Sex Bias in Clinical Judgment: Later Empirical Returns

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This paper updates an earlier review of research on sex bias in psychological evaluation and psychotherapy. The experimental analogue continues to dominate the literature and to return a resoundingly negative verdict. This evidence, however, is often discounted on the grounds of the analogue's transparency and clinical impoverishment. Naturalistic data have likewise failed to support claims of widespread sex bias, but have nonetheless whetted suspicions that gender and sex role attributes affect circumscribed clinical decisions. These correlational field studies are often dismissed, however, on the basis of their inadequate control for potential confounds. This empirical deadlock is discussed within the context of the sexual politics of research and of methodological preference in particular. The interpretive gerrymandering that has plagued this literature is linked to an unwillingness to be open about the sex role heritage of research strategies themselves and the deep personal and political investments at stake.

The politics of clinical judgment has flourished as the empirical superego of the mental health enterprise. We had little choice but to examine the political nexus of psychiatric treatment if we were to keep pace with rapid social changes that stimulated the expansion of mental health services and demanded closer scrutiny of hallowed clinical practices and principles. Much of the impetus for the development of an empirical social psychology of clinical practice came from the stirrings of the community mental health movement, which sensitized us to the potential for social discrimination under the banner of mental health care (e.g., Hurvitz, 1973; Szasz, 1961). Several researchers were thus emboldened to determine the impact of varying the patient's social-class designation on clinical evaluations,

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employing the now familiar clinical analogue adaptation of the Asch impression formation paradigm. Reinforced by overwhelming evidence of bias against the poor (Abramowitz & Dokecki, 1977), this investigative energy first radiated to concerns over covert racial prejudice in the clinic (Sattler, 1970, 1977) and has since ridden the feminist wave (Chesler, 1971).

THE SEXUAL POLITICS OF CLINICAL JUDGMENT

Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) and Neulinger (1968) are generally credited with the groundbreaking empirical work in the sexual politics of clinical judgment. Broverman et al.'s findings that clinicians asked to describe the mentally healthy man, woman, or adult made patterned attributions suggestive of sex role stereotypic conceptions sent a shudder through the mental health establishment. Actually, their results could have been anticipated from data turned up in a creative archival study conducted by Masling and Harris (1969). Surmising that clinical encounters with women could offer male clinicians an opportunity to gratify voyeuristic needs, these often neglected pioneers discovered that male psychology interns administered more TAT cards cued for sexual-romantic themes to female than to male clients.

Analogues have been more the fashion than naturalistic studies in research on sex bias in clinical practice. This is curious indeed since contextual strategies are more consistent with traditionally feminine modes of problem solving (Carlson, 1972) and would seem more appropriate to identifying the interpersonal nuances at issue than more mechanistic masculine approaches (Abramowitz & Davidson, in press). To appreciate the sources of the analogue's dominance as the field's research paradigm, we must look beyond the virtues of experimental social psychology to the sexual politics of the methodological hierarchy in psychology.

The empirical trial of *women versus the mental health establishment* has already stimulated four research reviews in addition to our own. Probably the most widely cited has been the report prepared by the APA Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice (1975). This influential document presents anecdotes that effectively dramatize brazen abuses of female patients. It has several weaknesses as a scholarly paper, however, including the relative neglect of disconfirmatory findings and the lackluster return rate (16%) among the women psychologists who

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provided the data on which the conclusions and recommendations are based. Stricker's (1977) blistering response suffers from the same kind of overdrivenness he railed against, albeit in the interest of the opposing point of view (Abramowitz & Abramowitz, 1977). He bemoaned the paucity of field data, offering that as a rationale for holding in abeyance any conclusions regarding the prevalence of sex bias in mental health care. His observation, however, was well taken and could serve as an inadvertent exhortation to approach the question of sex bias from a more contextual, feminine direction.

Some 19 analogue studies and several archival investigations relevant to charges of covert sexism in professional practice were examined in our earlier review (Abramowitz & Dokecki, 1977). Our main conclusion was that the empirical returns appeared to vary with the methodology employed. Findings from clinical judgment analogues were overwhelmingly negative, whereas those from institutional record searches were often positive. Efforts to resolve this discrepancy implicated both the possible transparency of the analogue's hidden agenda and the politics of publication.

Zeldow (1978) likewise characterized the empirical evidence as equivocal on the basis of the most thorough review to date devoted exclusively to the sex bias phenomenon. He regarded the results as "sufficiently diverse and ambiguous as to be interpretable both as strong and weak evidence for sexism . . ., depending on the point of view of the interpreter" (p. 93). Kirshner (1978) focused on the implications of gender for reconceptualization of the psychotherapeutic transaction and did not attempt a comprehensive empirical review. Even from so limited a data base, he concurred that the role of gender appears to be as elusive as it is complex.

This paper updates the sex and value (sex role) sections of our earlier treatment of the empirical politics of clinical judgment (Abramowitz & Dokecki, 1977). We have discussed more fully elsewhere (Abramowitz & Davidson, in press) pertinent issues steeped in the sexual politics of psychological research itself, such as the problem in data interpretation posed by ego involvement and the dominance of the experimental analogue paradigm. However, we have not hesitated to call on them in attempts to reconcile the empirical returns with our clinical wisdom and personal convictions. We begin with a broad overview of the recent studies and next place the new findings in the context of the earlier work. Results are presented in the order of patient gender and sex role, and clinician gender, values, experience, and training. Conclusions from the research are then drawn and recommendations made.

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OVERVIEW OF RECENT RESEARCH

If sheer output of studies is any yardstick of interest in the problem of sex bias in psychotherapy, we can assume that ego involvement and social controversy remain powerful research incentives. Thus although only a few years have passed since the foregoing reviews were prepared, a number of new analogue and field studies of sex bias in clinical (i.e., personal adjustment-oriented) evaluation have become available. We located 14 additional analogues (Aslin, 1977; Billingsley, 1977; Chasen, 1975; Cowan, 1976; Cowan, Weiner, & Weiner, 1974; Delk & Ryan, 1977; Feinblatt & Gold, 1976; Fischer, Dulaney, Fazio, Hudak, & Zivotofsky, 1976; Hill, Tanney, Leonard, & Reiss, 1977; Hobfall & Penner, 1978; Johnson, 1978; Maslin & Davis, 1975; Stearns, Penner, & Kimmel, 1978; Warner, 1978), plus an extended analysis (Neulinger, Stein, Schillinger, & Welkowitz, 1970) of an analogue (Neulinger, 1968) reviewed previously.

Conceptual and Methodological Advances

Considerable conceptual and methodological continuity exists between the more recent analogues and those covered in Abramowitz and Dokecki (1977). Gender has been the most frequently studied patient attribute, although sex role characteristics have often been varied as well. To rule out the possibility of effective cue utilization by clinicians, the most compelling documentation of bias requires that effects of patient gender or sex role be differential across clinician subgroups. Almost all of the analogue research has met this design criterion in that clinician-subjects have been routinely blocked into subsamples according to gender, values, or experience. Clinician gender has been the most frequently chosen moderator, stemming from strong feminist concerns about the fate of the female patient with the male clinician. When clinician values is the moderator, the issue is usually whether the more conservative-traditional practitioner is especially prone to sexism. Effects of A-B status, an index of femininity-masculinity of therapists' interests, have also been examined. Analogues in which clinicians are blocked on experience test the Szaszian hypothesis that greater absorption into the mental health establishment leads to more vigilant enforcement of social norms versus the alternative hypothesis that experience tempers bias effects.

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The written case summary has been the most popular but not the most ecologically desirable format for patient-stimuli. Close-ended diagnostic and prognostic judgments and treatment recommendations have been the most commonly used dependent measures.

Certain conceptual and methodological advances merit special comment. Delk and Ryan's (1977) work continues to move us in the direction of considering the interplay of multiple clinician characteristics in determining perceptions of patients. The question of whether sex bias occurs in clinical work with children has also attracted more attention. Besides the two family evaluation analogues cited by Abramowitz and Dokecki (1977), we now have two others specific to children (Chasen, 1975; Feinblatt & Gold, 1976). A few researchers (Aslin, 1977; Cowan, 1976; Maslin & Davis, 1975) got more mileage out of the Broverman et al. (1970) paradigm, but others voiced dissatisfaction with it. Stearns et al. (1978) comment, "It is difficult to conceive of a therapist who determines only the sex of a client during an initial interview" (p. 6). The demonstration that clinicians provided with such limited information resorted to sex role stereotypes does not indicate that they would do so if they had fuller (i.e., more typical) data or that they would work to foster such traits. Trends growing out of this realization are to include patient psychopathology as an independent variable and sex role adjective items as dependent measures of treatment intentions (Billingsley, 1977; Stearns et al., 1978).

Methodological advances include improvements in the realism of the patient-stimuli and the evaluative task. Videotape and audiotape presentations of patients are becoming more common (Hill et al., 1977; Hobfall & Penner, 1978; Johnson, 1978). Johnson (1978) built pauses into her videotapes during which clinician-subjects reported their feelings and what they would say to the patient. Videotaped case conferences in which patients were discussed, but apparently not shown, were used by Stearns et al. (1978). Such formats better approximate real-life clinical encounters than do written reports and thereby enhance generalizability. Empirical checks to determine whether the various versions of the patient-stimuli actually differed as intended but were equivalent in other respects have been taken more routinely. Also, dependent measures that would be expected to be maximally sensitive to countertransference are beginning to appear in the literature. Thus Johnson's (1978) battery included process-oriented measures and judges' ratings of subjects' comments during the tape pauses.

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RECENT FINDINGS

The specific patient and clinician attributes examined in each analogue are noted in the summaries of results that follow. Subjects in most studies were practicing clinicians. Three samples (Feinblatt & Gold, 1976; Hobfall & Penner, 1978; Maslin & Davis, 1975) were composed of trainees and two (Cowan et al., 1974; Hill et al., 1977) consisted of staff and trainees. Delk and Ryan (1977) compared professionals, trainees, and psychiatric patients. For the most part, cohorts of professionals were mixed by discipline.

Patient Gender

Results of the newer analogues give us little reason to modify Abramowitz and Dokecki's (1977) conclusion that analogue research has generally not confirmed allegations of sexism and evaluative prejudice against the female patient. The claim that clinicians have a double standard of mental health for men and women has received further support only among male clinicians, and even that evidence is mixed. The notion of a double standard was based on the Broverman et al. (1970) finding that clinicians' description of a "mature, healthy, socially competent adult woman" did not resemble their characterization of such an "adult person" (a presumably neutral standard of mental health), whereas their description of an "adult man" did. Maslin and Davis (1975) used these same stems, and Aslin (1977) employed the stems "female," "wife," "mother," and "adult." In both investigations the pattern of descriptions given by male clinicians was suggestive of a double standard, whereas that given by female clinicians was not. Cowan's (1976) predominantly male sample of consulting psychologists, however, described the problems of the typical female patient in terms of too much conformity to traditional feminine role standards. No tendencies to perceive male patients along the lines of sex role stereotypes were detected with the Broverman et al. bipolar adjective measure, but direct questioning of subjects revealed opinions that both sexes experience problems related to sex role expectations.

The four studies that afford the broadest and most clinically sophisticated tests of patient gender effects (Billingsley, 1977; Feinblatt & Gold, 1976; Johnson, 1978; Stearns et al., 1978) generally yielded null findings as did a fifth more limited investigation (Cowan et al., 1974). Billingsley (1977) did not detect any patient gender effects on diagnostic or prognostic judgments, and Stearns

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et al. (1978) found few such effects on those types of evaluations or on treatment recommendations. Moreover, as measured by clinicians' endorsement of adjective trait descriptions, neither initial perceptions (Stearns et al., 1978) nor desired treatment outcomes (Billingsley, 1977; Stearns et al., 1978) were formulated in terms of sex role stereotypes. Male and female child patient-stimuli did not elicit differential evaluations of problem severity, treatment need, or prognosis in Feinblatt and Gold (1976). Even the process measures in Johnson's (1978) study that were most clinically subtle and least likely to be vulnerable to social desirability responding (e.g., judges' ratings of clinician-subject defensiveness, identification with the client) did not detect evidence of differential reactions by patient gender.

To be sure, three recent analogues yielded positive data. In a study based on a literature review that pointed to similar clinical features in hysterical and antisocial personalities, Warner (1978) found a relationship between patient gender and assignment of these diagnoses. The same case description was judged indicative of a hysterical personality when it was attributed to a female, but was as often considered an antisocial as a hysterical personality when it was credited to a male. Warner (1978) reasoned that the inclination to assign female patients the diagnosis thought to indicate greater responsivity to psychotherapy suggests countertransference on the part of the therapist whose identity is tied to the role demand of "ability to protect, mold and gratify the female" (p. 843). In Hobfall and Penner (1978), male patient-stimuli were regarded as having better self-concepts than their female counterparts. However, the Fischer et al. (1976) findings of favoritism toward female patient-stimuli are contrary to the bias hypothesis.

Naturalistic data. Overrepresentation of women among the mentally ill continues to be reported in literature reviews (Gove, 1980; Weissman & Klerman, 1977) and epidemiological surveys (e.g., Weissman & Myers, 1978). We have chosen to focus on the very few nonexperimental studies in which patient disturbance was taken into account or moderating effects of a clinician attribute were examined. Such research is better able to rule out the possibility that differential evaluation of male and female patients reflects real variation in adjustment rather than biased clinical perception (Abramowitz & Dokecki, 1977).

A pair of archival studies are pertinent here. Samples of male and female patients found to be equally distressed on the basis of self-

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report were compared with regard to treatment length and prescription of medications. Female neurotic depressives were seen for more therapy sessions and were more often given medications, especially the more potent types, than were male neurotic depressives (Stein, Del Gaudio, & Ansley, 1976). However, no sex differences obtained in a more diagnostically heterogeneous sample (Del Gaudio, Carpenter, & Morrow, 1978).

Patient Sex Role

Sex role related symptoms. Although patient gender may have little or no effect on clinicians' reactions, aspects of symptomatology and history correlated with gender in real-life patients may have a substantial impact (Billingsley, 1977; Stearns et al., 1978). If we can assume that clinicians behave in their offices as they do in analogue research, then the studies summarized in this section offer some reassurance that clinicians respond primarily to psychopathology, which may be sex role linked; that they do not have a consistent inclination to view feminine-stereotypic dysfunctions as better or worse than masculine-stereotypic dysfunctions; and that they work to foster androgynous rather than sex role stereotypic characteristics in their psychotherapy patients. This assumption, however, remains risky in the absence of any direct test of validity.

In Billingsley (1977), an explosive psychotic patient was judged to be more disturbed and to have a poorer prognosis than a restricted phobic patient. Subjects' choices of adjective traits to describe their treatment goals indicated that they would want to foster more warmth and expressiveness (feminine traits) in the explosive patient and more competence (masculine trait) in the restricted patient. Unfortunately, confounding of sex role related (explosive vs. restricted) with more general (psychotic vs. nonpsychotic) aspects of symptomatology prohibits clear inferences about the impact of the sex role related attribute. Patients with aggressive versus depressive symptoms received similar prognostic evaluations and treatment recommendations, but they did elicit different trait descriptions in Stearns et al. (1978). The bulk of these findings obtained on item clusters that tapped warmth-coldness and dominance-submissiveness, with the aggressive patient being perceived as colder and more dominant. Trait descriptions regarding anticipated characteristics at termination of successful therapy revealed that the two patients were expected to be similar to one another in most regards, although the aggressive patient was still expected to be colder. In Feinblatt and Gold (1976) an aggressive child

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was viewed as less in need of treatment than a withdrawn child. The two symptom patterns, however, elicited comparable reactions concerning severity and prognosis. Johnson (1978) failed to find any differential reactions to angry versus depressed patients.

Sex role identity. Whether a patient's history and current interests fit masculine versus feminine role expectations affected trait descriptions in Stearns et al. (1978), although less strikingly so than did sex role related symptoms. More important, however, prognostic judgments and treatment recommendations were not differential, and expectations regarding personality and behavior at close of therapy were highly convergent.

Sex role conformity. In the language of experimental design, the foregoing were tests of main effects of patient sex role attributes. Those findings, then, held regardless of whether the patient-stimulus was male or female. Interactions between patient gender and sex role attributes are also pertinent to the bias formulation as they shed light on clinicians' reactions to the patient whose personality or behavior departs from expectations for his or her gender.

The newer analogues (Billingsley, 1977; Fischer et al., 1976; Johnson, 1978; Stearns et al., 1978), like their predecessors (Abramowitz & Dokecki, 1977), provide virtually no confirmation of claims that clinicians show favoritism to the sex role conforming man or woman. The lone positive finding was reported by Hobfall and Penner (1978). Better self-concepts were attributed to attractive than to unattractive persons of either sex, but attractive (i.e., normative) females elicited even more favorable perceptions when more biasing cues were presumably available (videotape) than when they were not (audiotape). This pattern of partisanship toward attractive women takes on added significance, however, because it had also turned up in a previously reviewed analogue (Schwartz & Abramowitz, in press) and in a nonexperimental study of retrospective staff reactions to former clients (Barocas & Vance, 1974).

Data regarding clinicians' appraisals of sex role deviant children are inconsistent. Children in Feinblatt and Gold (1976) whose symptoms were incongruent with their gender were viewed as more disturbed, as more in need of treatment, and as having a poorer prognosis than children whose symptoms were congruent with their gender. These investigators also detected a relationship between cross-gender behavior and psychiatric referral in an archival search that apparently stimulated the analogue. Boys far outnumbered girls

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among referrals for emotional and passive behavior, whereas girls were predominant among referrals for defiance and verbal aggressiveness. However, the opposite pattern of favoritism toward children whose behavior conflicted with traditional gender norms obtained in Chasen's (1975) analogue.

Clinician Gender

Tests for main effects of clinician gender have generally yielded null findings (Billingsley, 1977; Cowan et al., 1974; Feinblatt & Gold, 1976; Fischer et al., 1976; Hill et al., 1977; Johnson, 1978; Stearns et al., 1978). The few differences that have emerged do not form a readily interpretable pattern. Thus female counselors thought women who feared rape or were contemplating a nontraditional college major would profit more from counseling than did male counselors (Hill et al., 1977). Men and women sometimes chose different traits to describe patients in Stearns et al. (1978), the main difference being that the men saw the patients as more independent. Masculine traits were endorsed as treatment goals by female clinicians, and feminine traits by male clinicians in Billingsley (1977). Johnson's (1978) female subjects self-reported more empathy for patients, but were rated by judges (one male and one female) as angrier than male subjects. The women appeared to have manifested this anger primarily in their subjective reactions to an angry male patient-stimulus, yet were apparently able to temper it in their verbal responses to him.

Interactions with patient gender. The newer analogues have for the most part failed to support contentions that any particular pairing of patient and clinician according to gender ensures bias or immunity to it (Billingsley, 1977; Cowan et al., 1974; Fischer et al., 1976; Johnson, 1978; Neulinger et al., 1970; Stearns et al., 1978; Warner, 1978). The only major affirmative evidence that the female patient may not fare well with the male clinician comes from Maslin and Davis (1975) and Aslin (1977), whose data suggest that male clinicians have a sex role stereotypic conception of the mentally healthy woman. A few patient by clinician gender interactions obtained in Stearns et al. (1978). They were attributable to female clinicians making more distinctions on the basis of patient gender and to discrepancies in male and female clinicians' opinions about female patients.

Archival findings regarding the impact of patient-clinician gender combinations on clinical evaluations have been inconsistent. An

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earlier report that female personality assessors described women more favorably than did their male colleagues, whose evaluations were harsher regardless of subject gender (Haan & Livson, 1973), may have been premature (Werner & BLock, 1975). In addition, the relevance of those data to clinical practice was limited since the persons evaluated were normals in a longitudinal personality study rather than patients, and the evaluations were Q-sort descriptions rather than diagnoses. A recent record search conducted at a community mental health center (Wright, Meadow, Abramowitz, & Davidson, in press) did, however, find leniency among female clinicians toward adult female patients. Female clinicians assigned a higher proportion of transient situational disturbance to psychotic diagnoses than did their male co-workers, but primarily for female patients and for younger (under 30) patients. A clinician gender difference in the opposite direction emerged in an archival study at a university counseling center (Helms, 1978). In that case, female counselors attributed more problems to female clients than did male counselors.

Other naturalistic data (Abramowitz, Abramowitz, Roback, Corney, & McKee, 1976; Abramowitz, Davidson, Greene, & Edwards, 1979; Barocas & Vance, 1974) indicate an underrepresentation of male patients in the case loads of female clinicians, a finding consistent with feminine role prohibitions and anxiety around exercising authority over men. Whether some patient–clinician dyads maintain contact longer than others is not yet clear. Feminists have been particularly concerned about the possibility that male clinicians may unnecessarily prolong the treatment of female patients. An archival study conducted at a university counseling center and training hospital clinic and reviewed in Abramowitz and Dokecki (1977) yielded differences suggestive of such a pattern. Relatively inexperienced male clinicians carried their female patients for more sessions than their male patients, whereas female clinicians saw their male and female patients for about the same number of sessions (Abramowitz et al., 1976). However, no case length differentials were detected in a community mental health center record study that controlled for patient impairment (Abramowitz et al., 1979). Helms (1978) did find such a difference, but it was in the direction opposite to the bias hypothesis. Female clients were seen for more visits by female than by male counselors.

Interactions with patient sex role. Clinician gender did not have any important modifying effects on evaluations of patients with

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masculine- versus feminine-typed history (Stearns et al., 1978) or symptomatology (Johnson, 1978; Stearns et al., 1978) in two analogues. However, interactive patterns turned up in two others. Billingsley (1977) found that female clinicians made more distinctions between explosive and restrictive patients than did male clinicians. Chasen's (1975) female clinicians showed evaluative favoritism toward children whose behavior departed from gender norms, whereas their male colleagues did not differentiate between gender congruent and gender incongruent children.

Results of Barocas and Vance's (1974) naturalistic study provide male clinicians with some vindication of charges that they are particularly partisan toward attractive women. Staff at a university counseling center made retrospective clinical evaluations and (2 months later) rated physical attractiveness of former patients. The more attractive a woman was considered, the more favorable were the assessments of her initial and final clinical status and her prognosis. There correlations were stronger, however, when the clinician was also a woman. Relationships between perceived attractiveness and clinical impressions reached significance, but were of roughly equivalent magnitude, for male and female patients of male clinicians. The role of patient attractiveness in female clinicians' assessment of their male patients was minimal in that only the correlation between prognosis and attractiveness was significant.

Clinician Values

The weight of data in Abramowitz and Dokecki (1977) acquitted the value-traditional clinician of charges of evaluative discrimination on the basis of patient gender or sex role attributes, despite scattered incrimination (e.g., Abramowitz, Abramowitz, Jackson, & Gomes, 1973). A shred of substantiating data also obtained in one (Chasen, 1975) of the few pertinent new analogues that we have located, but this is not enough to cause us to modify our conclusions. Male school psychologists who espoused traditional sex role attitudes favored children whose behavior was consistent with their gender, whereas their untraditional colleagues favored those whose behavior departed from gender norms. Diagnostic sex role bias was not related to sex role attitudes among female school psychologists or to the more general attribute of authoritarianism among subjects of either sex. Aslin (1977) found that feminist and other female therapists reacted similarly to each other, but somewhat differently from male therapists, when asked to give their perceptions of the mentally healthy adult,

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female, wife, and mother. Subjects were recruited from known groups, but no attempt was made to validate that they indeed differed in sex role ideology. Thus whether this study disconfirmed clinician value effects among the women or simply did not test for them is unclear.

Delk and Ryan's (1977) research on the A-B therapist dimension constitutes a divergent line of inquiry into clinician value effects. A-status subjects (whose interests were presumably more feminine) sex role stereotyped more than B-status subjects (whose interests were presumably more masculine), and AB-status subjects sex role stereotyped at an intermediate level. This pattern obtained for both male and female subjects and was consistent with the investigators' earlier data (Delk & Ryan, 1975).

Clinician Experience and Discipline as Moderators

The mediating roles of clinician experience and discipline remain elusive (Abramowitz & Dokecki, 1977). In the main, investigators have not overcome the formidable logistical barriers to sampling procedures that would ensure reasonable representation across the broad spectrum of experience and training. Thus little can be pieced together even across investigations that have afforded these variables some emphasis (Delk & Ryan, 1977; Neulinger et al., 1970; Wright et al., in press).

Experienced clinicians emerged as neither more nor less prone to bias in the earlier review (Abramowitz & Dokecki, 1977). Delk and Ryan (1977) found that mental health professionals sex role stereotyped less than psychiatric patients, and trainees did so at an intermediate level. The underrepresentation of male patients in the case loads of female clinicians detected in Abramowitz et al. (1979) was slightly greater for trainees than nontrainees. Experience, however, was not related to clinical judgments in the other investigations (Billingsley, 1977; Helms, 1978; Neulinger et al., 1970; Warner, 1978) covered in this paper.

Diagnostic severity proved to be related to professional discipline among male, but not female, clinicians in the record search conducted by Wright et al. (in press). Increasingly higher proportions of psychotic to transient situational disturbance diagnoses were rendered by male nurses, social workers, psychologists, and psychiatrists, whereas females generally tended to assign the more lenient label. The investigators conjectured that doctoral-level training may "transmit a sense of comfort with diagnostic privilege [to men] . . . ,"

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but that "even the current generation of female clinicians may have been shortchanged by early sex role training in maternal and related nurturant-protective tasks at the expense of preparation for the exercise of critical authority." As was usually the case in the earlier research (Abramowitz & Dokecki, 1977), evaluative consensus among disciplines was the rule in the analogues (Billingsley, 1977; Neulinger et al., 1970; Warner, 1978). Neulinger et al. (1970) found Freudians' descriptions of the optimally integrated man and woman to be somewhat more "conservative" than Neo-Freudians or Sullivanians', but even across theoretical orientations there was more agreement than disagreement.

CONCLUSIONS

In the main, recent studies of sex bias in clinical judgment have yielded findings reminiscent of those of their predecessors. Clinical analogues have continued to produce unimpressive results, whereas naturalistic investigations have turned up more data consistent with sex bias formulations—a pattern more reassuring for its continuity than its accessibility to interpretation. Thus although analogues suggest that patient gender has little impact on clinicians' reactions, naturalistic data continue to reinforce feminists' suspicions that it does. Patient sex role-related attributes have more often affected judgments in analogues, but the direction of these differences has not necessarily been congruent with bias hypotheses. In fact, the limited data we have concerning treatment intentions suggest that clinicians consciously regard the development of androgynous characteristics as desirable treatment goals. There likewise appears to be little prejudice against the adult whose behavior departs from sex role norms, although there have been findings suggestive of evaluative partisanship toward attractive women. Data regarding clinicians' reactions to sex role nonconforming children are inconclusive.

Whether the patient–clinician dyad consisted of a woman and a man, a man and a woman, two women, or two men has made a negligible difference on clinical decisions in analogue studies. Yet there is some indication that male clinicians still subscribe to a double standard of mental health. Naturalistic data pertaining to the effect of various patient–clinician gender combinations on diagnositc impressions and treatment duration have been inconsistent. However, men have repeatedly been shown to be underrepresented in the case loads of female clinicians, a finding that suggests women's

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avoidance of roles that place them in dominant positions over men, despite the greater permission brought about by the women's movement. Analogue research largely continues to exonerate the value-traditional clinician of charges of bias, although there are shreds of confirmatory data. On the other hand, we are beginning to amass analogue evidence that A-status (feminine) clinicians are more prone to sex role stereotyping than B-status (masculine) clinicians. The picture regarding moderating effects of clinician experience and discipline remains unclear, primarily due to the lack of representative sampling methods.

It would be comforting to be able to conclude that the analogue data are accurate and that sexism in clinical practice, if it ever did exist, is no longer a problem. This conclusion, however, is difficult to draw. The analogue, although experimentally pristine, may have become so transparent to sophisticated clinician-subjects as to ensure findings coated with social desirability. Its failure to validate the operation of presumably more subtle sex biases is all the more puzzling in light of recent admissions by a handful of practitioners of the blatantly unethical practice of engaging in sexual relationships with patients (Holroyd & Brodsky, 1977). Even if glaring abuse of female patients is restricted to a small segment of mental health professionals, it seems unlikely—given the long-venerated traditions of sex role socialization in our culture—that subtle sexism is as rare as analogue research would appear to indicate.

RESEARCH DIRECTIONS

If anything has emerged clearly, it is that we need to move beyond the kinds of simple sex bias analogues that contributed so much to the early development of the field. This methodological strategy has returned a resoundingly negative verdict. Nevertheless, feminists continue to find their personal experience more compelling. Paradoxically, defenders of the mental health establishment are also quick to dismiss analogue data on the grounds of the method's clinical impoverishment. Some room can be made, however, for analogues enriched by the representativeness of the clinician sample, the patient-stimulus, and the clinical task. Prospective investigators should consult Kazdin (1978), Maher (1978), Worell (1978), Abramowitz and Dokecki (1977), Abramowitz and Davidson (in press), and Davidson (1978) for more specific recommendations regarding the design and interpretation of sex bias analogues.

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The archival strategy has proven a fruitful complement to the experimental approach and deserves a fairer hearing, despite its notorious drawbacks. For example, the poor reliability of institutional records data is frequently cited as a fatal limitation. Although it is indeed true that unreliability renders negative results uninterpretable, positive results that obtain despite a large percentage of misclassifications are actually all the more telling. Then again, the uncontrolled assignment of patients to therapists that occurs *in situ* creates two additional problems. Level of impairment may not be independent of patient gender, and the routine practice of analyzing data by patient rather than therapist *N* results in disproportionate weighting of therapists with larger case loads (Werner & Block, 1975). The first problem can be handled by covariance or other statistical control but, given the difficulty of recruiting female psychiatrists and certain other subsamples, the second can probably be overcome only by cross-agency collaboration.

The archival representation notwithstanding, the dominance of the analogue motif and the almost complete absence of intensive case analyses recall our earlier allusion to the sexual politics of sex bias research. Psychologists' preference for the experimental paradigm cannot alone account for this curiosa, since the relevant psychiatric and social work literatures are little more balanced in this regard. We have proposed an explanation based on Carlson's (1972) perceptive distinction between the traditionally masculine investigative modes of quantification, rationality, and dispassion and their historically feminine counterparts of qualification, intuition, and involvement (Abramowitz & Davidson, in press). To be sure, we are most assuredly *not* mandating "sloppy" research. We are asserting that recourse to qualitative modes of inquiry is justified when they are more appropriate to the question at hand than the male-oriented presumptions from the physical sciences.

Analogue procedures, which predominate in the sex bias literature, have the appeal of rigor, logic, and apparent objectivity—avowedly masculine virtues; but they also are saddled with that masculine nemesis, interpersonal insensitivity, in this case to clinician-subjects' prior cognitive states, possible misperceptions of the intended manipulation, and covert reactions to the patient-stimulus. Sex bias in psychotherapy is a manifestation of a social disorder, historically a feminine problem-solving domain. Is it not incongruous that the predominant research paradigm (i.e., the experimental analogue) has traditionally masculine qualities and the most underrepresented paradigm (i.e., the in-depth process account)

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has traditionally feminine qualities? How sweetly reminiscent of the finding of clinicians' double standard of mental health (Broverman et al., 1970)—researchers apparently place differential value on traditionally feminine and masculine modes of inquiry into sex bias in psychotherapy. Apparently a shift toward androgyny is as overdue in the psychotherapy research community as in the culture at large.

We introduced the notion of a "heartpothesis" in an attempt to understand the failure of research on racial effects in the clinic to influence formulations about the transaction between white therapist and black patient (Abramowitz, 1978). Whereas hypotheses accommodate to data, heartpotheses circumvent them by appealing to observers' personal experience. The question of sex bias in clinical practice is another case in point. Until the preponderance of negative returns is contributed by investigative strategies more compatible with their time-honored ways of knowing than the analogue, feminists cannot be expected to relinquish their conviction that covert sexism pervades the clinical marketplace.

REFERENCES

Abramowitz, C. V., & Dokecki, P. R. The politics of clinical judgment: Early empirical returns. *Psychological Bulletin,* 1977, *84,* 460–476.

Abramowitz, S. I. Splitting data from theory on the black patient-white therapist relationship. *American Psychologist,* 1978, *33,* 957–958.

Abramowitz, S. I., & Abramowitz, C. V. Sex-biased researchers of sex bias in psychotherapy and impartial reviewers. *American Psychologist,* 1977, *32,* 893–894.

Abramowitz, S. I., Abramowitz, C. V., Jackson, C., & Gomes, B. The politics of clinical judgment: What nonliberal examiners infer about women who do not stifle themselves. *Journal of Consulting and Clinical Psychology,* 1973, *41,* 385–391.

Abramowitz, S. I., Abramowitz, C. V., Roback, H. B., Corney, R., & McKee, E. Sex-role related countertransference in psychotherapy. *Archives of General Psychiatry,* 1976, *33,* 71–73.

Abramowitz, S. I., & Davidson, C. V. The sexual politics of sex-bias-in-psychotherapy research. *Political Behavior,* in press.

Abramowitz, S. I., Davidson, C. V., Greene, L. R., & Edwards, D. W. Sex-role related countertransference revisited: A partial extension. Unpublished manuscript, University of California at Davis, 1979.

American Psychological Association. Report of the Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice. *American Psychologist,* 1975, *30,* 1169–1175.

Aslin, A. L. Feminist and community mental health center psychotherapists' expectations of mental health for women. *Sex Roles: A Journal of Research,* 1977, *3,* 537–544.

Barocas, R., & Vance, F. L. Physical appearance and personal adjustment counseling. *Journal of Counseling Psychology,* 1974, *21,* 96–100.

Billingsley, D. Sex bias in psychotherapy: An examination of the effects of client sex, client psychopathology, and therapist sex on treatment planning. *Journal of Consulting and Clinical Psychology,* 1977, *45,* 250–256.

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

Carlson, R. Understanding women: Implications for personality theory and research. *Journal of Social Issues*, 1972, *28*, 17-32.

Chasen, B. Diagnostic sex-role bias and its relation to authoritarianism, sex-role attitudes, and sex of the school psychologist. *Sex Roles: A Journal of Research*, 1975, *1*, 355-368.

Chesler, P. Patients and patriarchs. In V. Gornick & B. K. Moran (Eds.), *Women in sexist society*. New York: Basic Books, 1971.

Cowan, G. Therapist judgments of clients' sex-role problems. *Psychology of Women Quarterly*, 1976, *1*, 115-124.

Cowan, M. L., Weiner, E. A., & Weiner, B. J. Therapist perceptions of clients and client self-report. *Journal of Clinical Psychology*, 1974, *30*, 227-230.

Davidson, C. V. Measures of clinician beliefs in value-bias research. Unpublished manuscript, University of California at Davis, 1978.

Del Gaudio, A. C., Carpenter, P. J., & Morrow, G. R. Male and female treatment differences: Can they be generalized? *Journal of Consulting and Clinical Psychology*, 1978, *46*, 1577-1578.

Delk, J. L., & Ryan, T. T. Sex role stereotyping and A-B therapist status: Who is more chauvinistic? *Journal of Consulting and Clinical Psychology*, 1975, *43*, 589.

Delk, J. L., & Ryan, T. T. A-B status and sex stereotyping among psychotherapists and patients: Toward a model for maximizing therapeutic potential. *Journal of Nervous and Mental Disease*, 1977, *164*, 253-262.

Feinblatt, J. A., & Gold, A. R. Sex roles and the psychiatric referral process. *Sex Roles: A Journal of Research, 1976*, *2*, 109-122.

Fischer, J., Dulaney, D. D., Fazio, R. T., Hudak, M. T., & Zivotofsky, E. Are social workers sexists? *Social Work*, 1976, *21*, 428-433.

Gove, W. R. Mental illness and psychiatric treatment among women. *Psychology of Women Quarterly*, 1980, *4*, 345-362.

Haan, N., & Livson, N. Sex differences in the eyes of expert personality assessors: Blind spots? *Journal of Personality Assessment*, 1973, *37*, 486-492.

Helms, J. E. Counselor reactions to female clients: Generalizing from analogue research to a counseling setting. *Journal of Counseling Psychology*, 1978, *25*, 193-199.

Hill, C. E., Tanney, M. F., Leonard, M. M., & Reiss, J. A. Counselor reactions to female clients: Type of problem, age of client, and sex of counselor. *Journal of Counseling Psychology*, 1977, *24*, 60-65.

Hobfall, S. E., & Penner, L. A. Effect of physical attractiveness on therapists' initial judgments of a person's self-concept. *Journal of Consulting and Clinical Psychology*, 1978, *46*, 200-201.

Holroyd, J. C., & Brodsky, A. M. Psychologists' attitudes and practices regarding erotic and non-erotic physical contact with patients. *American Psychologist*, 1977, *32*, 843-349.

Hurvitz, N. Psychotherapy as a means of social control. *Journal of Consulting and Clinical Psychology*, 1973, *40*, 232-239.

Johnson, M. Influence of counselor gender on reactivity to clients. *Journal of Counseling Psychology*, 1978, *25*, 359-365.

Kazdin, A. E. Evaluating the generality of findings in analogue therapy research. *Journal of Consulting and Clinical Psychology*, 1978, *46*, 673-686.

Kirshner, L. A. Effects of gender on psychotherapy. *Comprehensive Psychiatry*, 1978, *19*, 79-82.

Maher, B. A. Stimulus sampling in clinical research: Representative design reviewed. *Journal of Consulting and Clinical Psychology*, 1978, *46*, 643-647.

Maslin, A., & Davis, J. L. Sex-role stereotyping as a factor in mental health standards among counselors-in-training. *Journal of Counseling Psychology*, 1975, *22*, 87-91.

Masling, J., & Harris, S. Sexual aspects of TAT administration. *Journal of Consulting and Clinical Psychology*, 1969, *33*, 166-169.

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Neulinger, J. Perceptions of the optimally integrated person: A redefinition of mental health. *Proceedings of the 76th Annual Convention of the American Psychological Association*, 1968, *3*, 553–554 (Summary).
Neulinger, J., Stein, M. I., Schillinger, M., & Welkowitz, J. Perceptions of the optimally integrated person as a function of therapists' characteristics. *Perceptual and Motor Skills*, 1970, *30*, 375–384.
Sattler, J. M. Racial "experimenter effects" in experimentation, testing, interviewing, and psychotherapy. *Psychological Bulletin*, 1970, *73*, 137–160.
Sattler, J. M. The effects of therapist–client racial similarity. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research*. Elmsford, N.Y.: Pergamon, 1977.
Schwartz, J. M., & Abramowitz, S. I. Effects of client physical attractiveness on clinical judgment. *Psychotherapy: Theory, Research and Practice*, in press.
Stearns, B. C., Penner, L. A., & Kimmel, E. Sexism among psychotherapists: A case not yet proven. Paper presented at the Annual Meeting of the American Psychological Association, Toronto, Canada, 1978.
Stein, L. S., Del Gaudio, A. C., & Ansley, M. Y. A comparison of female and male neurotic depressives. *Journal of Clinical Psychology*, 1976, *32*, 19–21.
Stricker, G. Implications of research for psychotherapeutic treatment of women. *American Psychologist*, 1977, *32*, 14–22.
Szasz, T. S. *The myth of mental illness: Foundations of a theory of human conduct*. New York: Hoeber-Harper, 1961.
Warner, R. The diagnosis of antisocial and hysterical personality disorders: An example of sex bias. *Journal of Nervous and Mental Disease*, 1978, *166*, 839–845.
Weissman, M. M., & Klerman, G. L. Sex differences and the epidemiology of depression. *Archives of General Psychiatry*, 1977, *34*, 98–111.
Weissman, M. M., & Myers, J. K. Affective disorders in a U.S. urban community: The use of research diagnostic criteria in an epidemiological survey. *Archives of General Psychiatry*, 1978, *35*, 1304–1311.
Werner, P. D., & Block, J. Sex differences in the eyes of expert personality assessors: Unwarranted conclusions. *Journal of Personality Assessment*, 1975, *39*, 110–113.
Worell, J. P. Sex roles and psychological well-being. *Journal of Consulting and Clinical Psychology*, 1978, *46*, 777–791.
Wright, C. T., Meadow, A., Abramowitz, S. I., & Davidson, C. V. Psychiatric diagnosis as a function of assessor profession and sex. *Psychology of Women Quarterly*, in press.
Zeldow, P. B. Sex differences in psychiatric evaluation and treatment: An empirical review. *Archives of General Psychiatry*, 1978, *35*, 89–93.

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