The manner in which the counselor exerts power over the client can build a stronger alliance or negatively impact it. The counselors' level of self-acceptance for their femininity or masculinity and how important these concepts are to their own sense of identity also plays a significant role in the development of a strong working alliance.

The results regarding soft and harsh power bases in this study are not surprising. Research has demonstrated counselors' efforts to be respectful of their clients while they attempt to assist them to make positive changes in their lives. Therefore the results of this study replicate what research has indicated. Harsh power bases were only slightly stronger in prediction (standardized coefficient β of -.303) than soft power bases. Results indicate that the more harsh power tactics the counselor endorses, the more the quality of the working alliance suffers. Soft power bases, however, positively predicted a quality working relationship (standardized coefficient β of .284).

The results regarding gender self-definition and gender self-acceptance are revealing. Gender self-definition was slightly more predictive than gender self-acceptance, but in a negative relationship (standardized coefficient β of -.248). Results

indicate that the more important the counselors' femininity/masculinity was to their perception and definition of who they were as individuals, the less likely they were to have a strong working alliance with their clients. Self-acceptance, on the other hand, had a significantly positive relationship with working alliance (standardized coefficient β of -.244). Results indicated that the more counselors felt they were living up to what they believed it was to be feminine or masculine, the better able they were to build strong working alliances with their clients.

Biological sex was the only variable that did not have a significant relationship with the working alliance. The results of this study support the statements made by Hinkelman and Granello (2003) regarding the overutilization of biological sex as a variable in research. In their study, biological sex was not predictive of attitudes towards the mentally ill. Instead it was the participants' gender role adherence that predicted intolerance of the mentally ill. The current study lends support to the idea that biological sex is not a valid way in which to determine the impact of participants' opinions/thoughts.

Discussion of the Supplemental Analysis

Interpersonal Power Inventory

In a supplemental *t* test, the correlation between IPI Soft and IPI Harsh power bases was found to be statistically significant ($r = .66$, $p < .01$). The Interpersonal Power Inventory had never been used on the counselor/client dyad prior to this study. It had been used with several other dyads, such as the university professor/student dyad (Elias, 2007) and the psychologist/teacher dyad (Erchul et al., 2001). The IPI was modified in

collaboration with the tool's author in order to fit the counselor/client dyad. The results of this study, along with the pilot study, seem to indicate the modification was successfully understood by the respondents. Results seem to reflect counseling's professional expectations and ethics, and provide the field with a valuable tool to further explore the utilization of power by counselors in the counseling session.

The rankings of the 11 power bases in this study compared to those of the pilot study are interesting. The most dramatic difference is the ranking of the Direct Informational power base. For the participants of this study Direct Informational power was the highest ranked base of power, but for the counselors-in-training in the pilot study it was ranked in eleventh place. This is likely reflecting the confidence level of the seasoned counselors. The Direct Informational power base suggests that the influencing agent, in this case the counselor, is seen as an expert by the client (Erchul, Raven, & Wilson, 2004; French & Raven, 1959; Raven, 1992). Counselors-in-training typically have much less confidence and would not rate this power base very highly. The IPI appears to have captured this lack of confidence and lends more credibility to the effectiveness of this tool in measuring counselor use of power in the counseling session.

The highest ranked power base endorsed by the counselors-in-training in the pilot study was Impersonal Reward (ranked as fifth for the seasoned counselors in this study). This power base implies that the client complies with the counselor due to the belief that the counselor can give the client a tangible reward or approval (French & Raven, 1959; Raven, 1992). Counselors-in-training seem to feel that clients will comply with the requests of the counselor due to the need for approval. The respondents of this study

ranked this power base more towards the middle of the grouping in recognition that this power base is present in the counseling relationship, but not of primary importance. Again, the IPI appears to be a sensitive enough tool to identify these differences between seasoned counselors and counselors-in-training.

Some of the differences found between the power base rankings in this study versus the Erchul et al. study (2001) could be due to the open recognition of the school psychologist's role in relationship to the teacher. The school psychologist's prime role is that of a consultant, and the success of consultation depends upon the ability "to influence the attitudes, beliefs, and behaviors of others" (p. 2). Recognition of the need to influence others is more clearly apparent.

This is not the case with counselors. The influence of the counselor has been problematic both theoretically and practically (Spong, 2007). Counselors reach into the experiences of the client and encourage change, through client self-reflection and self-examination. It is important to note that it is the counselor that reaches and encourages change. It is the counselor that offers interpretations and reflections.

Counselors are even encouraged to display their expertise in the field, through diplomas and licenses on the wall and initials after their names. They work within buildings and offices designated for the counseling purpose. They set the tone for the counseling process, describing the theory and approach within which they practice. Given this encouragement, it is not surprising to see the Expert power base in second place in the rankings for both this study and the pilot study.

Yet counselors may not recognize that these trappings of expertise denote power. Spong (2007) interviewed 28 counselors regarding their thoughts about social influence and found three themes. The participants believed that 1) counselors should not influence their clients, 2) influence is inevitable in relationships (even in counseling), and 3) counseling is an influencing process. In the interviews, these counselors struggled with how to make sense of contradictory themes. They were uncomfortable with the idea of a counselor intentionally attempting to influence a client. They argued over the idea of unintentional influence and the need for the counselor to be self-aware in the belief that this would minimize unintentional influence.

This researcher experienced many examples of this discomfort and struggle in the communications with potential participants for this study, as well as many comments written on the surveys themselves. Thirty-four of the counselors responding to the study wrote comments on the survey itself, documenting their distress at the questions. One counselor called this researcher with questions regarding some of the questions regarding the IPI and ultimately did not send in a completed survey. Two counselors emailed their discomfort with the questions and three mailed back the entire survey with a statement regarding not wanting to participate. Although the number of surveys returned was 187, the number for the final analysis was reduced to 161. This may be in large part due to the IPI, with respondents either not completing the tool or leaving questions unanswered.

Erchul et al. (2001) documented similar discomfort with the participants of their study as well. Several counselors in the current study were unable to finish the IPI due to discomfort with the questions. One participant wrote “Why would I want a client to

please me or do something for me? This is disturbing!" Many counselors wrote comments such as "inappropriate," "not ethical," "I wouldn't do this," and "does not apply." Several potential participants communicated their refusal to participate via email or sending a letter (or the whole survey) back to the researcher. One counselor wrote:

> …your questions truly make me uncomfortable. I read over the questions the first time you sent me a copy and decided not to respond. However, after having received another copy of the research study I decided to review it once again. The suggestion that a therapist would use the relationship between therapist and client to manipulate the client into complying with counseling goals seems disrespectful to the dignity of the people we serve.

Another counselor wrote "I answered NO to items that I found offensive. I really strive to relate to clients with unconditional positive regard. The therapeutic alliance produces any change that occurs. The session is for the client, not my objectives." Still another counselor wrote:

> This was extremely difficult for me to answer, as you can see. My clients are all voluntary and while many may have respect for me, I don't feel they make changes because I "tell" or "ask" them to do so. I was really not able to "guess" what a client might think about our counseling process.

Spong (2007) documents similar discomfort with the counselors she interviewed. If social influence is inevitable in all relationships, how can these seasoned counselors be reacting to a survey regarding the use of influence in the counseling setting with such discomfort? Perhaps one reason for this discomfort is the emphasis placed on respect for

the client in the educational training of counselors and an almost absent level of instruction regarding the use of influence. The instruction of the types of counseling theories often differentiates them by the level of directiveness in the theory. Client centered therapy is often touted as nondirective, yet it is the counselor who decides what parts of the client's statements to give more importance to and reflect back to the client. If counselors believe that influence equals inappropriate or unethical manipulation (which the statements made by participants of the current study indicate), then the use of influence in the counseling session will not be acknowledged or examined.

This lack of focus on the use of influence presents a concern, since influence is present in all social relationships. The current study demonstrates a significant positive relationship between soft power bases and working alliance. Therefore, there are power bases that enhance the alliance between the counselor and client, which would lead to more positive treatment outcomes. Yet the counselors in this study indicated discomfort with and at times an inability to answer the questions on the IPI.

Hoffman Gender Scale

There have been challenges raised regarding the historical dichotomous pattern of classifying feminine and masculine (Block, 1973; Constantinople, 1973; Deaux, 1984; Hare-Mustin & Maracek, 1988; Lewin, 1984). The HGS is a newly developed instrument that attempts to address this challenge. The authors have endeavored to create a tool that honors the human experience of both feminine and masculine traits within the same person. As early as 1984, researchers were asking whether tests that assess femininity and masculinity should be measuring gender self-confidence. They asked are these

individuals “meeting their own standards of femininity or masculinity” (Lewin, 1984, p. 200)?

A supplemental *t* test demonstrated that HGS Self-Definition and HGS Self-Acceptance were found to be statistically significantly correlated ($r = .34$. $p < .01$). Gender self-definition and gender self-acceptance have been documented by Hoffman et al. (2000) as existing on a continuum describing the single factor of gender self-confidence. Gender self-confidence is “the intensity of one’s belief that she/he meets her/his personal standards for femininity/masculinity” (Hoffman, p. 481). Self-definition is defined as how important masculinity or femininity is to the person’s idea of who she/he is. If the individual believes that his/her masculinity or femininity is very important, a strong gender self-definition is established. Gender self-acceptance is defined as how comfortable an individual is with how she/he is living up to a personal sense of femininity/masculinity (Hoffman et al.,2000). Figure 4 is a depiction of the possible combinations of gender self-definition and gender self-acceptance described by Hoffman, et al (2000) as a possible grouping of four categories.

Low Self-Definition/Low Self-Acceptance Individual does not place much importance on being feminine/masculine. Self-confidence is not centered on this aspect. Individual does not feel comfortable with ability to demonstrate femininity/masculinity.	**High Self-Definition/Low Self-Acceptance** Individual places a lot of importance on being feminine/masculine. Self-confidence is centered on this aspect. Individual does not feel comfortable with ability to demonstrate femininity/masculinity.
Low Self-Definition/High Self-Acceptance Individual does not place much importance on being feminine/masculine. Self-confidence is not centered on this aspect. Individual feels comfortable with ability to demonstrate femininity/masculinity.	**High Self-Definition/High Self-Acceptance** Individual places a lot of importance on being feminine/masculine. Self-confidence is centered on this aspect. Individual feels comfortable with ability to demonstrate femininity/masculinity.

Figure 4. Gender Self-Definition and Self-Acceptance Combinations.

Respondents in this study demonstrated a high level of comfort with the ability to live up to their own expectations of femininity and masculinity. The mean for HGS Self-Acceptance was 5.34, and the highest score possible was 6.0. Respondents in this study also demonstrated a moderate level of importance on femininity or masculinity. The mean for HGS Self-Definition was 3.88.

When the results of females and males were separated, males reported the HGS Self-Acceptance mean as 5.35 and the HGS Self-Definition mean as 3.57. Females reported the HGS Self Acceptance mean as 5.32 and the HGS Self-Definition mean was 3.95. These results suggest that the males and females participating in this study felt similarly, with females placing slightly more importance on defining themselves as female. In the Hoffman et al. (2000) study, the female participants endorsed self-

definition (with means for the 7 items comprising self-definition ranging from 3.57 to 4.51) more than the male participants (means ranging from 2.21 to 3.16). Participants in the Hoffman et al. study also demonstrated a high level of comfort with their ability to live up to their expectations of femininity and masculinity. In a 2006 study, Hoffman studied ethnicity, gender self-definition and self-acceptance. Here again, gender self-acceptance received higher scores (with means ranging from 4.92 to 5.47) than gender self-definition (with means of 3.48 to 4.43).

The participants in the current study were older than participants in prior studies using the HGS (Hoffman, 2006; Hoffman et al., 2000). The Hoffman et al. (2000) study had a mean age of 20.45, and the Hoffman (2006) study had a mean age of 25.08. In the current study, the mean age was 47.65. It is interesting to note that the trend of a higher level of self-acceptance than self-definition continues into adulthood. Also noteworthy is the fact that the participants of the current study rated self-acceptance noticeably higher than the younger participants in the Hoffman et al. study. It would seem that age has a positive impact on gender self-acceptance. Table 10 compares the means of the individual items of both gender self-definition and self-acceptance in the Hoffman et al. study and the current study.

Table 11

Comparison of Means for Gender Self-Definition and Gender Self-Acceptance Items for Females and Males

	Hoffman et al., 2000		Current Study	
Item Number	*Females*	*Males*	*Females*	*Males*
Gender Self-Definition				
1. Describe	3.69	3.16	3.44	2.87
4. Biology	4.52	2.21	4.88	4.51
6. Define	3.57	3.15	3.44	2.85
7. Identity	3.71	2.99	3.68	2.98
9. Critical	3.98	2.87	3.81	3.70
12. Self-concept	4.24	2.63	4.29	3.85
13. Contribu-tion	4.16	2.44	4.16	3.47
Gender Self-Acceptance				
2. Confidence	5.35	5.56	5.31	5.45
3. Stand	5.24	5.36	5.16	5.32
5. Secure	5.36	5.47	5.42	5.53
8. Regard	5.23	5.00	5.06	4.55
10. Happy	5.60	5.57	5.40	5.47

Table 11: continued

11. Comfort	5.69	5.73	5.51	5.62
13. Sense	5.49	5.55	5.41	5.43

The HGS begins with a question asking "What do *you* mean by femininity (masculinity)?" In 2005, Hoffman et al. explored the answers to this question and ended up with 14 categories within which they place the participants' answers. In the current study, respondents offered 298 (226 from females and 72 from males) entries that this researcher placed within the 14 categories established in 2005 by Hoffman et al., as well as four additional categories (needed to accommodate the entries). The categories most endorsed by the females in this study were Expressive/Relational (36.73%), Attractiveness (11.06%), and Forceful/Assertive (8.41%). The categories most frequently endorsed by the males in this study were Forceful/Assertive (20.83%), Societal Standards (15.28%), and Gender Self-Definition (11.11%). The categories that were the least endorsed by females in this study were Biological Sex (0%), Protective/Influential (0.44%), and Sexual Orientation (0.44%). There were five categories that did not have any entries for the male participants of this study. These categories include: Attractiveness, Androgyny, Insight/Spirituality, Personal Feeling/"a sense", and Sexual Orientation.

In the Hoffman et al. (2005) study, females endorsed Biological Sex (31.4%), Expressive/Relational (29.5%), and Societal Standards (21.4%) as the top three categories. Males endorsed Forceful/Assertive (35.0%), Biological Sex (31.3%) and

Societal Standards (22.5%). The categories that were least endorsed by females were Sexual Orientation (2.4%), Self-Reliance (2.9%), and Attractiveness (3.8%). Males least often endorsed Attractiveness and Gender Self-Definition (both representing only 1.3%) as well as a Personal Feeling/"a sense" (5.0%).

There were some differences between the results of the present study and the results of the Hoffman et al. (2005) study. Some of these differences may be due to the manner in which this researcher interpreted the categories that had been established by the Hoffman et al. study. For instance, in the Hoffman et al. study, biological sex was the top category endorsed by female participants, and in this study there were no entries in that category. In reviewing the entries, this researcher identified 6 entries that could possibly be moved to Biological Sex. Some of these entries had to do with a pleasing appearance (for example "delicate, fine featured, and elegant in build"), and this researcher placed the entry in the Appearance category.

There were also similarities between the two studies. Expressive/Relational was a category in the top three for females in both studies. Forceful/Assertive and Societal Standards were two of the top three categories for males in both studies. Paired along with Attractiveness for females and Gender Self-Definition for males, gender stereotypes appear evident. This supports the findings of the Hoffman et al. (2005) study.

Implications of Findings

The results of this study have implications for counselors and counselor educators. This study validates the position that counselors not only use influence in the counseling session, but demonstrates that certain kinds of influence have a positive

impact on the working alliance. The literature has shown that counselors who are perceived as empathetic, nonjudgmental and congruent are more likely to be positively related to a good working alliance and, therefore, positive treatment outcomes. However, although there is abundant literature on the association between a strong working alliance and positive treatment outcomes (53 studies between 1985 and 2006 documented by Tyron, Blackwell, & Hammil in 2007), and the impact of moderating variables, there is minimal research on the use of counselor influence in the counseling relationship.

Results of this study demonstrate that how a counselor uses influence strategies in order to achieve the treatment goal is important. Openness and responsiveness on the counselor's part allows the counselor to fit treatment approaches to the needs of the client. Clients report strong therapeutic alliances with counselors that use more responsive, collaborative qualities. They rate counselor qualities such as insight, increased awareness of feelings and experiences, and the progress made on the presenting problem highly.

Counselors in the current study not only endorse soft power bases (such as direct informational, positive expert, and positive referent), but results state that these soft power bases positively impact the working alliance. Yet counselors tend to downplay and seem uncomfortable with the subject of counselor power. Literature has rarely explored this counselor characteristic. Some have stated that power can be kept out of the counseling setting, yet counseling is not a democratic process. As long as the counselor downplays or denies the presence of counselor influence in the counseling setting, the use of that influence remains hidden and obscure.

Influence can be categorized in many ways, and counselors would benefit from the knowledge that not all use of influence is coercive or disrespectful of the client. The results of this study demonstrate how soft power bases can enhance the working alliance and lead to positive treatment outcomes. It also demonstrates what happens if harsh power bases are used (decreasing the quality of the working alliance). If counselors reflected on their use of soft/harsh power bases and influence in the counseling session, then the use of influence would be thoughtful and counselors would enhance their own self-awareness.

Yet how can this self-reflection occur for the clinicians already in the field? This study identifies that a lack of understanding regarding the undeniable presence of power and social influence in the counseling relationship exists. Even when offered a chance to more deeply explore this presence of power/influence, the clinicians in this study were often uncomfortable. It appears there is a need for clinicians in the field to experience purposeful self-reflection in order to understand their own use of power and influence in the counseling session and how that power/influence enhances or diminishes the working alliance with their clients. Without this purposeful self-reflection, counselors will lose an opportunity to build stronger relationships with their clients, which has been shown to have a direct impact on the success of treatment.

The results of this study also validate the position that the use of biological sex as a predictor variable in research has been over utilized, a concern that has been raised in the literature (Hinkelman & Granello, 2003). In the current study, if biological sex had been used as the only gender-linked variable, biological sex would not have come out as

a significant predictor variable for a quality working alliance. Instead, the predictor variables of gender self-definition and gender self-acceptance accounted for significant amounts of the variance. As Hinkelman and Granello have stated, this may explain why research that has used biological sex as a predictor variable has yielded mixed results.

This study demonstrates the need to view females and males as more than an either-or dichotomy. By use of the Hoffman Gender Scale, significant prediction came from the way in which the participants defined and accepted themselves. The significant prediction did not come from whether the participants were biologically female or male. Researchers have struggled with the dichotomy regarding femininity and masculinity since the 1970s, recognizing that this did not allow for the complexity that reflects the reality of human beings.

Results of this study give evidence to the continuation of gender role stereotypes in the attitudes and opinions of the counseling profession. Participants in this study are mature, seasoned counselors, yet they endorsed stereotypical responses to the question "What do *you* mean by femininity (masculinity)?" The presence of stereotypes in the beliefs and attitudes of females and males in the helping profession have been documented since the 1970s. In spite of the belief that stereotypes regarding female and male have been successfully dealt with, this study shows that this is not the case. These stereotypical attitudes have also been recorded as having an impact on diagnostic decisions.

Counselors need to become aware of their own biases regarding masculinity and femininity. As Hoffman et al. (2005) states:

> Counselors who reinforce the "humanness" of human qualities with their clients, rather than supporting a dichotomy between those traditionally seen as either masculine or feminine, can help clients understand that men can and should access emotions such as their compassion just as women can and should access attributes such as their leadership abilities. (p. 79)

Due to the importance of counselor characteristics (such as the use of power/influence and gender self-definition/acceptance) counselor self-awareness is an area that needs a deliberate and systematic training focus within counseling programs. With the consistent correlation between working alliance research and treatment outcomes, this is an area of professional ethics that requires attention of counselor educators and professionals in the field seeking further training. This research further demonstrates the importance of counselor characteristics. Counselor educators and counselor licensing boards have the responsibility to provide opportunities for counselors-in-training and counselors already in the field to engage in self-reflection.

Counselor educators should enhance the self-awareness of counselors-in-training regarding the presence of power in the counseling relationship, as well as challenge their biases regarding the dichotomy of femininity and masculinity. This enhancement could occur through purposeful inclusion of self-reflection into the required coursework of the counseling program, as well as including training in counselor self-awareness as part of the core curriculum. This training could include one course dedicated to self-awareness and self-reflection. In this way the counselor-in-training would have to dedicate time to this effort (a task that might not happen otherwise).

Another possibility that can enhance the self-awareness of the counselor-in-training is for counselor education programs to require students to participate in their own counseling. In this way, the student experiences the role of the client, as well as having dedicated time to reflect upon their own values, opinions and perceptions. While there are ethical considerations to weigh in counseling education programs requiring their students to experience counseling themselves, this study demonstrates the importance of these counselors-in-training develop a deeper understanding of who they are as individuals before they begin engaging in the influencing process of counseling.

Counselors already in the field are required to obtain continuing education credits in order to maintain their license. Some of these credits in the state of Ohio are mandated to be in the area of professional ethics. Ethics training programs targeting the use of power/influence in the counseling relationship, the level of stereotypical beliefs/values, the counselors' personal definitions of feminine and masculine, and the importance they place upon these definitions need to be developed and attendance encouraged. Trainings could also be developed under the subject of increasing the degree of positive treatment outcomes. In this way counselors seeking to improve their professional ethics and counselors seeking to improve their success rate in treatment will receive training.

Limitations of the Study

There were several limitations associated with this study. First, the instruments used for this research were self-report tools. Although the results of the social desirability scale (Personal Reaction Inventory by Crowne & Marlowe, 1960) indicated truthfulness, there remains the risk that some of the participants altered answers according to what

seemed socially desirable. Second, the participants came from one state. It is possible that similar studies conducted in other geographical areas might yield different results. Third, participants came from the counseling profession, thereby limiting the ability to generalize the results to helping professionals from other disciplines. Fourth, due to the nature of the instruments used in the study, there was no opportunity to probe into the feelings and opinions of the respondents, or to clarify meanings for some of the questions. There were some communications from respondents stating their discomfort, but this researcher did not have an opportunity to delve into this discomfort. Fifth, the predictor variable of HGS Self- Acceptance was not a normal distribution, limiting the strength of the findings with this variable. Sixth, an increase in the sample size of male participants could increase confidence in the results. Seventh, the instructions of the WAI and the IPI asked the respondents to identify a client for the questions. Respondents may not have used the same client for the two tools in the survey, the criteria for choosing which client to choose may have been different (opting for a more compliant or more resistant client), or the respondent may have conceptualized "client" to be a generalized term (rather than a specific client).

Directions for Future Research

The current study focused on counselor gender self-confidence (including self-definition and self-acceptance), use of power in the counseling session (including soft and harsh power bases), biological sex, and the working alliance between the counselor and client. Future studies are recommended to deepen the understanding of the use of counselor power in the counseling session. This could be accomplished by replicating

this study with counselors from other geographical areas and helping professionals from other disciplines. Future studies could give more specific instructions to respondents regarding how to select the client for the survey (i.e., select by date or client characteristics). Qualitative studies could probe more deeply into the feelings, opinions, conceptualizations, and rationale for some of the answers regarding power (especially the reasons behind the discomfort that several of the counselors described).

Future research regarding gender self-definition and gender self-acceptance is recommended. A more complete understanding of gender self-confidence will help the field explore important questions having to do with the subjective area of gender identity. Due to a pressure to conform to the standard set by our culture, the current minimization of the importance of gender issues, and the belief of many that gender has been successfully dealt with, this may be a difficult task. Added research will assist the counseling field to refocus on this important area. This could be accomplished by further use of the Hoffman Gender Scale with diverse populations, thereby replicating the results of this study and those of the authors of the tool. Qualitative research could investigate with more depth the meanings of the answers given by participants for the question "What do *you* mean by femininity (masculinity)?"

Counselor education programs could begin assessing the self-awareness of their incoming students and re-examining this self-awareness at certain points during the educational program. This would measure the enhancement of self-awareness of the counselors-in-training for those programs that implement efforts to target and build the self-awareness of their students. This could also identify what occurs to the self-

awareness of students in programs that do not implement efforts to enhance self-awareness. This information could then be used to further efforts at educating effective counselors.

Conclusion

This study provided additional strength to the literature exploring what promotes a quality working alliance between a counselor and client. It provided an opportunity to explore the counselor's use of power in the counseling session, filling in a gap in the research. This study also provided an opportunity to explore gender self-definition and gender self-acceptance with a different population than had been studied in the past. The results demonstrated a significant finding between the counselor's gender self-definition, gender self-acceptance, use of soft and harsh power bases in the counseling session, and working alliance. This study makes a significant contribution to the field by enhancing the understanding of counselor characteristics that add to the quality of the working alliance between a counselor and client.

REFERENCES

Alexander, L.B., Barber, J.P., Luborsky, L., Crits-Christoph, P., Auerbach, A. (1993). On what bases do patients choose their therapists? *Journal of Psychotherapy Practice and Research, 2,* 135-146.

American Heritage Dictionary (3rd college ed.). (1992). Boston: Houghton Mifflin Company.

Ametrano, I.M., & Pappas, J.G. (1996). Client perceptions of counselors-in-training: The effects of sex and gender role orientation. *Counselor Education & Supervision, 35*, 190-201.

Assay, T.P., & Lambert, M.J. (2001). Therapist relational variables. In D. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 531-558). Washington, DC: American Psychological Association.

Austin, J.M. A study of athletic training education facility attitudes' toward instructional technology and their extent of utilization of that technology. Unpublished doctoral dissertation. Ohio University, Athens, OH.

Bargad, A., & Hyde, J.S. (1991). Women's studies: A study of feminist identity development in women. *Psychology of Women Quarterly, 15,* 181–201.

Bakan, D. (1966). *The duality of human existence: An essay on psychology and religion.* Chicago: Rand McNally & Company.

Baker Miller, J. (1991). Women and power. In J. Jordan, A. Kaplan, J. Baker Miller, I. Stiver, & J. Surrey (Eds.), *Women's growth in connection.* New York: Guilford.

Barry, H., Bacon, M.K., & Child, I.L. (1957). A cross-cultural survey of some sex differences in socialization. *Journal of Abnormal and Social Psychology, 55,* 327-332.

Basow, S.A. (1992). *Gender: Stereotypes and roles* (3rd ed.). Monterey, CA: Brooks/Cole.

Beere, C.A. (1990). *Gender roles: A handbook of tests and measures.* New York: Greenwood Press.

Bem, S.L. (1977). On the utility of alternative procedures for assessing psychological androgyny. *Journal of Consulting and Clinical Psychology, 45,* 196-205.

Bem, S.L. (1979). Theory and measurement of androgyny: A reply to the Pedhazur Tetenbaum and Locksley-Colten critiques. *Journal of Personality and Social Psychology, 37,* 1047-1054.

Bem, S.L. (1996). Transforming the debate of sexual inequality. From biological difference to institutionalized androcentrism. In J. Chrisler, C. Golden, & P. Ruzee (Eds.), *Lectures on the psychology of women* (pp. 9-21). New York: McGraw-Hill.

Bem, S.L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological Review, 88,* 354-364.

Benetti-McQuoid, J., & Bursik, K. (2005). Individual differences in experiences of and responses to guilt and shame: Examining the lenses of gender and gender role. *Sex Roles*, *53*, 133-142.

Blanton, P., & Vandergriff-Avery, M. (2001). Marital therapy and marital power: Constructing narratives of sharing relational positional power. *Contemporary Family Therapy, 23*, 295–308.

Block, J.H. (1973). Conceptions of sex role: Some cross-cultural and longitudinal perspectives. *American Psychologist,* 512-526.

Bohart, A., Elliott, R., Greenberg, L.S., & Watson, J C. (2002). Empathy. In J.C. Norcross (Ed.) *Psychotherapy relationships that work.* New York: Oxford University Press.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, *16*, 252-260.

Bordin, E. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13-37). New York: Wiley.

Bourgeois, L., Sabourin, S., & Wright, J. (1990). Predictive validity of therapeutic alliance in group marital therapy. *Journal of Consulting and Clinical Psychology, 58,* 608–613.

Brewer, L. (2001). Gender socialization and the cultural construction of elder caregivers. *Journal of Aging Studies, 15*, 217-236.

Broverman, I.K., Broverman, D.M., Clarkson, F.E., Rosenkrantz, P.S., & Vogel, S.R. (1970). Sex-role stereotypes and clinical judgments of mental health. *Journal of Consulting & Clinical Psychology, 34,* 1-7.

Broverman, I.K., Vogel, S.R., Broverman, D.M., Clarkson, F.E., & Rosenkrantz, P.S. (1972). Sex-role stereotypes: A current appraisal. *Journal of Social Issues, 28,* 59-78.

Burr, V. (2000). *An introduction to social constructionism.* London: Routledge.

Busseri, M.A., & Tyler, J.D. (2003). The interchangeability of the Working Alliance Inventory and Working Alliance Inventory, Short Form. *Psychological Assessment, 15,* 193-197.

Carli, L.L. (1999). Gender, interpersonal power, and social influence. *Journal of Social Issues, 55,* 81-99.

Carpenter, J. (1994). Power and politics in practice: Finding people in family therapy. *Dulwich Centre Newsletter, 1,* 32-38.

Chodorow, N.J. (1989*). Feminism and psychoanalytic theory.* New Haven, CT: Yale University Press.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences (2nd ed.).* Hillsdale, NJ: Erlbaum.

Constantinople, A. (1973). Masculinity-femininity: An exception to a famous dictum? *Psychological Bulletin, 80,* 389-407.

Cook, E.P. (1985). Androgyny: A goal for counseling? *Journal of Counseling and Development, 63,* 567-571.

Corrigan, J.D., Dell, D.M., Lewis, K.M., & Schmidt, L.D. (1980). Counseling as a social influence process: A review. *Journal of Counseling Psychology, 27,* 395-441.

Council for Accreditation of Counseling and Related Educational Programs. (n.d.) *The 2001 standards*. Alexandria, VA: Author.

Courchaine, K E., & Loucka, P.A. (1995). Effects of counsellor interpretations and client reactance on social influence and the working alliance. *Counselling Psychology Quarterly, 8,* 123-138.

Crawford, M. (2003). Gender and humor in social context. *Journal of Pragmatics, 35,* 1413-1430.

Crits-Christoph, P., Barber, J., & Kurcias, J. (1993). The accuracy of therapists' interpretations and the development of the therapeutic alliance. *Psychotherapy Research, 3,* 25–35.

Crits-Christoph, P., & Gibbons, M.B. (2003). Research developments on the therapeutic alliance in psychodynamic psychotherapy. *Psychoanalytic Inquiry, 23,* 332-350.

Crowne, D.P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24,* 349-354.

Darchuk, A.J. (2007). *The role of the therapeutic alliance and its relationship to treatment outcome and client motivation in an adolescent substance abuse treatment setting.* Unpublished doctoral dissertation, Ohio University, Athens.

Deaux, K. (1984). From individual differences to social categories: Analysis of a decade's research on gender. *American Psychologist, 39,* 105-116.

Delaney, R.O. (2006). *Therapeutic alliance in couples therapy: The influence of gender, who initiated therapy, split alliance, and the presenting problem.* Unpublished doctoral dissertation, The Ohio State University, Columbus.

Dell, D.M. (1973). Counselor power base, influence attempt, and behavior change in counseling. *Journal of Counseling Psychology, 20,* 399-405.

Depret, E., & Fiske, S.T. (1993). Social cognition and power: Some cognitive consequences of social structure as a source of control deprivation. In G. Weary, F. Gelicher, & K.L. Marsh (Eds.), *Control Motivation and social cognition* (pp. 176-202). New York: Springer-Verlag.

Dillman, D.A. (2000). *Mail and internet surveys: The tailored design method.* New York: John Wiley & Sons, Inc.

Dorn, F.J., & Day, B.J. (1985). Assessing change in self-concept: A social psychological approach. *American Mental Health Counselors Association Journal,* 7, 180-186.

Edwards, P., Proberts, I., Clarke, M., DiGuiseppi, D., Pratap, S., Wentz, R., & Kwan, I. (2002). Increasing response rates to postal questionnaires: Systematic review. *British Medical Journal, 324,* 1183-1191.

Elias, S.M. (2007). Influence in the ivory tower: Examining the appropriate use of social power in the university classroom. *Journal of Applied Social Psychology, 37,* 2532-2548.

Erchul, W.P., Raven, B.H., & Ray, A.J. (2001). School psychologists' perceptions of social power bases in teacher consultation. *Journal of Educational and Psychological Consultation, 12,* 1-23.

Erchul, W.P., Raven, B.H., & Wilson, K.E. (2004). The relationship between gender of consultant and social power perceptions within school consultation. *School Psychology Review, 33,* 582-590.

Erikson, E. (1968). *Identity: Youth and crisis*. New York: Norton.

Erikson, R.J. (2005). Why emotion work matters: Sex, gender, and the division of household labor. *Journal of Marriage and Family, 67,* 337-351.

Erwin, W.J., & Wheelright, L.A. (2002). Improving mail survey response rates through the use of a monetary incentive. *Journal of Mental Health Counseling, 24,* 247-255.

Evans, K.M., Kincade, E.A., Marbley, A.F., & Seem, S.R. (2005). Feminism and feminist therapy: Lessons from the past and hopes for the future. *Journal of Counseling & Development, 83,* 269-277.

Fitzpatrick, M.R., Iwakabe, S., & Stalikas, A. (2005). Perspective divergence in the working alliance. *Psychotherapy Research, 15,* 69-79.

Flanagan, E.H., & Blashfield, R.K. (2005). Gender acts as a context for interpreting diagnostic criteria. *Journal of Clinical Psychology, 61,* 1485-1498.

Foote, C.E., & Frank, A.W. (1999). Foucault and therapy: The disciplining of grief. In A.S. Chambon, A. Irving & L.Epstein (Eds.), *Reading Foucault for social work* (pp. 157-187). New York: Columbia University Press.

Foucault, M. (1980). *Power/Knowledge: Selected interviews and other writings.* Brighton: Harvester.

Foucault, M. (1981) *The history of sexuality, Vol. 1*. Harmondsworth: Penguin.

Foucault, M. (1982). *Beyond structuralism and hermeneutics.* Chicago: The University of Chicago Press.

French, J.R.P., Jr., & Raven, B.H. (1959). The bases of social power. In D. Cartwright (Ed.), *Studies in social power* (pp. 157-167). Ann Arbor, Michigan: Institute for Social Research.

Freud, A. (1954). The widening scope of indications for psychoanalysis. Discussion. *Journal of the American Psychoanalytic Association*, *2*, 607-620.

Freud, S. (1895/1966). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud, Vol. 1 (1886-1899), pre-psych-analytic publications and unpublished drafts.* London: The Hogarth Press.

Freud, S. (1912/1994). *The Dynamics of Transference. In Essential papers on transference analysis*, ed by G. P. Bauer, Ph.D., Northvale, NJ: Jason Aronson, Inc.

Gilligan, C. (1983). *In a different voice.* Cambridge, MA: Harvard University Press.

Gilligan, C. (1991). Women's psychological development: Implications for psychotherapy. *Women In Therapy, 11,* 5-31.

Gold, J.M., & Hawley, L.D. (2001). A study of the gender role orientations of beginning counselors. *Journal of Humanistic Counseling, Education, and Development, 40,* 200-207.

Goldman, G.A. (2005). *Quality of object relations, security of attachment, and interpersonal style as predictors of the early therapeutic alliance.*. Unpublished doctoral dissertation, Ohio University, Athens.

Golombok, S., & Fivush, R. (1994). *Gender development.* New York: Cambridge University Press.

Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. *Journal of Consulting and Clinical Psychology, 46,* 1023-1035.

Gough, H.G. (1952). Identifying psychological femininity. *Educational and Psychological Measurement, 12,* 427-439.

Granello, D.H. (2007). Publishing quantitative manuscripts in Counselor Education and Supervision: General guidelines and expectations. *Counselor Education & Supervision*, 47, 66-75.

Green, R., Mandel, J.B., Hotvedt, M.E., Gray, J., & Smith, L. (1986). Lesbian mothers and their children: A comparison with solo heterosexual mothers and their children. *Archives of Sexual Behavior, 15,* 167-184.

Greenson, R.R. (1967). *The technique and practice of psychoanalysis*. London: Hogarth Press.

Guilfoyle, M. (2002). Power, knowledge, and resistance in therapy: Exploring links between discourse and materiality. *International Journal of Psychotherapy, 7,* 83-97.

Guilfoyle, M. (2003). Dialogue and power: A critical analysis of power in dialogical therapy. *Family Process*, *42*, 331–343.

Guilfoyle, M. (2005). From therapeutic power to resistance? Therapy and cultural hegemony. *Theory & Psychology, 15,* 101-124.

Guttman, D. (1965). Women and the conception of ego strength. *Merrill-Palmer Quarterly, 11*, 229-240.

Hall, T.W. (2004). Christian spirituality and mental health: A relationship paradigm for empirical research. *Journal of Psychology & Christianity, 23*, 66-81.

Hanson, W.E., Curry, K.T., & Bandalos, D.L. (2002). Reliability generalization of Working Alliance Inventory scale scores. *Educational and Psychological Measurement, 62,* 659-673.

Hare-Mustin, R.T. (1983). An appraisal of the relationship of women and psychotherapy: 80 years after the case of Dora. *American Psychologist, 38,* 593-601.

Hare-Mustin, R.T., & Marecek, J. (1988). The meaning of difference: Gender theory, postmodernism, and psychology. *American Psychologist, 43,* 455-464.

Hartley, D., & Strupp, H. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. In J. Masling (Ed.), *Empirical studies of psychoanalytic theories* (pp. 1-27). Hillsdale, NJ: Erlbaum.

Hathaway, S R., & McKinley, J.C. (1943). The Minnesota Multiphasic Personality Inventory. New York: Psychological Corporation.

Heesacker, M., Wester, S.R., Vogel, D.L., Wentzel, J.T., Mejia-Millan, C.M., Goodholm, Jr., C.R. (1999). Gender-based emotional stereotyping. *Journaling of Counseling Psychology, 46,* 483-495.

Heppner, P.P., & Claiborn, C.D. (1989). Social influence research in counseling: A review and critique. *Journal of Counseling Psychology, 36,* 365-387.

Heppner, P.P., & Heesacker, M. (1983). Perceived counselor characteristics, client expectations, and client satisfaction with counseling. *Journal of Counseling Psychology, 30,* 31-39.

Hinkelman, L., & Granello, D.H. (2003). Biological sex, adherence to traditional gender roles, and attitudes towards persons with mental illness: An exploratory investigation. *Journal of Mental Health Counseling, 25,* 259-270.

Hoffman, L. (1988). Reply to Stuart Golann. *Family Process*, *27*, 65–68.

Hoffman, L. (1992). Constructing the theoretical context. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 7–24). London: Sage.

Hoffman, R.M. (2001). The measurement of masculinity and femininity: Historical perspective and implications for counseling. *Journal of Counseling & Development, 79,* 472-485.

Hoffman, R.M. (2006). Gender and self-definition and gender self-acceptance in women: Intersections with feminist, womanist, and ethnic identities. *Journal of Counseling & Development, 84,* 358-372.

Hoffman, R.M., Borders, L.D., & Hattie, J.A. (2000). Reconceptualizing femininity and masculinity: From gender roles to gender self-confidence. *Journal of Social Behavior and Personality, 15,* 475-503.

Hoffman, R.M., Hattie, J.A., & Borders, L.D. (2005). Personal definitions of masculinity and femininity as an aspect of gender self-concept. *Journal of Humanistic Counseling, Education and Development, 44,* 66-83.

Horvath, A.O., & Greenberg, L.S. (1986). The development of the Working Alliance Inventory. In L.S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529-556). New York: Guilford Press.

Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36,* 223-233.

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139-149.

Houser, R., Feldman, M., Williams, K., Fierstien, J. (1998). Persuasion and social influence tactics used by mental health counselors. *Journal of Mental Health Counseling, 20,* 238-250.

Johnson, P. (1976). Women and power: Toward a theory of effectiveness. *Journal of Social Issues, 32,* 99-110.

Kanter, R.M. (1977). *Men and women of the corporation.* New York: Basic Books.

Kaschak, E. (1992). *Engendered lives: A new psychology of women's experience.* New York: Basic Books.

Kazan, Z. (1994). Power: A multi-dimensional perspective. *Dulwich Centre Newsletter, 1,* 28-31.

Kendall, G., & Wickham, G. (1999). *Using Foucault's methods.* London: Sage.

Kokotovic, A.M., & Tracey, T.J. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology, 37,* 16-21.

Koslowsky, M., Schwarzwald, J., & Ashuri, S. (2001). On the relationship between subordinates' compliance to power sources and organizational attitudes. *Applied Psychology: An International Review*, *50*, 455–476.

Krupnick, J.L., Stoksy, S.M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P.A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health treatment of Depression Collaborative Research Program. *Journal of Consulting & Clinical Psychology, 64,* 532-539.

Kubitz, N., Thornton, G., & Robertson, D.U. (1989). Expectations about grief and evaluation of the griever. *Death Studies, 13,* 39-47.

LaCrosse, M.B. (1980). Perceived counselor social influence and counseling outcomes: Validity of the Counselor Rating Form. *Journal of Counseling Psychology, 27,* 320-327.

Lambert, M.J., & Cattani-Thompson, K. (1996). Current findings regarding the effectiveness of counseling: Implications for practice. *Journal of Counseling & Development, 74*, 601-608.

Larner, G. (1999). Derrida and the deconstruction of power as context and topic in therapy. In I. Parker (Ed.), *Deconstructing psychotherapy* (pp. 39-53). London: Sage.

Levant, R.F. (1996). The new psychology of men. *Professional Psychology: Research and Practice, 27,* 259-265.

Lewin, M. (1984). Psychology measures femininity and masculinity, 2: From "13 gay men" to the instrumental-expressive distinction. In M. Lewin (Ed.), *In the shadow of the past: Psychology portrays the sexes* (pp. 179-204). New York: Columbia University Press.

Lietaer, G. (1992). Helpful and hindering processes in client-centered-experiential psychotherapy: A content analysis of client and therapist post therapy perceptions. In S. Toukmanian & D. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 134-162). Newbury Park, CA: Sage.

Lips, H. (1991). *Women, men, and power.* Mountain View, CA: Mayfield.

Lorber, J. (1998). Guarding the gates: The micropolitics of gender. In D. L. Anselmi & A. L. Law (Eds.), *Questions of gender: Perspectives and paradoxes* (pp. 607-628). Boston: McGraw-Hill.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Cleghhorn (Ed.), *Successful psychotherapy* (Ch. 2 and 3). New York: Brunner/Mazel.

Luborsky, L., McLellan, A.T., Diguer, L., Woody, G., & Seligman, D.A. (1997). The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and practice, 4,* 53-65.

Maccoby, E.E., & Jacklin, C.N. (1975). *The psychology of sex differences.* Stanford, CA: Stanford University Press.

Mahalik, J.R., Morray, E.B., Coonerty-Femiano, A., Ludlow, L.H., Slattery, S.M., & Smiler, A. (2005). Development of the conformity to Feminine Norms Inventory. *Sex Roles, 52,* 417-435.

Mallinckrodt, B., Gantt, D.L., & Coble, H.M. (1995). Attachment patterns in the psychotherapy relationship: Development of the client attachment to therapist scale. *Journal of Counseling Psychology, 42,* 307-317.

Marmar, C.R., Gaston, L., Gallagher, D., & Thompson, L.W. (1989). Alliance and outcome in late-life depression. *Journal of Nervous and Mental Disease, 177,* 464-472.

Marmar, C., Weiss, D.S., & Gaston, L. (1989). Toward the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1*, 46-52.

Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438-450.

Martin, C.L., & Ruble, D. (2004). Children's search for gender cues: Cognitive perspectives on gender development. *Current Directions in Psychological Science, 13*, 67-70.

Marziali, E. (1984). Three viewpoints on the therapeutic alliance scales similarities, differences and associations with psychotherapy outcome. *Journal of Nervous and Mental Disease, 172,* 417-423.

Marziali, E., Marmar, C., & Krupnick, J. (1981). Therapeutic alliance scales: Development and relationship to psychotherapy outcome. *American Journal of Psychiatry, 138,* 361-364.

McHale, S.M., Crouter, A.C., & Whiteman, S.D. (2003). The family contexts of gender development in childhood and adolescence. *Social Development*, *12*, 125-148.

McNeill, B.W., May, R.J., & Lee, V.E. (1987). Perceptions of counselor source characteristics by premature and successful terminators. *Journal of Counseling Psychology, 34,* 86-89.

Mead, M. (1949). *Male and female: A study of the sexes in a changing world.* New York: William Morrow & Company.

Mendelsohn, M., & Sewell, K.W. (2004). Social attitudes towards traumatized men and women: A vignette study. *Journal of Traumatic Stress*, *17*, 103-111.

Menninger, K.A. (1958). *Theory of psychoanalytic technique*. New York: Basic Books.

Merluzzi, T.M., Merluzzi, B.H., & Kaul, T.J. (1977). Counselor race and power base: Effects on attitudes and behavior. *Journal of Counseling Psychology, 24,* 430-436.

Mintz, L.B., & O'Neil. J.M. (1990). Gender roles, sex, and the process of psychotherapy: Many questions and few answers. *Journal of Counseling and Development, 68,* 381-387.

Money, J. (1994). The concept of gender identity disorder in childhood and adolescence after 39 years. *Journal of Sex and Marital Therapy, 20,* 163-177.

O'Malley, K.M., & Richardson, S. (1985). Sex bias in counseling: Have things changed? *Journal of Counseling and Development, 63,* 294-299.

Orlinsky, D., Grawe, K., & Parks, B.K. (1994). Process and outcome in psychotherapy. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 270-276). New York: Wiley.

Ossana, S.M., Helms, J.E., & Leonard, M.M. (1992). Do "womanist" identity attitudes influence college women's selfesteem and perceptions of environmental bias? *Journal of Counseling & Development, 70,* 402–408.

Phinney, J. (1992). The Multigroup Ethnic Identity Measure: A new scale for use with diverse groups. *Journal of Adolescent Research, 7,* 156–176.

Pollack, W.S. (1992). Should men treat women? Dilemmas for the male psychotherapist: Psychoanalytic and developmental perspectives. *Ethics & Behavior, 2*, 39-49.

Proctor, G. (2002). *The dynamics of power in counselling and psychotherapy: Ethics, politics and practice*. Ross-on-Wye: PCCS Books.

Raven, B.H. (1965). Social influence and power. In I.D. Steiner & M. Fishbein (Eds.), *Current studies in social psychology* (pp. 371-381). New York: Holt, Rinehart, Winston.

Raven, B.H. (1992). A power/interaction model of interpersonal influence: French and Raven thirty years later. *Journal of Social Behavior & Personality, 7,* 217-244.

Raven, B.H. (1993). The bases of power: Origins and recent developments. *Journal of Social Issues, 49,* 227-251.

Raven, B.H., Schwarzwald, J., & Koslowsky, M. (1998). Conceptualizing and measuring a power/interaction model of interpersonal influence. *Journal of Applied Social Psychology, 28,* 307–332.

Reynolds, W.M. (1982). Development of reliable and valid short forms of the Marlowe Crowne Social Desirability Scale. *Journal of Clinical Psychology, 38,* 119-125.

Ritter, P., Lorig, K., Laurent, D., & Matthews, K. (2004). Internet versus mailed questionnaires: A randomized comparison. Journal of Medical Internet Research, 6. Retrieved May 12, 2008, from http://www.jmir.org/2004/3/e29/

Roberts, C.W., Green, R., Williams, K., & Goodman, M. (1987). Boyhood gender identity development: A statistical contrast of two family groups. *Developmental Psychology, 23,* 544-557.

Robyak, J.E. (1981). Effects of gender on the counselor's preference for methods of influence. *Journal of Counseling Psychology, 28,* 7-12.

Rochlen, A.B., Rude, S.S., & Baron, A. (2005). The relationship of stages of change to working alliance and outcome in short-term counseling. *Journal of College Counseling, 8,* 52-64.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21.* 95-103.

Rose, N. (1989). *Governing the soul: Technologies of human subjectivity.* London: Routledge.

Russell, C.D., & Ellis, J.B. (1991). Sex-role development in single parent households. *Social Behavior and Personality, 19,* 5-9.

Safran, J.D., & Muran, J.C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide.* New York: Guildford Press.

Safran, J.D., & Segal, Z. (1990). *Interpersonal process in cognitive therapy.* New York: Basic Books.

Sebera, K.E. (2005). An analysis of the relationship between leadership attributes and the overall job satisfaction of professional school counselors in the United States. Unpublished doctoral dissertation, Ohio University, Athens, OH.

Seem, S.R., & Clark, M.D. (2006). Healthy women, healthy men, and healthy adults: An evaluation of gender role stereotypes in the twenty-first century. *Sex Roles, 55*, 247-258.

Seem, S.R., & Johnson, E. (1998). Gender bias among counseling trainees: A study of case conceptualization. *Counselor Education and Supervision, 37,* 257-268.

Simon, L., Gaul, R., Friedlander, M.L., & Heatherington, L. (1992). Client gender and sex role: Predictors of counselors' impressions and expectations. *Journal of Counseling & Development, 71,* 48-52.

Speight, S.L., & Vera, E.M. (2005). University counseling center clients' expressed preferences for counselors: A four year archival exploration. *Journal of College Student Psychotherapy, 19,* 55-68.

Spence, J.T., & Helmreich, R.L. (1978). *Masculinity and femininity: Their psychological dimensions, correlates and antecedents.* Austin: University of Texas Press.

Spence, J.T., & Helmriech, R.L. (1980). Masculine instrumentality and feminine expressiveness: Their relationships with sex role attitudes and behaviors. *Psychology of Women Quarterly, 5,* 147-163.

Spence, J.T., Helmreich, R.L., & Stapp, J. (1974). The Personal Attributes Questionnaire: A measure of sex-role stereotypes and masculinity-femininity. *JSAS Catalog of Selected Documents in Psychology, 4,* 43-44.

Spence, J.T., Helmreich, R.L., & Stapp, J. (1975). Ratings of self and peers on sex-role attributes and their relation to self-esteem and conceptions of masculinity and femininity. *Journal of Personality and Social Psychology, 32,* 29-39.

Spong, S.J. (2007). Ideas of influence: Counsellors' talk about influencing clients. *British Journal of Guidance & Counselling, 35,* 331-345.

Stadler, H.A., Suh, S., Cobia, D.C., Middleton, R.A., & Carney, J.S. (2007). Reimagining counselor education with diversity as a core value. *Counselor Education & Supervision, 45,* 193-206.

Sterba, R. (1934). The fate of the ego in psychoanalytic therapy. *International Journal of Psychoanalysis, 15*, 117-126.

Stevenson, M.R., & Black, K.N. (1988). Paternal absence and sex-role development: A meta-analysis. *Child Development, 59,* 793-814.

Stiles, W.B., Honos-Webb, L., & Suko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology; Science and Practice, 5,* 439-458.

Strong, E.K. (1927). *Strong Vocational Interest Blank*. Palo Alto, CA: Consulting Psychologists Press.

Strong, S.R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology, 15*, 215-224.

Strupp, H.H., & Hadley, S.W. (1979). Specific vs. nonspecific factors in psychotherapy. *Archives of General Psychiatry, 36,* 1125-1136.

Symonds, D., & Horvath A.O. (2004). Optimizing the alliance in couple therapy. *Family Process, 43,* 443-455.

Terman, L.M., & Miles, C.C. (1936). *Sex and personality.* New York: McGraw-Hill.

Tew, J. (2006). Understanding power and powerlessness: Towards a framework for emancipatory practice in social work. *Journal of Social Work, 6,* 33-51.

Thomas, S.E., Werner-Wilson, R.J., & Murphy, M.J. (2005). Influence of therapist and client behaviors on therapy alliance. *Contemporary Family Therapy, 27,* 19-35.

Tomlinson-Clarke, S., & Camili, G. (1995). An exploratory study of counselor judgments in multicultural research. *Journal of Multicultural Counseling & Development, 23,* 237-245.

Totton, N. (2000). *Psychotherapy and politics.* London: Sage.

Trepal, H.C., Wester, K.L., & Schuler, M. (2008). Counselors'-in-training perceptions of gendered behavior. *Family Journal, 16*, 147-154.

Tyron, G.S., Blackwell, S.C., & Hammel, E.F. (2007). A meta-analytic examination of client-therapist perspectives of the working alliance. *Psychotherapy Research, 17,* 629-642.

Versalle, A., & McDowell, E.E. ((2005). The attitudes of men and women concerning gender differences in grief. *Omega*, *50*, 53-67.

Vogel, D.L., Epting, F., & Wester, S.R. (2003). Counselors' perceptions of female and male clients. *Journal of Counseling & Development, 81,* 131-141.

Watson, J.C., & Gellar, S.M. (2005). The relation among the relationship conditions, working alliance, and outcome in both process-experiential and cognitive behavioral psychotherapy. *Psychotherapy Research, 15,* 25-33.

Watson, J.C., & Greenburg, L.S. (1994). The working alliance in experiential therapy: Enacting the relationship conditions. In A. Horvath & L. Greenburg (Eds.), *The working alliance: Theory, research, and practice* (pp. 153-172). New York: Wiley.

Werner-Wilson, R.J. (1997). Is therapeutic alliance influenced by gender in marriage and family therapy? *Journal of Feminist Family Therapy, 9*, 3–16.

Werner-Wilson, R.J., Michaels, M.L., Thomas, S.G., & Thiesen, A.M. (2003). The influence of therapist behaviors on therapeutic alliance. *Contemporary Family Therapy*, *25*, 381-390.

Wetherell, M., & Edley, N. (1999). Negotiating hegemonic masculinity: Imaginary positions and psycho-discursive practices. *Feminism and Psychology 9,* 335–356.

Wintersteen, M.B., Mensinger, J.L., & Diamond, G.S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology: Research and Practice*, *36*, 400-408.

Young, I.M. (1990) *Justice and the politics of difference*. Princeton: Princeton University Press.

Zamostny, K.P., Corrigan, J.D., & Eggert, M.A. (1981). Replication and extension of social influence processes in counseling: A field study. *Journal of Counseling Psychology, 28,* 481-489.

Zetzel, E. (1956). Current concepts of the transference. *International Journal of Psycho analysis*, *39*, 369-376.

Zook II, A., & Sipps, G.J. (1985). Cross-validation of a short form of the Marlowe Crowne Social Desirability Scale. *Journal of Clinical Psychology, 41,*236-238.

APPENDIX A: CORRESPONDENCE FROM THE INSTITUTIONAL REVIEW BOARD

OHIO UNIVERSITY
Office of the Vice President for Research

A 08EC42

Office of Research Compliance
Research and Technology
Center 117
Athens OH 45701-2979

T: 740.593.0664
F: 740.593.9838
www.research.ohiou.edu

The amendment, detailed below, and submitted for the following research study has been approved by the Institutional Review Board at Ohio University. Approval date of this amendment does not affect the expiration date of the original approval.

Amendment: Minor Revisions to Scales; Add New Scale

Project: Counselor Gender Self-Confidence and Social Influence in Counseling: Counselor Perceptions of the Therapeutic Alliance

Project Director: Ruthann Anderson

Advisor: (if applicable) Dana Heller Levitt

Department: Counselor Education

Rebecca G. Cale

Rebecca G. Cale
Institutional Review Board

3/19/08
Date

OHIO
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for Research

08E042

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A determination has been made that the following research study is exempt from IRB review because it involves:

Category 2 - research involving the use of educational tests, survey procedures, interview procedures or observation of public behavior

Project Title: Counselor Gender Self-Confidence and Social Influence in Counseling: Counselor Perceptions of the Therapeutic Alliance

Project Director: Ruthann Anderson

Department: Counselor Education

Advisor: Dana Heller Levitt

Rebecca Cale 2/27/08

Rebecca Cale, Associate Director, Research Compliance
Institutional Review Board

Date

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.

APPENDIX B: PERMISSION TO USE THE INSTRUMENTS

SFU SIMON FRASER UNIVERSITY
THINKING OF THE WORLD

Ms. Ruthann Anderson
Ohio University
Mt. Pleasant
Athens Ohio
P. O. Box 118
U.S.A.

February 25, 2008

LIMITED COPYRIGHT LICENSE (ELECTRONIC) # 2007252.63

Dear Ms. Anderson

You have permission to use the Working Alliance Inventory (WAI) for the investig ation: "COUNSELOR GENDER SELF-CONFIDENCE AND SOCIAL INFLUENCE IN CO UNSELING: COUNSELOR PERCEPTIONS OF THE THERAPEUTIC ALLIANCE ."

This limited copyright release extends to all forms of the WAI for which I hold copy right privileges, but limited to use of the inventory for not-for-profit research, and does not include the right to publish or distribute the instrument(s) in any form.

I would appreciate if you shared the results of your research with me when your work is completed so I may share this information with other researchers who mig ht wish to use the WAI. If I can be of further help, do not hesitate to contact me.

Sincerely,

Dr. Adam O. Horvath
Professor
Faculty of Education and
Department of Psychology

Ph# (778) 782-3624
Fax: (778) 782-3203
e-mail: horvath@sfu.ca
Internet: http://www.educ.sfu.ca/alliance/allianceA

Quoting Rosemarie Hoffman <rhoffman@csulb.edu>:

Hi Ruthann,

Please excuse my delay in responding. My husband passed away unexpectedly recently and I am dealing with a lot.

Of course you may use the HGS. Please let me know if you have the current version and if you need additional references. Also, I'd love to know what your study will examine.

Best,
Rose Marie Hoffman

On Sat, 10 Nov 2007 11:43:05 -0500
ra718087@ohio.edu wrote:

Hello Dr. Hoffman,

My name is Ruthann Anderson, and I am a doctoral student at Ohio University, and am preparing my study for my dissertation. I would very much like permission to use your tool, the Hoffman Gender Scale in my study. I will be researching gender identity, power and the counseling relationship.

I appreciate the paradigm shift in your instrument, and am excited to see what my study might find.

I have never asked permission to use someone's work before, and I hope I am approaching this correctly. If there is a step I am missing, please let me know.

I look forward to hearing from you, and thank you for your work.

Ruthann Anderson
ra718087@ohio.edu

~~~~~~

Rose Marie Hoffman, Ph.D.
Professor; Coordinator, School Counseling Programs
Department of Educational Psychology, Administration, & Counseling
College of Education
California State University, Long Beach
1250 Bellflower Blvd.; Long Beach, CA 90840-2201
voicemail: 562.985.5626
fax: 562.985.4534
email: rhoffman@csulb.edu
website: http://www.ced.csulb.edu/school-counseling
~~~~~~

Hi Ruthann,

Yes, you have my permission to reproduce the diagram. Subsequent to the publication of that article, I had help from a former grad asst. in revising the diagram to make it even more representative of what I'd like to convey. Unfortunately, I do not currently have that to email to you (crash!). If you think that the former diagram appropriately captures what needs to be conveyed, that's great. What Saody, my asst., did for me was to redo it as a pie chart. If you are interested in that I will try to recoup that. I'll trust your judgement on it.

Rose Marie Hoffman

On Wed, 30 Jan 2008 17:33:08 -0500
ra718087@ohio.edu wrote:

Hello Dr. Hoffman,

I hope you are doing well, and that you are enjoying your weather out there! We had a wind chill (and it was blowing at about 60 mph at times) of zero!!

I an requesting your permission to reproduce a diagram from one of your articles (Hoffman, Border, & Hattie, 2000, p. 494). I think it will help my dissertation readers better understand gender identity and how the HGS measures gender self-confidence.

I am expecting to propose next month. I am a little overwhelmed with all of the details, but my dissertation chair is really wonderful and says she has a lot of confidence in me (Dana Levitt).

I thank you for you help thus far and will keep you posted regarding my results!!

Ruthann Anderson

~~~~~~

Rose Marie Hoffman, Ph.D.
Professor; Coordinator, School Counseling Programs
Department of Educational Psychology, Administration, &
Counseling
College of Education
California State University, Long Beach
1250 Bellflower Blvd.; Long Beach, CA 90840-2201
voicemail: 562.985.5626
fax: 562.985.4534
email: rhoffman@csulb.edu
website: http://www.ced.csulb.edu/school-counseling
~~~~~~

Dear Ruthann:

I am delighted that you will be studying social power in the Counseling situation. Unfortunately, French is no longer with us, but you certainly have my permission to use any of our material in your doctoral research. Professor William Erchul, at North Carolina State University, and his students have done considerable research in that specific area. I am sure he would be pleased to share what he can with you. I am copying this to him, but you can contact him directly at:
"William P. Erchul" <William_Erchul@ncsu.edu>

It is particularly satisfying to see this research at OSU. I received my BA in psychology there in 1948, and my MA in 1950, after which I went to Michigan for my doctorate, where I worked with John R. P. French.

I hope all goes well with your thesis.

With warm regards,

Bert Raven

Hello Dr. Raven,

My name is Ruthann Anderson and I am preparing my dissertation for my Ph.D.from Ohio University in Counselor Education and Supervision.

I am requesting permissing to use your tool, the Interpersonal Power Inventory. I will be researching how the gender of the counselor and the counselor's use of power within the counseling setting predict the quality of the relationship.

I appreciate the work you have done in this area of research, and see great value in applying the power bases that you and Dr. French have researched to my study.

I am unsure if I need to contact you or Dr. French, and hope to hear from you soon. If I have missed a step in the process of requesting permission, please excuse me, and let me know how to proceed from here.

I am sending this request via the mail, also. I am not sure which method of communication you prefer.

Thank you,

Ruthann Anderson
ra718087@ohio.edu

Dear Ruthann:

Relative to your questions --

1. I think #1, 32, and 39 seem fine. For #31, I'd consider wording that makes it more comparable to #1, such as "I can make it more difficult for him/her to get an earlier release from court-ordered counseling or obtain other benefits."

2. Please note, too, that at the bottom of pp. 1-3 ("REMINDER"), the word "effect" under option 4 should be "affect."

3. IPI scoring is quite straightforward -- you just sum (or average) the ratings given to the items underlying each power base/strategy. I have attached the Appendix from the Erchul, Raven, and Ray (2001) article that shows the item/power base assignments.

Bill Erchul

From: <ra718087@ohio.edu>
Date: Fri, 01 Feb 2008 20:12:06 -0500
To: <william_erchul@ncsu.edu>
Cc: <raven@ucla.edu>
Subject: Re: just checking in

Dear Dr. Erchul,

I have attached only one example of the IPI rewording this time. I have fixed the scale in the instructions, and have worked on the wording of items 1, 31, 32, and 39.

How do these changes fit?

If I can get the wording of these items finalized, I hope to run the pilot study next week!

Is there scoring information for the IPI that you would be willing to share? I would really appreciate it.

Thank you for your help!!

Quoting William Erchul <william_erchul@ncsu.edu>:

Dear Ruthann:

Again, it was largely meetings that kept me away from your questions until now. Please see my inserted replies** below. Thanks.

WPE

From: <ra718087@ohio.edu>
Date: Wed, 30 Jan 2008 15:29:10 -0500
To: William Erchul <william_erchul@ncsu.edu>
Cc: <ra718087@ohio.edu>, <"Bertram, H., Raven"@ohio.edu>,
<RAVEN@UCLA.edu>,
<MISSING_MAILBOX_TERMINATOR@.SYNTAX-ERROR>
Subject: Re: just checking in

Hello Dr. Erchul,

Thank you for the recommendations. I have changed the direction of
the numbering and reworded the midpoint to mimic the information given in the directions.

***You're certainly welcome. But please note that the scale direction has been changed in the "Reminder" sections on the bottom of pages 1-3 but NOT in the opening "instructions" section!*

I also have a question about items 1, 31, 32, and 39 on the tools.
In your version of the tool, the reward for item #1 was a promotion. In counseling, rewards are a little more ambiguous. I can't say that a reward would be release from counseling, because some clients may not see that as a reward. I could say the reward might be "recommending release from court-ordered counseling", but this would not apply to all clients. I used the words "certain benefits" as opposed to your wording of "an increase in pay or other benefits". My question is would it be better for me to word item #1 "A good evaluation from me could lead to benefits (such as a recommendation to release the client from court-ordered counseling). OR do I leave item #1 the way it is "A good evaluation from me could lead to certain benefits".

***My thoughts are as follows:*

1. When adapting the IPI, it is critical to remain true to the power base/strategy that an item is supposed to assess. For example, item #1 was designed to tap into "impersonal

reward," so any contemplated changes need to reflect the target's perception that the agent is capable of delivering tangible rewards. From the client's point of view, what are "tangible rewards" in counseling? It sounds to me that a recommendation to release the client from court-ordered counseling would constitute an unambiguous, tangible reward, so your modified wording strikes me as OK.[But are there other tangible rewards you could incorporate into other IR items (reduced fees, for example)?]

2. I make this recommendation to include the specific example in item #1 in part because if it were not changed, items 1 and 32 would be very similar AND ambiguous (i.e., what are "certain benefits," anyway?). In other words, with at most four items to assess a given power base/strategy on the IPI, you want to maximize diversity in the items yet still retain a strong, clear connection to the core base/strategy. I used this principal (and the one above) in developing my IPI adaptations by keeping the examples of "increase in pay" and "promotion" in impersonal reward items -- even though they really didn't pertain to the school psychologist/teacher relationship.

3. With regard to items 31 and 39 -- both designed to assess "impersonal coercion" -- you should note that, with your recent wording changes, these items are now nearly identical. Again, from the client's perspective, are there unambiguous "tangible punishments" in counseling that you could incorporate into one (or both) of these items? Increasing fees or time commitments, perhaps?

By way of summary: I think that the phrase, "certain benefits," can be used but it can be overused in items that tap impersonal reward and impersonal coercion. Consequently, you may want to insert more specific language or examples when possible while retaining allegiance to the specific power base/strategy. I believe the payoffs will be an easier instrument for respondents to complete and higher reliability/internal consistency of the IPI.

Again, continued good luck with your research!

Bill Erchul

Would you recommend the same treatment of items 31,32, and 39 as well?

I have attached my versions of the IPI, with the changes included.

Thank you for your quickness. My methodologist wants me to run a pilot study since I am changing the wording, and I am hoping to propose in February!

I know that both you and Dr. Raven are busy!

Ruthann Anderson

Quoting William Erchul <william_erchul@ncsu.edu>:

Dear Ruthann:

Sorry about this delayed response; it seems that I have had a steady stream of meetings since you sent me your materials. Here are a few comments I have:

Except for the minor change from letters to numbers, you certainly have retained the seven-point scale that I used originally in my research. As I recall, when I adapted the IPI for my purposes in the late 1990s I was working from a pre-publication draft version of the IPI that preceded the one reported by Raven, Schwarzwald, and Koslowsky (1998). This fact alone may explain some minor differences between my IPI and the Raven et al. (1998) IPI.

One of these differences is that I used lower numbers on the scale to indicate greater levels of compliance. Relative to ease of completion by participants and subsequent response rates, this turned out to be a big mistake for my research! However, I was trying to emulate what I had seen in that draft version of the IPI. So, my first bit of advice is to change the direction of the rating scale so that 1 = much less likely to comply and 7 = much more likely to comply. My later adaptations of the IPI have used this ordering and I believe it has significantly reduced the burden placed on respondents.

Relative to Dr. Raven's concern that that your seven-point response scale includes three points where the influence strategy would lead the target to not only not comply but to do the opposite of what was requested, I have a couple of thoughts. First, it is important that Likert scaling demonstrate a roughly equal interval (or at least ordinal) positioning, ranging from 'none of the construct present' on one end to 'all of the construct present' on the other. I think the weak link in the rating scale as described is the midpoint (#4/D), which reads "would not affect their tendency to comply" in the opening instructions BUT then changes to "No Effect" on the reminders placed at the top of each subsequent page. A respondent tuning in only to the "No Effect" message might well misinterpret the intent of the rating scale--as Bert has suggested--even though the opening instructions clearly specify the continuous nature of the scale. In thinking back almost 10 years ago, I recall we made that change only because of spacing considerations (i.e., the longer descriptor didn't ‘fit'). For your research I strongly recommend that you retain a clear label for the midpoint of the scale to avoid any confusion.

Second, I'll just add that researchers using the IPI have always retained the seven-point rating scale but have used different midpoint (#4/D) descriptors (and frequently, anchors) on the scale. For example, all of these represent a midpoint rating on target forms of the IPI: "Would not affect your tendency to comply" (Erchul, Raven, & Whichard, 2001): "Possibly a reason you would comply" (Raven et al., 1998); "I would possibly comply" (Elias and Loomis, 2004). My point is that the rating scale may differ slightly

based on the dyadic relationship under study but it always needs to be logically constructed and internally consistent.

I apologize for the length of this response but trust it contains
Some helpful information.

Bill Erchul
****
William P. Erchul, PhD, ABPP
Professor, Department of Psychology
President, American Academy of School Psychology
North Carolina State University
2310 Stinson Drive, 640 Poe Hall
Campus Box 7650
Raleigh, NC 27695-7650
919/515-1709 (o) 919/515-1716 (f)
william_erchul@ncsu.edu

From: <ra718087@ohio.edu>
Date: Tue, 29 Jan 2008 15:03:00 -0500
To: "William P. Erchul" <william_erchul@ncsu.edu>
Cc: <ra718087@ohio.edu>
Subject: Re: just checking in

Hello Dr. Erchul,

I have attached my attempts to change the wording of the tools to reflect the counselor/client relationship. I asked Dr. Raven about the original tools, but he said he might have to "dig them up". I would appreciate your help. I want to honor Dr. Raven's work as much as possible.

I highlighted the wording changes, so that it would be easier to see what I have done. Also, I have removed the demographic information from the end, since I intend to use 2 other surveys in my research and will Collect demographic information separately from the IPI.

The 7 point scale Dr. Raven mentioned is the scale that the tools you sent me use (A through G). I changed the use of letters to the use of numbers (1 through 7). I did not change anything else with the scale. If You think this is a problem for the tool I can easily change the numbers back to letters.

Thank you for your assistance!

Ruthann Anderson

Quoting "William P. Erchul" <william_erchul@ncsu.edu>:

Dear Ruthann:

I certainly would like to help you, but I don't have access to the materials that Bert has specifically referenced in his reply.

In particular, could you please forward copies of your instruments that incorporate the seven point response scale that he mentions? (Obviously I do not need either the IPI-CT or IPI-CE.)

Thanks --

Bill Erchul

On 1/28/08 12:02 PM, "Bert Raven" <raven@ucla.edu> wrote:

Dear Ruthann:

I am sorry for my delay in answering your queries, particularly since you are waiting for a response in order to continue your work on your dissertation. My delay was due to the fact that I have been working away from the university over the past few weeks. The instrument which you received from Professor Erchul was one which he developed specifically for his research program, although I am sure that he sent me a copy to review. My concern is that the 7-point response scale included three points where the influence strategy would lead the target to not only not comply but to do the opposite of what was requested. I thought it unlikely that you would get any significant number who would pick those three alternatives, so that you end up, in effect, with a four-point scale. If you will be making comparisons to the findings of Erchul, et al, you would, of course, need to use the same scale. Otherwise, your revised 7-point scale might be preferable.

But I am forwarding this communication to Professor Erchul and would defer to his judgment. Since he is now back to his office, I am sure he would respond to you quite quickly.

Bert Raven

Hello Dr. Raven,

I don't want to bother you, but I have reached a point in my dissertation process where I cannot move forward without your assistance. I hope there is nothing wrong on your end!

I really like the IPI and am excited about applying it to the counselor/client relationship. I have tried to respect the scale and wording of your tool as much as possible.

In your last email to me (1-9-08) it sounded as though you were recommending a change of your scale. I was surprised that you were considering that as an option.
I have taken the liberty to attach my attempts to reword the IPI (I have highlighted these attempts in yellow) and also have attached the files sent to me by Dr. Erchul. I have not yet changed the scale, because I was not sure you intended for me to do so.

Please let me know what you think! And thank you!

Ruthann Anderson

APPENDIX C: COVER LETTER AND SURVEY INSTRUMENT

Date

Name of Participant
Address of Participant

Dear _____,

You are being asked to take part in a research study focusing on how we, as counselors, establish working relationships with our clients. As a profession, we recognize the importance between a strong therapeutic working relationship and successful completion of treatment goals.

The survey will take about 20 minutes to complete. I will keep your answers completely confidential. Your identifying information will be used only to send out a follow-up survey to those counselors who have not responded to the initial mailing. The results of this research study will be reported only for groups, not individuals.

There is no foreseeable risk to you when completing this survey and participation is completely voluntary. If you agree to be a part of this research study, please complete the enclosed survey and return it in the enclosed, self-addressed, stamped envelope by _____.Return of the completed survey will serve as your consent to participate.

In order to thank you for participating in this important research, your name will be entered into a drawing for ONE OF FIVE $20 gift certificates from Barnes & Noble book stores. If you have not responded within three weeks, I will send you another copy of the survey.

Thank you for taking part in research which will provide important information for our profession. If you have any questions about this study, please contact me or my advisor, Dana Heller Levitt by phone or e-mail using the information below. If you have any questions about the rights of research participants, please contact Dr. Jo Ellen Sherow, Director of Research Compliance at (740) 594-0664.

Sincerely yours,

Ruthann Smith Anderson
Doctoral Candidate
Ohio University
(740)769-7830
ra718087@ohio.edu

Dana Heller Levitt
Dissertation Advisor
Ohio University
(740)593-4163
levitt@ohio.edu

Wor k in g **A** l l i a n c e **I** n v e n t or y

Form T

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences mentally insert the name of your client in place of _____in the text.

Below each statement inside there is a seven point scale:

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

If the statement describes the way you ***always*** feel (or think) write the number 7; if it ***never*** applies to you write the number 1. Use the numbers in between to describe the variations between these extremes.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO ***EVERY*** *ITEM.*)
Thank you for your cooperation.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

If the statement describes the way you ***always*** feel (or think) write the number 7; if it ***never*** applies to you write the number 1. Use the numbers in between to describe the variations between these extremes.

_____ 1. I feel uncomfortable with _____.

_____ 2. _____ and I agree about the steps to be taken to improve his/her situation.

_____ 3. I have some concerns about the outcome of these sessions.

_____ 4. My client and I both feel confident about the usefullness of our current activity in therapy.

_____ 5. I feel I really understand _____.

_____ 6. _____ and I have a common perception of her/his goals..

_____ 7. _____ finds what we are doing in therapy confusing.

_____ 8. I believe _____ likes me.

_____ 9. I sense a need to clarify the purpose of our session(s) for _____.

_____ 10. I have some disagreements with _____ about the goals of these sessions.

_____ 11. I believe the time _____ and I are spending together is not spent efficiently.

_____ 12. I have doubts about what we are trying to accomplish in therapy.

_____ 13. I am clear and explicit about what _____'s responsibilities are in therapy.

_____ 14. The current goals of these sessions are important for _____.

_____ 15. I find what _____ and I are doing in therapy is unrelated to her/his current concerns.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

If the statement describes the way you ***always*** feel (or think) write the number 7; if it ***never*** applies to you write the number 1. Use the numbers in between to describe the variations between these extremes.

_____ 16. I feel confident that the things we do in therapy will help _____ to accomplish the changes that he/she desires.

_____ 17. I am genuinely concerned for _____'s welfare.

_____ 18. I am clear as to what I expect _____ to do in these sessions.

_____ 19. _____ and I respect each other.

_____ 20. I feel that I am not totally honest about my feelings toward _____.

_____ 21. I am confident in my ability to help _____.

_____ 22. We are working towards mutually agreed upon goals.

_____ 23. I appreciate _____ as a person.

_____ 24. We agree on what is important for _____ to work on.

_____ 25. As a result of these sessions _____ is clearer as to how she/he might be able to change.

_____ 26. _____ and I have built a mutual trust.

_____ 27. _____ and I have different ideas on what his/her real problems are.

_____ 28. Our relationship is important to _____.

_____ 29. _____ has some fears that if she/he says or does the wrong things, I will stop working with him/her.

_____ 30. _____ and I have collaborated in setting goals for these session(s).

_____ 31. _____ is frustrated by what I am asking her/him to do in therapy.

_____ 32. We have established a good understanding between us of the kind of changes that would be good for _____.

_____ 33. The things that we are doing in therapy don't make much sense to _____.

_____ 34. _____ doesn't know what to expect as the result of therapy.

_____ 35. _____ believes the way we are working with her/his problem is correct.

_____ 36. I respect _____ even when he/she does things that I do not approve of.

Interpersonal Inventory

Form CN

INSTRUCTIONS: When providing treatment, counselors may ask clients to do something differently (e.g., behave more assertively with a coworker), and clients may be initially reluctant to change. In such cases, clients tend either to resist making the changes or to do as requested. We are interested in understanding when clients are more likely or less likely to do what the counselor asks.

Think about a time when you were providing treatment for a client about a particular situation and the client was initially reluctant to follow your suggestions or comply with your requests. Asking a client to keep a journal or to start a new behavior on a particular day are two examples of these types of situations.

On the following pages, there are a number of considerations that might have influenced the client's decision to do or not to do as you requested. Read each statement carefully, and decide how likely it would be that for each of these considerations the client would tend to comply or not comply. Use the following scale in estimating how you believe the client would react:

1. Much less likely to comply.
2. A bit less likely to comply.
3. A bit more likely to comply.
4. Would not affect their tendency to comply.
5. Less likely to comply.
6. More likely to comply.
7. Much more likely to comply.

Remember that you are indicating the likelihood that the client would or would not tend to comply given these specific circumstances.

Thank you for your cooperation.

REMINDER: You have asked a client to do something differently (e.g., behave more assertively with a coworker) and he/she is initially reluctant to change. Using numbers from the following scale, indicate the likelihood that the client would comply for each of the following items.

1	2	3	4	5	6	7
Much less likely to comply	**Less likely to comply**	**A bit less likely to comply**	**Would not affect tendency to comply**	**A bit more likely to comply**	**More likely to comply**	**Much more likely to comply**

Please indicate the degree to which the following considerations would have made the client more or less likely to comply.

The client has realized that:

____ 1. A good evaluation from me could lead to an earlier release from court-ordered counseling or other benefits.

____ 2. After all, I am the counselor, and the client should feel some obligation to go along.

____ 3. He/she probably feels I know the best way to handle the situation.

____ 4. Once I point it out, he/she can see why the change is necessary.

____ 5. He/she admires or respects me and does not wish to disagree.

____ 6. I can give the client more difficult assignments.

____ 7. I have done some nice things for him/her in the past and so he/she does this in return.

____ 8. He/she likes me and my approval is important to him/her.

____ 9. It is clear that I really depend on the client to do this for me.

____ 10. He/she does not want me to dislike him/her.

____ 11. By doing so, he/she can make up for some difficulties he/she may have caused in the past.

REMINDER: You have asked a client to do something differently (e.g., behave more assertively with a coworker) and he/she is initially reluctant to change. Using numbers from the following scale, indicate the likelihood that the client would comply for each of the following items.

1	2	3	4	5	6	7
Much less likely to comply	**Less likely to comply**	**A bit less likely to comply**	**Would not affect tendency to comply**	**A bit more likely to comply**	**More likely to comply**	**Much more likely to comply**

Please indicate the degree to which the following considerations would have made the client more or less likely to comply.

The client has realized that:

____ 12. For past considerations he/she has received, he/she feels obliged to comply.

____ 13. I can make things unpleasant for clients.

____ 14. It makes the client feel better to know I like him/her.

____ 15. He/she sees me as someone he/she can identify with.

____ 16. He/she knows that unless he/she does so, my job will be more difficult.

____ 17. I have carefully explained the basis for this request.

____ 18. It would be disturbing for the client to know that I disapprove of him/her.

____ 19. He/she feels I probably know more about this particular situation.

____ 20. It is my job to tell him/her how to handle this situation.

____ 21. Complying helps make up for things he/she has not done so well previously.

____ 22. I can help the client receive special benefits.

____ 23. I may be cold and distant if he/she does not do as requested.

____ 24. I gave the client good reasons for changing how he/she handled the situation.

REMINDER: You have asked a client to do something differently (e.g., behave more assertively with a coworker) and he/she is initially reluctant to change. Using numbers from the following scale, indicate the likelihood that the client would comply for each of the following items.

1	2	3	4	5	6	7
Much less likely to comply	**Less likely to comply**	**A bit less likely to comply**	**Would not affect tendency to comply**	**A bit more likely to comply**	**More likely to comply**	**Much more likely to comply**

Please indicate the degree to which the following considerations would have made the client more or less likely to comply.

The client has realized that:

____ 25. He/she understood that I really needed his/her cooperation on this.

____ 26. He/she trusts me to give him/her the best direction.

____ 27. We are both working towards the same goal and should see eye to eye on things.

____ 28. I have the right to request that he/she handle the situation in a particular way.

____ 29. I make the client feel more valued when he/she does as requested.

____ 30. He/she has made some mistakes and therefore feels that he/she owes this to me.

____ 31. I can make it more difficult for him/her to get an earlier release from court-ordered counseling or obtain other benefits.

____ 32. I can help him/her get reduced counseling fees.

____ 33. I have previously done some good things that he/she has requested.

____ 34. It makes the client feel personally accepted when he/she does as asked.

____ 35. As a client, he/she has an obligation to do as I say.

____ 36. He/she looks up to me and generally models his/her behavior accordingly.

____ 37. He/she has not always done what I have asked so this time feels he/she should.

____ 38. He/she feels that I probably have more knowledge about this than he/she does.

____ 39. I can make it more difficult for him/her to get reduced counseling fees.

____ 40. He/she realizes that a counselor needs assistance and cooperation from clients.

____ 41. He/she expects some favorable consideration from me for going along on this.

____ 42. He/she now understands why the recommended change is for the better.

____ 43. I have let the client have his/her way earlier so he/she feels obliged to comply now.

____ 44. He/she would be upset knowing that he/she was on the bad side of me.

Demographic Information

1. What is your biological sex? ____ Male ____ Female

2. How old are you? _____

3. To what race do you belong?

___Caucasian/White ___Black/African American

___ Asian or Pacific American ___ Indian/Alaska Native

___ Hispanic/Latino ___ Other Minority

4. How many years have you practiced a licensed counselor? _____ years

5. Which options best describe the type of clinical setting in which you practice?

a. ___ Inpatient/Acute ___ Outpatient ___ Residential

b. ___ Community Agency (Medicaid and/or free services) ___ Private Practice

c. ___ Voluntary clients ___ Involuntary clients

6. Please briefly describe the type of counseling situation with a client that you were thinking of in responding to this questionnaire:

_____

_____

_____

Hoffman Gender Scale (Form A) (Revised)

PLEASE NOTE: Complete Form A if you are female. Complete Form B (reverse side) if you are male.

What do *you* mean by femininity?

_____

_____

Please indicate your level of agreement with each of the following statements by rating it a "1," "2," "3," "4," "5," or "6" as follows:

1	2	3	4	5	6
Strongly Disagree	**Disagree**	**Somewhat Agree**	**Tend to Agree**	**Agree**	**Strongly Agree**

1. When I am asked to describe myself, being female is one of the first things I think of. ____
2. I am confident in my femininity (femaleness). ____
3. I meet my personal standards for femininity (femaleness). ____
4. My perception of myself is positively associated with my biological sex. ____
5. I am secure in my femininity (femaleness). ____
6. I define myself largely in terms of my femininity (femaleness). ____
7. My identity is strongly tied to my femininity (femaleness). ____
8. I have a high regard for myself as a female. ____
9. Being a female is a critical part of how I view myself. ____
10. I am happy with myself as a female. ____
11. I am very comfortable being a female. ____
12. Femininity (femaleness) is an important aspect of my self-concept. ____
13. My sense of myself as a female is positive. ____
14. Being a female contributes a great deal to my sense of confidence. ____

Hoffman Gender Scale (Form B) (Revised)

PLEASE NOTE: Complete Form B if you are male. Complete Form A (reverse side) if you are female.

What do *you* mean by masculinity?

_____

_____

Please indicate your level of agreement with each of the following statements by rating it a "1," "2," "3," "4," "5," or "6" as follows:

1 Strongly Disagree	2 Disagree	3 Somewhat Agree	4 Tend to Agree	5 Agree	6 Strongly Agree

1. When I am asked to describe myself, being male is one of the first things I think of. ____
2. I am confident in my masculinity (maleness). ____
3. I meet my personal standards for masculinity (maleness). ____
4. My perception of myself is positively associated with my biological sex. ____
5. I am secure in my masculinity (maleness). ____
6. I define myself largely in terms of my masculinity (maleness). ____
7. My identity is strongly tied to my masculinity (maleness). ____
8. I have a high regard for myself as a male. ____
9. Being a male is a critical part of how I view myself. ____
10. I am happy with myself as a male. ____
11. I am very comfortable being a male. ____
12. Masculinity (maleness) is an important aspect of my self-concept. ____
13. My sense of myself as a male is positive. ____
14. Being a male contributes a great deal to my sense of confidence. ____

Personal Reaction Inventory

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is *true* or *false* as it pertains to you personally. Circle your answer.

True False 1. It is sometimes hard for me to go on with my work if I am not encouraged.

True False 2. I sometimes feel resentful when I don't get my way.

True False 3. On a few occasions, I have given up doing something because I thought too little of my ability.

True False 4. There have been times when I felt like rebelling against people in authority even though I knew they were right.

True False 5. No matter who I'm talking to, I'm always a good listener.

True False 6. There have been occasions when I took advantage of someone.

True False 7. I'm always willing to admit it when I make a mistake.

True False 8. I sometimes try to get even rather than forgive and forget.

True False 9. I am always courteous, even to people who are disagreeable.

True False 10. I have never been irked when people expressed ideas very different from my own.

True False 11. There have been times when I was quite jealous of the good fortune of others.

True False 12. I am sometimes irritated by people who ask favors of me.

True False 13. I have never deliberately said something that hurt someone's feelings.

Thank you for your time and cooperation!