CLINICIANS' APPRAISAL OF MENTAL HEALTH IN HOMOSEXUAL AND HETEROSEXUAL WOMEN AND MEN

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CONTENTS

ABSTRACT

114 NZ Registered Psychologists participated in a study which examined diagnostic perceptions and procedures and investigated the effects of client sex, sexual orientation and clinician sex on clinical assessments of mental health. Subjects were presented with one of four hypothetical case studies which varied client sex (male, female) and sexual orientation (heterosexual, homosexual) and were asked to respond to exploratory questions regarding their first impressions, major assessment issues and diagnoses. They also evaluated one of four types of mentally healthy adults (heterosexual male or female; and homosexual male or female) on 14 masculine-instrumental and 14 feminine-nurturant traits. Content analyses of exploratory questions indicated a trend to treating homosexual orientation as salient but not heterosexuality or client sex.

A 2(Stimulus Person Sex)x2(Stimulus Person Sexual Orientation)x2(Subject Sex)x2(Rating) analysis of variance revealed a main effect for stereotype sex. Masculine traits were perceived as more important overall determinants of mental health. This, however, was qualified by two interaction effects. A stimulus person x rating interaction demonstrated an androgynous model of mental health for men and a masculine model of mental health for women.

A sexual orientation x rating interaction suggested an androgynous model of mental health for homosexuals and a masculine model for heterosexuals. This was affected primarily by the evaluations of gays and heterosexual women. There was no evidence of sex-role inversion for homosexual clients, nor were there any effects for clinician sex.

Results were discussed in terms of the hypothesised androgynous model only holding for males and homosexuals and that the masculine model for women suggested a continued double-standard for mental health as was found by Broverman, Broverman, Clarkson, Rosenkrantz and Vogel in 1970. Implications in clinical assessment were also considered. Suggestions for improvements to the research design and ideas for future research were offered.

INTRODUCTION

"If we conceive of feminism as more than a frivolous label, if we conceive of it as an ethics, a methodology, a more complex way of thinking about, thus more responsibly acting upon, the conditions of human life, we need a self-knowledge which can only develop though a steady, passionate attention to all female experience. I cannot imagine a feminist evolution leading to radical change in the private/political realm of gender that is not rooted in the conviction that all women's lives are important; that the lives of men cannot be understood by burying the lives of women; and that to make visible the full meaning of women's experience, to reinterpret knowledge in terms of that experience, is now the most important task of thinking."
[Adrienne Rich (1979), p 213].

In trying to make sense of the world, humans have historically attempted to classify and structure reality. One aspect of such classification is in the area of sexually prescribed norms: society's "givens" about what is considered feminine and what is masculine. For example, it is considered feminine to be gentle, warm and passive while it is considered masculine to be strong, aggressive and independent. This sex-role stereotyping operates at many different levels: at home in terms of sex-appropriate tasks whereby a man's work is in the yard and fixing things while a woman's domain is housework and indoors; at work, whereby an acceptable male job would be firefighting, doctor or higher management while a woman's work would be more in hairdressing, nursing or being the secretary or assistant to the manager; leisure activities, where tough contact sport like rugby would be considered masculine while women are expected to be inclined to rhythmic gymnastics; educationally a boy would be expected to enter the field of physics and maths while a girl would be expected to focus on the arts. Another level of society where sex-stereotyping operates is in the area of health assessment which is the focus of this study.

Research in the area of sex-roles and stereotyping by clinicians has grown since Broverman, Broverman, Clarkson, Rosenkrantz and Vogel's landmark study of 1970. In these past two decades there has been a proliferation of research focused on challenging the existence of such stereotypes and seeking to support a view of androgyny and the ideal of fairness in relation to attributions of feminine and masculine descriptors. In this author's career to date in the field of psychology the Broverman study has been frequently cited to support the view that sex-role

stereotyping exists and works against women. However this is open to being discounted in the context of contemporary clinical practice as being out of date as well as having methodological problems. This raises the need for updated empirical research to overcome such complacent claims.

Throughout the clinical literature on sex-stereotyping the focus has been mainly on the sex of the client and/or the sex of the clinician. Androgynous views have led this literature into a "sameness is healthy" stance which raises questions regarding the issue of difference and deviance from societal norms being classified as unhealthy. Sexual orientation of the client has been neglected.

WHAT IS FEMININITY AND WHAT IS MASCULINITY?

At the outset, it is important to define the concepts of femininity and masculinity. These have been described as: masculine traits are those within an instrumental domain versus the feminine domain of relational traits. It is of importance to attempt to clarify what the "givens" of femininity and masculinity mean. There has been much debate in the literature as to whether masculinity and femininity are unidimensional in that one cluster of traits defines masculine and another defines feminine; or if they are multidimensional in that instrumental and nurturant traits would be only part of multiple clusters of traits. There is also debate as to these concepts being bipolar constructs or independent. In this respect the question is whether masculine and feminine are independent of each other as in Bem's analysis whereby they do not alter relative to each other while in Broverman's work they are dependent in that if one increases the other decreases. This study is based on a unidimensional/orthogonal view of the concepts in that different traits are used as descriptors for the two separate domains while they are considered as independent. This means a person can have a high score on both masculinity and femininity. Femininity is thus a concept that appears to describe behaviours that are essentially expressive whilst masculinity is used to describe essentially instrumental behaviours. It would seem that masculinity and femininity are independent, gender-linked domains but there is little agreement

as to whether the relative desirability of these traits is gender-dependent. The concept of androgyny: having high and relatively equal levels of masculine instrumental traits and feminine expressive traits has also been debated extensively. The link between psychological androgyny and mental health continues to be an issue for dispute.

WHY IS THERE A DIFFERENCE IN FEMININE AND MASCULINE PATHOLOGY?

Chesler (1972) stated that relative and absolute increases in rates of psychiatric treatment of women had occurred since 1964. She also contended that there is a double standard of mental health as supported by the Broverman et al landmark research. In New Zealand Mental Health Data women outnumber men by two to one in presenting psychiatric problems to a General Practitioner, twice as many women as men attempt suicide (Downey & Werry 1980), two thirds of calls to telephone counselling agencies are from women (Antoniadis 1984) and three times as many women as men have psychotropic drugs prescribed for them (Reinken, Sparrow, & Campbell,1982).

Kaplan (1983) was critical of the inattention to gender-role issues in the Axis II diagnoses of the DSM III. Axis II refers to developmental and personality disorders that begin early in life while Axis I refers to mental disorders not usually associated with development or childhood. Laura Brown (1986) pointed out this lack of attention to gender issues leads to a confirming of the Broverman et al results. Rosewater (1985) provided examples of misdiagnosis of battered women as being either schizophrenic or personality disordered. Brown (1986) considered that knowledge of gender role meaning and experience is a necessary but not sufficient aspect of psychological assessment with a gender-role analysis approach. She suggests the last aspect lies in the assessor who needs to be aware of cultural meanings as well as the specific meanings within the particular client.

Zeldow (1984) considered that patient sex rarely acts "alone" but that sex-related effects are common, complex and diverse. He referred especially to patient, judge and situational variables especially if the patient is "norm deviant". He said:

"norm deviant females may be the primary victims of this bias but norm-deviant men are also at risk.....we know that a host of variables may interact with patient sex to influence clinical judgments but we cannot say with precision that they will." p 369.

Oakley (1981,1985) discussed the issue of sex differences and contended that the question is "what makes a male?" rather than women being seen as the problem and she argued that women are defined relative to the prevailing masculine standard of normality.

Miles (1988) offered data on research about women and neurosis compared with men in which the author claimed that neurosis is a social disorder lending itself to social remedies. She stated that psychiatric skills are inappropriate to treat neurosis and that those who describe the symptoms as "women's troubles" are right even if for the wrong reason. Neurosis, according to Miles, is unhappiness and for women this has contextual links. It is acknowledged that there are many reasons why differences in feminine and masculine pathology emerge and one of these is based within the social domain. There are also the diagnostic and clinical labeling issues to consider. Even though there is a strong possibility of a social link, for this study the focus is on the clinical issues. Notwithstanding this, the social implications of the clinical diagnostic process are acknowledged.

Judgments about what is normal and what is abnormal are made within a context and are thus always to some extent value-laden relative to the epistemological influence of context. Clinical judgment, therefore, can risk serving a political purpose of social control. Schur (1984) extended this further by contending that the concept of deviance is actually produced by those who are in positions of power to socially control, particularly clinicians. Recent media reports further support this (The Press 1991) in which the situation in Britain, for example, indicates that women are more likely than men to be classified as psychopathically disordered and confined to special hospitals. A similar report from Australia indicated that poverty, single

parenthood and inequities in work and education could place women at a greater risk of mental health problems. Thus social issues are suggested as correlated to mental health. Furthermore, marriage was cited as beneficial to male mental health but not female mental health while breakdown of marriage entailed women being at a higher risk of poverty associated with single parenthood. It would seem that married or not, women are at a higher risk.

Kitzinger (1991) provided an overview of psychology in its oppression of women:

"-a discipline which has taken man as norm and woman as deviant, labeling us intellectually and morally inferior when we comply with patriarchal models of femininity, and mad when we refuse; a discipline deeply implicated in the enforcement of compulsory heterosexuality and the pathologising of lesbians; a discipline which blames women for our own oppression, locating the cause of men's violence against us in their inadequate mothers, seductive daughters, collusive or masochistic wives." p 49

Epistemology: Labeling Issues

Epistemology is how we make sense of the world. Labels are given as an aspect of this understanding so that structure can be given to the existing structure or environment. Kimball encapsulated the epistemological question raised by much of the research on sex-bias by stating (1975):

"Should a woman change toward being a healthy adult she becomes sick as a woman. If she is a healthy woman, she is sick as a person."

Chesler (1972) discussed that the woman who fulfils the female role is labeled as neurotic or psychotic and those who reject the female role become ostracized due to the fear they can induce in themselves and society by being out of line. Such is this process in making sense of the world that Schur (1984) pointed out that clinicians are trained to look for and find illness and thus there is a raised expectation of female mental illness that is supported by its being found.

Power Differences

In addition to the difficulties of deciding what is healthy and normal for women and men there is the issue of who makes the decision. In the field of clinical assessment it is the clinician who is in the powerful position of making mental health prescriptions. Thus the issue of the therapy

role in relation to power is of importance here. Although clinicians are not all male, they all have this relative therapist power. Combined with this is the clinician's own sex as a potential influencer. Thus a male therapist is considered to have greater power on two counts: as a therapist and as a man (see Rosewater 1985 for further consideration of this issue).

Horwitz (1982) looked at the relative lack of power of women to men. He considered power as having a dominant role in the family and controlling resources. Results of his analysis showed that every group who had a powerful role had few psychological disorders in comparison to groups who were in powerless roles. Married employed women without children had few problems, for example, but unemployed married men had many problems. Thus being female itself is insufficient for being predisposed to psychological disorder but being powerless adds to this picture. Thus being female and the relative status of being female combine to produce such data. It would seem fair to add that other minority classifications such as sexual orientation would be an issue here also.

Travis (1988) stated that views of women have traditionally been based on dichotomous categories of masculine and feminine (e.g. active/passive, public/private, autonomy/attachment, etc.). Feminists offer differing perspectives of the self and social framework (Travis 1988; Wilson-Shaef 1987). Travis went on to say:

"sex stereotypes and a general attribution bias contribute to a tendency to limit the search for causes of symptoms to the intrapsychic events of women" p90.

Travis contended that social events can be understood in terms of the individual coming to terms with attachment and autonomy issues which differ for male and female as individuation proceeds along different tracks. Attachment for females can be costly in individuation whilst the converse is true for males. Travis went on to discuss how behaviour becomes labeled male or female because this is how they exhibit such behaviour. In terms of dependence she notes that the female's dependence allows the male to play a contrasting role of "competent dominance" while at the same time insuring that his own needs for attachment will continue to

be met. He acts as helpless as a means of influencing her that he is incompetent in the housework arena especially. In turn the woman is "indispensable" to such a male and thus the woman has a sense of security.

To begin to understand women's experience as a reality, or system, in its own right Anne Wilson Shaef (1985, 1987) presented a compelling argument that women's reality is different and yet women continue to live within a white, male, middle class system. She goes on to describe this system as the "addictive" system that in itself sustains a sense of alienation from the self for men and for women but that is still more favourable for males than females. Indeed, Lewis Carroll in Alice Through the Looking Glass gave an appropriate metaphor:

"Now if you'll only attend, Kitty, and not talk so much, I'll tell you all my idea about Looking-Glass House. First, there's the room you can see through the glass - that's just the same as our drawing-room, only the things go the other way...the books are something like our books, only the words go the wrong way..." p 213.

Indeed, the decision as to which is the "right" or "wrong" way to look at the looking glass lies in the hands of the assessor. Broverman et al's study amplified this point eloquently.

REVIEW OF BROVERMAN ET AL STUDY

Broverman et al (1970) considered defining characteristics of mental health for men and women and the social desirability of these defining traits. They believed these characteristics would be paralleled by clinical assessment of men and women. In other words, what was considered healthy behaviour for one sex may be considered indicative of pathology in the other sex. In addition they considered that the ideal of health would be standardised on a male value system due to greater social value being placed on masculine characteristics than on feminine characteristics.

Broverman et al (1970) used a sex-role Stereotype Questionnaire consisting of 122 bipolar items to assess clinicians' appraisal of clients. Examples of these items include descriptors such as: Very adventurous (masculine pole) versus Not at all adventurous (feminine pole); and Very gentle (feminine pole) versus Very rough (masculine pole). The clinician subjects had to assess either a healthy, mature socially competent adult, man or woman. It was hypothesised that clinicians would judge characteristics of health as a function of sex of the stimulus person and the differences would parallel sex-role difference. In addition it was considered that an adult, sex unspecified, would be deemed as normed on male as the ideal standard of health and that this would differ for female. The results of the study confirmed both these hypotheses, reflecting a double-standard of health in clinical appraisal.

In their discussion of the double-standard, the researchers considered biological difference, the notion of adjustment and innate drives. They concluded that there is no evidence to indicate that the attributes stereotypically attributed to men and to women are biologically based. They also concluded that health can be measured as meaning a person has adjusted to the environment. This means that adjusting to societal norms would be deemed healthy even if, from the female perspective, these requirements are socially less desirable than for males. However, if there is such a thing as an innate drive to self-actualization the concept of adjustment is contradicted. So adjustment concepts mean that a woman has to choose between showing characteristics considered desirable for men and adults at the expense of being considered unfeminine and thus deviant. Or she opts to be feminine and masks such desirable yet "unfeminine" characteristics.

Further, societal mores imply that equal opportunity is the norm when in reality these stereotypical views restrict the actualisation of women and restrict the choices of women and, to a lesser extent, of men too. Thus clinicians reflect these dilemmas placed on people by society and play an influential role in sustaining such stereotypes both on the individual level and in their role as being "experts" which has wide political implications.

Critique of the original study

Poole and Tapley (1988) considered much of the criticism of the Broverman study and reported that several flaws had been found in it. They discussed the problems of comparing studies where different instruments and subjects were used to the original research. Some of these difficulties are outlined here:

With regard to the instrument:

For example, Silvern and Ryan (1983) found there was a far larger number of male valued items to female valued items in the Broverman questionnaire, being 54:22 (71%:29%). They pointed out that examination of the items employed revealed a large number (unspecified) of apparent synonyms among those items for which the masculine pole was the more ideal. Examples cited include "not at all emotional", "almost always hides emotions", "not at all excitable in a minor crisis", "never cries", "very independent", "not at all dependent", "not at all easily influenced", "very worldly", and "knows the ways of the world". Thus Silvern and Ryan contend that the Broverman 1970 research contained an overrepresentation of masculine items through redundancy. This could be rectified by providing an equal number of male to female items and, furthermore, to ensure that these characteristics were equally favourable. Furthermore, the questionnaire used a bipolar approach which is too rigid. That is because the conceptualisation of femininity and masculinity becomes an opposing polarity and this raises conceptual problems. In addition the masculine characteristics were more favourable than the feminine. Further research would need to consider a continuum Likert-type format as opposed to the no-choice format of bipolar scaling. This issue was addressed by Phillips and Gilroy (1985) who used a 7 point Likert scale as forced-choice measures tend to produce more extreme scores than does continuous scoring.

With regard to the subjects:

There were only 79 clinicians in the Broverman et al research and, if possible, a larger sample is needed. In 1968 Rosenkrantz, Vogel, Bee, Broverman and Broverman used students for subjects to explore the issue of sex-role concepts as opposed to clinicians. It could be argued

that a study that focuses on clinical appraisal needs to have as its subjects the people trained to make such assessments. The group that the measurements are normed on, therefore needs to relate to the group being researched or other confounding variables could be introduced. However, the Broverman et al "classic" research of 1970 used clinicians as subjects.

On the other hand, the use of non-clinical populations widens the evaluation to society. This raises the question as to who influences stereotypes: society as a whole or particular sections such as clinicians? Or is it an interaction of both wider society and specialists that maintains the status-quo?

With regard to the stimulus persons:

The focus on sex alone limits this study in that it does not consider the added implications of other aspects of the clinician and the client: age, class, race, sexual orientation for example. An expansion beyond sex to another variable that taps into sex stereotypes is begging to be addressed. Poole and Tapley argued this point (1985) and selected context as such a variable. Another variable would be that of sexual orientation.

In addition the adjustment notion of health discussed by the Brovermans works against women as such an adjustment for women within a patriarchy is less favourable for them than it is for men within a patriarchy whose values are male values. Such an adjustment notion needs further consideration when approaching the issue of sex-stereotyping within a homosexual as well as heterosexual context.

Finally, as in all research of this nature to date, the focus is on self-reported attitudes as opposed to observed behaviour of clinicians. Phillips and Gilroy raised this point as a matter for consideration in future research in this field.

LITERATURE THAT FOLLOWED THE 1970 STUDY

There followed considerable literature after the 1970 study (see, for example Zeldow 1978 and Davidson & Abramowitz 1980 for detailed reviews). Much of this research considered overt and covert bias of mental health practitioners that works against the expansion of a range of behaviours as appropriate for women. Despite the vast amount of research Zeldow (1978) noted that those studies he reviewed did not give grounds for strong conclusions and Davidson and Abramowitz noted that results seemed to vary with methodology.

Instrument and task issues

A literature search found seven later studies from the United States that used the same instrument or a modification of that used in the Brovermans' study although instructions and samples varied. In 1975 Delk and Ryan considered the concept of adaptation and found no differences between professional therapists and students while in 1979 Fabrikant used a different instrument (although an adjective check-list) and found the predicted stereotyping. The Brovermans used a bipolar scale as opposed to checking the absence or presence of a trait as in the Williams and Best approach. However it is difficult to determine comparability of the instrument with other research instruments.

Zeldow (1984) observed that later studies recognised the inadequacy of either/or formulations and had looked at improving understanding of the conditions under which sex-related effects do or do not occur.

Later in this Introduction a separate section will discuss androgyny research.

Samples

It is of note that samples varied across the literature being mainly students or clinicians. There is some question here regarding the generalisability of students to professionals' appraisal processes. In some studies the task was similar but the sample varied. For example, Nowacki and Poe (1973) found differences between male and female judges and a tendency to

stereotyping. They used a similar format but their sample were undergraduate students. In 1973 Maslin and Davis used predoctoral counsellors in training as subjects and found the females did not hold sex-role stereotypes while their male colleagues did. Harris and Lucas (1976) found male judges distinguished between men and women subjects in a stereotypical manner while female judges rated healthy women closer to the masculine pole than did the male judges. Again a comparable format was used but a different sample (undergraduate and graduate social-work students). Another study using a different sample was conducted by Kravetz in 1976 using 150 college age women who described healthy women and men but this did not correspond to sex-role stereotypes. Hayes and Wollent (1978) used 40 graduate students to rate audiotaped interviews of female and male clients on a Broverman-type questionnaire. They found a tendency for those counsellors-in-training to rate opposite-sex clients as more deviant from traditional sex-role stereotypes than same sex clients. In this example a different task and a different sample were used.

In 1976 Cowan used 30 consulting psychologists to rate patients. Female patients were perceived as too feminine while male patients problems were not perceived to be related to their sex-role. Similarly, Aslin (1977) studied community mental health centre psychotherapists and feminist therapists to rate mentally healthy adults, females, wives and mothers. They found a single standard of mental health for all of these categories was maintained by all female therapists regardless or work setting. However, male therapists' perceptions of health for females and mothers differed significantly from the females' perceptions.

It is of note that the seven studies located that used the same instrument or a modification of the Broverman instrument there are conflicting results. Phillips and Gilroy noted that despite the similarities to the original research none replicated it as there were differences on sample and/or task. Fabrikant (1974) and Delk and Ryan (1975) used modified instruments.

Demand Characteristics in the research

Matlin (1987) addressed the growing sophistication of clinicians in terms of their knowledge of what is appropriate to say in relation to their attitudes as opposed to what they actually believe and put into action. Matlin suggested that by now most therapists should know that they are supposed to respond to women and men in a similar way and she cites Davidson and Abramowitz (1980) and Phillips and Gilroy (1985) as studies that may underestimate sex bias among therapists.

Zeldow (1984) noted the shift in attitudes of researchers themselves saying that earlier studies were motivated by the desire to demonstrate or disconfirm the existence of sex-bias and sex-role stereotyping in clinical practice.

ANDROGYNY RESEARCH

Prior to Bem (1974) masculinity and femininity had been conceptualised as bipolar constructs, as in the Broverman research. Bem postulated that masculinity and femininity were independent clusters of traits and that individuals have both masculine and feminine psychological attributes. A psychologically androgynous person would have comparable levels of both masculine and feminine qualities. Such a person would be seen as being relatively advantaged in terms of psychological well-being and behavioural functioning compared with sex-typed individuals. Thus the concept of the androgynous person as the healthy ideal began to emerge in the literature. According to Mischel (1986) a person who is androgynous is not rigidly sex typed but incorporates masculine and feminine attributes equally. This approach was to challenge the nature of masculine and feminine domains. The change in focus was from traditional, past research and theory which had seen masculine and feminine as two opposites and that mental health was related to being sex-role consistent. This moved to androgyny which saw these as independent domains. It was a major advance in theory to consider masculinity and femininity as independent clusters and that people should ideally have combinations of both clusters of traits to be healthy as opposed to having one or the other as previously.

In 1974 Bem had identified three typologies: predominantly feminine, predominantly masculine and those who had a balance of feminine and masculine traits (the androgynous). Spence, Helmreich and Stapp (1975) challenged this operational definition of androgyny and they advocated that androgynous people should be those who were high in both masculinity and femininity. This resulted in four typologies: male-typed, female-typed, androgynous and undifferentiated (balanced but low scoring on femininity and masculinity). [See Footnote at end of this Introduction with regard to the model used in this study].

There has been criticism of the concept of androgyny in relation to how it is measured (Pedhazur & Tetenbaum 1979) and based on its rationale (Locksley & Colten 1979). The notion that an androgynous person is better adjusted due to greater flexibility in behaviour as a consequence of not being confined to sex stereotypes is something to consider in relation to mental health assessment issues. Several studies used Bem's questionnaire for sex-role preferences and the subjects were rated on degrees of masculinity, femininity and androgyny. Within these studies the same subjects were measured for self-esteem, helplessness, sexual maturity and personal adjustment (Jones, Chernovertz & Hansson 1978). However better adjustment for the androgynous was not found. In fact, for both sexes high masculinity scores, rather than androgyny scores, tended to predict better flexibility and adjustment. Other studies indicate the contrary: that androgynous people are better adjusted (for example, Flaherty and Dusek 1980). Therefore it is difficult to form clear conclusions from this literature.

In discussing the conceptual and methodological problems that are raised by the androgyny literature, Taylor and Hall (1982) suggested that in terms of analysis of variance, Spence et al's (1975) proposal predicted a main effect of masculinity and a main effect of femininity while Bem's (1974) notion represented an interaction effect. By using a two-way anova framework, Taylor and Hall pointed out that these hypotheses can be independent rather than competing. They stated that those who support the androgyny interpretation use this as evidence to support therapists in encouraging a full range of behaviours of men and women and yet androgyny itself

is simply an umbrella term for masculinity and femininity. On the other hand, they argued, those who emphasise the imbalance of masculinity and femininity effects take this as further evidence of a society rewarding masculine behaviour. Taylor and Hall suggested that a misconception of androgyny is that it is said to bring the good things in life and thus produce bias in therapeutic practice and furthermore, it could foster:

"a false consciousness that problems entailed in current sex-role definitions have psychological rather than social structural solutions." p 362.

Silvern and Ryan (1983) added yet another dimension to the variety of findings and views in the field when they found that all subjects other than traditional men characterised the ideal person as significantly more feminine than masculine and women other than traditional ones did not have great discrepancies between the ideal woman versus person.

Locksley and Colten (1979) stated that the idea of psychological androgyny is initially appealing in that it is less restricting of all people. They go on to state that androgyny research shares a number of problematic assumptions with femininity/masculinity theory and research. For example, androgyny is defined as having the presence of both masculinity and femininity. Thus, there is a need to measure these concepts and a return to the same problems of polarities raised by masculinity/femininity research. Further, a person who would be considered in Bem's analysis (1976, cited by Kaplan & Bean) to be androgynous has a composite of traits. Locksley and Colten presented such a composite in terms of a young female academic who portrays adaptive abilities in terms of analytical, assertive, competitive, independent traits in her studies while being affectionate, childlike, flatterable, soft-spoken, warm and yielding to her boyfriend. As Locksley and Colten pointed out, she has adapted to the needs of her environmental cues and by Bem's terms is androgynous yet she portrays behaviour that is not independent of sex-role norms.

Cheryl Brown Travis (1988) noted that relational androgyny attempts to eliminate the negative view of female development and aims to heal the split between attachment and individuation,

building on earlier theory (e.g. Bem, 1974). Relational androgyny challenges the concepts of dependency and autonomy as polarities and argues that the incorporation of both behaviour patterns is a step to healthy development. Long before this, in 1976, Miller said:

"In no society does the person, male or female, emerge full grown.....the ability to grow psychologically is necessarily an ongoing process involving repeated feelings of vulnerability all through life." p. 31.

Brown (1988) stated that research critiquing androgyny provides a growing database that indicates masculinity and androgyny may have the same implications for mental health (which reverts to the Broverman argument of male and healthy adult equating but female and healthy adult not equating). She pointed out that the literature emphasises philosophical issues regarding feminist values.

She also considered androgyny as an artifact in wanting to appear acceptable in modern culture in much the way that some of the positive associations of androgyny as measured by the BSRI and self-esteem may be determined to a large extent by the nature of the self-esteem test used. She pointed out that designs have been correlational and there is no clear causal relationship supported by the data.

From a feminist analysis (Brown 1988) stated that the ideal of androgyny devalues that which is feminine so that androgyny is a sell-out to men with the ideal of becoming "like a man" as opposed to valuing being a woman. Androgyny falls short of changing relationships of males and females where women often end up with multiple roles while men continue to predominate in the Good Provider role. A summary of the literature on this theme is that mental health is a social as well as a personal phenomenon where women, though no more vulnerable to mental health problems than men, are presented as such because culture shapes the views of this. Measurement of health and treatment processes can thus reflect various artifacts and errors.

Kaplan and Sedney (1981) discussed the issue of research on sex differences and pointed to the fact the differences are averages; there is a trend for the research to reflect a masculine bias; the

situational context of such research affects behaviour; and there are further problems of interpretation of the findings. Lucia Gilbert (1981) also brought into the discussion aspects of a client's self-appraisal of ideal self and what attributes one should possess. Thus what patriarchal society says is desirable and what is actually experienced can differ greatly! Gilbert pointed out that although psychological androgyny is important for effective functioning of the individual it is not a solution to social problems in terms of institutional sexism and discrimination.

Mischel (1986) added to this discussion by stating that although clinicians may like to think they do not endorse societal norms, they are likely to inadvertently perpetuate sex-role stereotypes because there is a distinction between ideals and reality in the clinicians as well as in the clients they assess.

Brooks-Gunn and Fisch found (1980) similar results to Broverman et al in college students judgments of mental health while Thomas (1985) reviewed 15 previous studies in which male therapists were shown to no longer engage in sexual stereotyping and that an androgynous standard of mental health was held. However, Thomas pointed out that this research has all focused on attitudes and it has long been demonstrated that there is a low correlation between attitude and behaviour and suggests *in vivo* research is needed to check if the beliefs are translated into action.

Zeldow (1984) observed that the pendulum had begun to swing in terms of actual as opposed to stereotypically perceived sex differences. Interestingly, more recent research (1990) by Hort, Fagot and Leinbach studied people's notions of maleness and femaleness and found maleness to be more stereotypically framed than femaleness.

By 1985 Phillips and Gilroy attempted to update the work in this area and contended that there should be no female/male polarities. Indeed, Bem (1976) had questioned the notion of masculinity and femininity as two polarities of a single dimension. She said such polarisation

could mask the possibility of a person being "androgynous". Phillips and Gilroy shared this view in relation to mental health workers who would see mentally healthy men and women who had a broad repertoire of healthy male and female stereotyped behaviours regardless of sex. They adjusted the instrument and questioned if desirable masculine characteristics would be more healthy for men than women while the reverse would not be true of socially desirable female characteristics. They supported the Brovermans in finding a significant difference between scores but there was a major difference in methodology: an incremental format as opposed to a bipolar scale. Unlike the Brovermans, Phillips and Gilroy conducted a specific item analysis which yielded relatively meaningless differences between mean masculine and mean feminine health scores on individual items. This could possibly be a reflection of the methodology. Once again attitudes as opposed to actual clinical practice were under scrutiny.

It seems that the issue is not so much that men and women are treated differently but the ways in which judgments are made especially in terms of clinical assessment. Does a clinician complete as effective and as accurate an assessment of a client by "ignoring" the issue of the person's sex, or of the clinician's own sex as an influencer, for example? Is it truly possible to ignore these aspects? Is it enough for clinicians to know that a person's sex is an influencer or can this simply reflect a phallocentrism in that women are assessed in relation to men or as lacking in relation to men? When a person presents with a sense of unreality is this a psychotic symptom or is it a sign of a healthy woman within a patriarchy?

SEX OF CLIENT AND CLINICAL ASSESSMENT

This section will provide an empirical focus on what happens when sex of client is varied. Literature of this type has used a hypothetical case-study approach whereby variables such as client sex can be manipulated whilst retaining the same client-profile. Zeldow (1984) reviewed a selection of these analogue studies with a focus on client sex and clinical judgment. For example in 1975 Zeldow asked 50 male and 50 female university undergraduates to consider 56 self-statements alleged to have been made by psychiatric patients. Students were to rate on a 7

point scale " how maladjusted or disturbed the patient must have been to make such a statement". Half of each sex evaluated females and half of each sex evaluated males. No effect was found for stimulus person sex or subject sex in terms of judgment of psychopathology.

In 1976 Zeldow expanded the study and the results showed a three-way interaction (subject sex x stimulus person sex x type of statement) that showed a female patient, already identified as seriously disturbed, who makes statements that are conventionally associated with males, to be judged more harshly by male judges than males fitting the same description who make statements that are conventionally associated with females.

In 1985 Zeldow presented eight case histories and requested judgments of severity of psychiatric disturbance, need for professional intervention and prognosis. The judges in this study were all mental health professionals (although not clinical psychologists). No effects were found for stimulus person sex but subject sex consistently effected ratings. This was shown to be 50% of cases resulted in females being said to need greater need for intervention than was the situation for the males.

As Zeldow discussed (1984) these results are like many other analogue studies in that stimulus person sex alone is rarely a factor in determining degree of psychopathology, professional need or prognosis. He concluded that simple sex-bias in clinical judgment is less pervasive than sometimes claimed. However, he acknowledged that sex-related effects do occur but they are embedded within complex contents. For example Abramowitz, Abramowitz, Jackson and Gomes (1973) found politically conservative counsellors attribute more psychological mal-adjustment to a politically left-oriented female than to her male counterpart. Zeldow (1984) cited Hill, Tanney, Leonard and Reiss (1977) who, in studying university counsellors, found no diagnostic or prognostic differences as a function of traditional versus nontraditional career interest. However there were complex interactions for sex of counsellor, age of client and type of problem (personal social versus vocational). From such studies emerged a theme of sex-related effects but with situation-specific interactions.

Kelly and Kiersky (1979, cited by Zeldow, 1984) looked at sex differences in clinical judgment of 50 practising psychotherapists and had trained actors posing as patients. With the assumption that depressive symptoms are consistent with female patient role and aggression and impulse control problems are consistent with male patient role, clinicians were hypothesised to judge role-deviant patients as more disturbed than patients with sex-appropriate symptoms. This was supported although only for male clinicians and especially with regard to depressed men who they often diagnosed as psychotic and would often recommend medication.

A more recent example of research of this nature was conducted by Adler, Drake and Teague (1990) who used case studies that included a clinical profile constructed to meet DSM III Axis II diagnoses of various personality disorders and changed only the sex of client for clinicians' assessment. They found that clinicians tend to make global judgments about personality disorders and are influenced by the sex of the client even when it has no known relevance.

Morawski (1985) discussed how the research literature that considers the concepts of masculinity and femininity shares ethnopsychological origins: roots in social prescription and practice. Morawski argued that these studies have a striking commonality that in itself engenders the very stereotyping and categorisation that the literature challenges. Morawski asked how are such stereotypes sustained. She contended that procedure, assessment technique and that "normal" scientific practices have engendered psychological reality. In this analysis she argued compellingly that it is not enough to produce empirical findings as it is necessary to consider the criteria of reliable knowledge and who the knower is to whom these are attributed. Thus knowledge claims must, she argued, be seen for what they are: the produce of history and constructions guided by specific interests.

In 1990 Adler, Drake and Teague asked clinicians to assess a client based on DSM III criteria. Adler et al asked questions with regard to gender and assessment that they acknowledge have clinical as well as sociocultural and political significance. As they stated:

*"Clinicians, like others, make causal attributions based on salient pieces of information, whether or not these pieces of information are related to diagnostic criteria...."*p130

Laura Brown (1990) said that despite the vast research in gender issues in psychotherapy that has been presented since the Broverman et al (1970) study, there is little research in relation to the study of sex bias in clinical assessment. She considered this has meant the descriptive and predictive validity of psychological assessment has been reduced. She claimed that non-normative behaviours may be pathologised when contextual issues such as gender are ignored or, conversely, that insufficient identification of problems may also result. She also said that if a clinician attempts to integrate gender awareness with the psychological assessment this can lead to avoiding formal assessment due to a lack of models for such an integration. She provided useful suggestions on how a psychologist may incorporate gender role analysis into the clinical interview with a view to greater precision in diagnosis and more appropriate treatment strategies.

OTHER STIMULUS PERSON VARIABLES

It is important to recognise that the stimulus person description for a study on sex-roles may include several variables, including: sex, sexual orientation, age, race, class, etc. (as discussed by Zeldow 1984). One other factor that has been considered is that of context (Poole & Tapley 1988). They reviewed the previous literature and noted the differences being related to subject samples, task and influences of changing times. In their research Poole and Tapley found socially desirable polarity in the direction reported by the Brovermans but not as great.

Without contextual cues, Poole and Tapley postulated that earlier studies would lead subjects to imagine females in a home environment and a male in the context of the work-force outside the home. Poole and Tapley used a modification of the task by Broverman et al with 104 practising psychologists who were to rate the appropriate behaviour for a mature healthy socially competent man in the home or work environment, or woman in the home or work environment.

The researchers suggested ratings would be an artifact of expectations clinicians hold about how adults should behave at home versus work. What they did not address were complexities about the expectations of behaviour in that if a woman is perceived in the workforce does this mean she is expected to behave like a man and man perceived at home to behave like a woman? One other point to add to the complexity of these ideas is that the clinicians' perception of the working environment itself could be influenced by stereotypes (as in a woman mechanic or a male secretary for example being outside the norms of sex-role stereotyping).

The most striking finding from Poole and Tapley's work was that clinicians expected both men and women to adjust behaviour to the environment with more traditional masculinity associated with work and traditional femininity associated with the home environment. This would challenge the question of the seeming influence of changing times! It also begs for further research to investigate whether other subject groups agree with the expectations of clinicians and to consider the notion of adjustment with regard to the person who can switch gears between home and work environments.

Back in 1981 Settin and Bramel suggested also that class be a further variable in the subtle ways that prejudicial assessment occurs. It would seem that many variables can operate in this way as was found by Bellezza and Bower (1981) with regard to sexual orientation. Next in this introduction, the issue of sexual orientation in the research literature will be more fully addressed.

SEXUAL ORIENTATION

General

Since the Gay Liberation movements of the 1960s and 1970s, there has been a marked growth in the research literature with regard to homosexuality. Up to then there was a considerable psychopathological focus due to common beliefs held at that time. It is of note that with the acknowledgment that homosexuality was not deviant sexual behaviour or mental disorder it was voted by the American Psychological Association that it be removed from the Diagnostic and

Statistical Manual of Mental Disorders in 1973. Thus research took a different approach looking at comparisons of homosexuals and heterosexuals (for example, a proliferation of material on homosexual versus heterosexual parenting as in Cramer 1986; Golombok, Spencer & Rutter 1983; and Green, Barclay, Hotvedt, Gray, & Smith 1985;) and issues of psychological adjustment within a homophobic society (for example, Miranda & Storms 1989). Other literature concerned itself with children's acquisition of characteristics of gay and lesbian parents (Hoeffer 1981; Kirkpatrick, Smith & Ron 1981; Whittlin 1983). Many of these papers were implicit if not explicit that homosexual meant something less desirable than heterosexual with regard to the issues discussed. However literature continued to abound that viewed homosexuality as a "problem" *per se*. For example, Glasser in 1977 suggested that a different form of homosexuality emerges in the adolescent and that clinicians must have their "feelers out" to pick it up. There was no suggestion what should be done once these feelers had located it.

There are many terms used for prejudicial attitudes against homosexual men and women (gays and lesbians). For example, Casey (1989) cited Hudson and Rickets 1980 who called this homonegativism; Morin and Garfinkle (1978) discussed heterosexism; while the term homophobia has been used extensively (Smith 1971; Weinberg 1972; cited in Herek 1984). Casey (1989) discussed this term as somewhat misleading in that it implies a phobic response based on a classic fear reaction. She said there is little evidence to show that heterosexuals present a phobic reaction to homosexuals. However, Perkins (1991) stated that psychologists consider homophobia to be an irrational fear, hatred and intolerance of homosexuals. She stated that to define fear of lesbians as irrational is a paradox from a feminist perspective in that as lesbians we do not define ourselves in terms of men, or service men in the socially required manner, and lesbians are a threat to heteropatriarchal structures. Such a fear of a real threat, she argued, cannot be irrational. Her view is that redefining a realistic fear as pathology serves to depoliticise the threat.

Hostile attitudes to homosexuals are a more measurable phenomenon than "homophobia". For example Larsen, Reed and Hoffman (1980) in constructing the Heterosexual Attitudes Toward Homosexuals Scale found a significant effect for sex in that females were found to be more tolerant of homosexuals than males. Herek (1984) also found negative attitudes of heterosexual males were greater than in heterosexual females especially in relation to gay men while in 1978 Morin and Garfinkle had found that males were more negative to homosexuality regardless of whether it be against gay men or lesbians.

It is hardly surprising that homosexuality receives such a stigmatised attitude in psychology when psychotherapeutic attitudes of its being a "perversion" continue to be presented. For example, Etchegoyen 1989 not only referred to the homosexual as a pervert but also to "his" (sic) attempts to *"pervert the transference process."* p82.

Regarding salience, Dunkle and Francis (1990) found that individuals make inferences regarding sexual orientation of men and women based solely on a static photograph of the face. This raises questions regarding the subtleties of salient factors that influence clinical judgments.

Sexual orientation of clinicians was not a focus of this study. It would be of interest to identify the proportion of clinicians who are homosexual and whether their sexual orientation changes their perception of clients in that the literature implies a heterosexist stance acts as an influence in the assessment process. Indeed, Lenskyj (1990) suggested the sexual orientation of subjects is important and, within an anonymous format, the research does not have to be invasive of subjects' privacy. It is of note, however, that several anonymous communications to the author of this study suggested that simply asking the subjects to provide anonymous replies based on a homosexual stimulus person was considered quite threatening. For example, questions regarding the ethics, supervision and bias of the writer were raised even though the subjects' own sexual orientation had not been requested.

Indeed it is of note that in the current study the author was challenged for having a specific interest and bias in conducting research that considered sexual orientation. The author's own sexual orientation was considered to be pivotal in this suggestion of bias! One male respondent managed to totally sexualize all his responses including the standard biographical information (for example, in giving his sex he responded "Yes Please"). Another male respondent suggested the research was more suited to the NZ Woman's Weekly, within such a statement lies considerable sexism.

As Becker and Horowitz said, 1972,

"Every group in power tells its story as it would like to have it believed, in the way it thinks will promote its interests." cited by Kitzinger, 1987, p1.

Despite the "changes" in the research, it is of note that as recently as 1990 the American Psychological Association's "Monitor" journal, Buie reported that the APA had rebuked a psychologist for continuing to address homosexuality as a disease that required "reparative therapy." In this same article it is noted that although the law and the DSM have changed, heterosexist attitudes still prevail in the psychological profession. Indeed, 1991 has produced a survey of US psychologists and social workers in which 70% would feel "slightly nervous" being in a group of homosexuals. This same survey is reported to show many as "homophobic". (The Press, November 1991).

Heterosexism in Psychology

In 1975 Plummer noted that understanding homosexuality needs to be based from within the context of society as an interactive phenomenon. He suggests that "cause" of deviance in relation to homosexuality is not within the homosexual but within the society that reacts to that person. Thus the meaning of behaviour is produced through a reactive process and as such clinicians are in a position to contribute powerfully to creating deviance and pathologising it.

Hilary Haines (1986) said that

"just as women's psychology is partly determined by our dependent condition, so is lesbian psychology partly determined by stigmatisation" p 18.

Laura Brown (1989) asked what would happen if the universe was redefined in terms of how we know and legitimise knowledge so that understandings are rooted in a gay and lesbian phenomenology. She asked some challenging questions:

" How has psychology so far been shaped through the distorted lens of heterosexist psychological science and practice?....What happens if a lesbian/gay paradigm is used as core to psychological science and practice in general? How do psychologists change their understandings of such phenomena as intimacy, parenting, attraction, relationships, or gender, if they make assumptions based in experiences of being lesbian or gay?" p 447

To begin to answer such questions some underlying assumptions were addressed by Brown such as the notion that North American psychology is biased by heterosexual experience and the assumption of the norm of white, middle class, North American, married, Christian, able-bodied heterosexuality while all other forms of experience are not the norm. She discussed the issue of deconstructing these norms in terms of the language used, such as "family" meaning the nuclear family as opposed to the gay or lesbian family and "women" being split into two groups: heterosexual women and lesbians. Thus the norm is used as the yard-stick by which all others are compared.

To define lesbian and gay reality is also complex as it is a multiple reality and Laura Brown described the lesbian and gay experiences as forms of biculturalism:

"The bicultural perspective of lesbians and gay men facilitates an understanding of the rules by which the mainstream culture operates, while simultaneously being able to envision new forms by which the same tasks might be accomplished." p450.

Brown added that the existential sense of "otherness" experienced by lesbians and gays may allow a different way of seeing and hearing which can challenge conventional knowing. This is what Judy Grahn meant by "another mother tongue" (1984). Adrienne Rich (1980) presented a similar theme when she challenged heterosexual insistence on being the norm as a compulsory doctrine. She challenged with questions regarding ontology in which heterosexuality is considered innate and thus inevitable and epistemologically: how a cluster of social forces sustain compulsory heterosexuality as a sociopolitical institution. She critiqued issues of

methodology and the ideological bases of analysis. In this paper she presented two themes: that compulsory heterosexuality is the central social structure that perpetuates male dominance and secondly that the concept lesbian be reconstructed in a cross-cultural, trans-herstorical fashion that encapsulates female resistance to patriarchal oppression. Ferguson et al (1982) challenged some of Rich's contentions in regard to terminology: how to define lesbian, methodological issues and the overlap of female resistance to male oppression that has not entailed these women being lesbian. Michele Dominy (1986) added to the debate by stating:

"We need to examine not only the spectrum of women's activities but also women's conceptions of gender and their perceptions of each other. Just as women and men may have separate conceptual systems and standards of evaluation, so also may women differ within the same culture." p275.

Recent literature (Herek, Kimmel, Amaro & Melton 1991; Helen Lenskyj 1990) referred to heterosexist bias in research generally in terms of how research questions are formulated, the language used and the methodology. Celia Kitzinger (1987) approached the issue of homosexuality in the research literature from the point of view of how homosexuality has been managed and controlled and that the so-called scientific approach is in itself a construction of reality, a selection of information and as such a deflection. She stated that the issue is not whether to use rhetoric in scientific writing but:

" how to use it, in whose interests and how to recognise and analyse its use. "p 31.

Laura Brown (1989) identified three interconnected themes of being lesbian and gay: biculturalism with its need to balance being in two cultures at once; marginality with the experience of being inside and outside the mainstream and normative creativity which opens the possibility to create new norms where none exists. She wondered if psychologists adopted these as guides, where could it and does it lead? As she noted, by defining norms within gay and lesbian realities, the psychologist could ask how these new paradigms might help to broaden understanding of heterosexual realities too.

Heterosexism and Sex-Roles

Plummer (1975), in discussing the literature at the time relating to homosexual male stereotypes that described such people as "sick" and "dangerous", considered such points were on not fitting socially prescribed norms especially with regard to sexual behaviour and then generalised to all behaviour. The literature's use of terminology can contribute to the confusion here. For example, Howells (1986, appearing in Hargreaves & Colley) discussed the term Gender identity as referring to the subjective sense of being male or being female, presumed established in early childhood. He described Sexual Orientation in terms of the preference of sexual partner. Although this can be problematic in that a person's sexual orientation may exist without the person even having a sexual relationship. Further, he described Sex Role (sometimes called Gender Role) as referring to behaviours expected to characterise males and females according to society's prescription. These distinctions are important as homosexuality is not usually the result of a gender identity disturbance (transexuality).
Bem, on the other hand, stated in 1981 that:

"regardless of how closely an individual's attributes and behaviour match the male or female prototypes stored within the gender schema, violation of the prescription to be exclusively heterosexual is sufficient by itself to call into question the individual's adequacy as a man or woman." p361

Hansen (1982) studied the relationship between "homosexism" and psychological androgyny and normative sex-role orientation using a student sample who he asked to complete questionnaires that entailed a variation on Bem's measure of androgyny. Subjects had to show the degree to which they possessed the characteristics indicated on a seven point scale. This was used to assess the degree of androgyny in the subjects. Sex-role orientation was assessed using Brogan and Kutner's scale while "homosexism" was assessed using Hansen's scale. The results showed that males were less androgynous and more traditional in sex-role orientation and more homosexist than females. Homosexism seemed to assist in maintaining traditional sexual differentiation in both sexes more on a normative than on a psychological level. Psychologically feminine women were the most homosexist.

Hansen (1982) said that the magnitude of the variance in sex-role orientation scores explained by homosexism was important to note: 23.48% of the variance of the males in his study and 30.76% for females. So he concluded that in considering change with respect to sex-roles will require a focus also on homosexism and vice-versa. Hansen suggests these findings give some support to the claim that the end of sex-role stereotyping cannot occur until the elimination of homosexism or homophobia.

In 1987 Bernard Whitley found that both female and male respondents had less negative attitudes when they were older, less conservative and held less traditional sex-role beliefs. When women had more stereotypically masculine behaviour patterns they were assessed more negatively by men than by women. Women assessors demonstrated more liberal attitudes to women who deviated from the feminine sex-role stereotype than did male assessors. Newman (1989) found a similar trend and Krulewitz & Nash (1978) noted that more liberal respondents were more accepting of homosexuals than traditionals. Both these studies used student samples.

In 1991 Judd, Ryan and Park considered perceptions of group disparity and group stereotypicality. They used two diverse student groups as subjects and asked them to rate both groups with respect to each of eight trait and attitude dimensions. Half of the trait and half of the attitude dimensions were stereotypical of the one group and counterstereotypical of the other. They also were to give self-ratings as a form of accuracy criteria against which subjects' perceptions of group variability could be compared. It is of note that Judd, Ryan and Park found accuracy of judgments was a function of being in the in-group or the out-group with out-group stereotyping being overestimated and overgeneralised. It is of interest that with clinicians who are assumed to be largely heterosexual, the assessment of those in the out-group (the homosexual clients) may reflect such an overgeneralisation of stereotypy.

Homosexuality and Sex-Role Inversion

When sex-roles are inverted, females portray the behaviour that is typically male while males portray the behaviour that is typically female: a form of role-reversal. This theory suggests that male homosexuals will display more typically female stereotypes than male heterosexuals and that female homosexuals will display more typically male stereotypes than female heterosexuals.

Methodology in testing sex-role inversion was mainly focused on retrospective accounts of homosexuals' memories of childhood behaviour (Howells, 1986 cites Saghir & Robins 1973; Whitam 1977 for example). Howells also cites large-scale studies of non-clinical samples of homosexuals by Bell, Weinberg & Hammersmith (1981) who interviewed homosexual and heterosexual men and women based on self-reports of gender non-conformity in childhood. No literature was found that used hypothetically produced case-studies to assess perceived sex-role inversion in homosexuals This suggested a need to contribute to this literature. The question of homosexuality being a product of inversed sex-role behaviour is a controversial one.

Howells stated (1986) that sex-role behaviour would be a likely consequence of homosexuality and that common cultural stereotypes of homosexuals differ from heterosexuals not only through choice of sexual partner but also with regard to sex-role behaviours. The notion of homosexual sex-role inversion has a history in classical sexual and psychodynamic theory (see for example, Storms 1980). Many empirical studies have attempted to test this theory and Whitam and Zent (1984) demonstrated a consistency in such an inversion model. However Storms (1981) showed that homosexual orientation can occur without significantly deviating from sex-roles. Despite much retrospective research indicating a pattern of sex-role inversion, Howells stated that sex-role inversion is not a necessary or sufficient condition for the development of homosexuality but that it seems to increase the probability of it occurring.

There has been considerable research to challenge this model (cited by Howells 1986) which suggests that other aspects such as different methodologies are involved. For example, Howells discusses the retrospective nature of homosexual studies in that current homosexuals are asked to think back to how they behaved, perceived themselves and the world before they had come out as homosexuals. Much of this research has a focus on causality of homosexuality. In studies of heterosexuals and even heterosexuality there is no empirical data that focuses on causality of heterosexuality as it is taken as a given. In this way there is an implication of the "norm" and, conversely that homosexuality is not normal. In addition Ross (1980) suggested that homosexuals may internalise the culture's prescribed expectations of homosexual stereotypes (thus conforming to models of deviance prescribed by the majority of heterosexuals!!).

It is not clear if sex-role inversion causes homosexual behaviour or if early homosexual interest causes sex-role inversion. Howells points out that a third variable such as parental behaviour may affect both forms of behaviour. Although empirical studies offer the suggestion of a relationship between sex-role inversion and homosexuality, this is not conclusive.

Although literature exists that used a questionnaire none was located that included a hypothetical case-study. The current study thus contributes to the literature by attending to this omission. Over and above adding something extra to the methodology what such an approach achieves is to give the subject a specific person focus rather than a more global approach such as a questionnaire about people's behaviour generally.

By combining a specific and a general aspect to this study it was considered a way of encouraging the clinician-subjects to think in a more specific way that was more likely to reflect their one to one working with their clients.

HOW PSYCHOLOGY NEEDS TO SHIFT TO ACCOUNT FOR SEX AND SEXUAL-ORIENTATION

De Beauvoir (1970) argued that socially prescribed female roles have much influence on a woman's personality and Janeway (1971) stated that a woman is set up to be helpless by societal pressures rather than internal characteristics. Contentions such as these are a core issue in the debate so far described in relation to how gender must be addressed differently in psychology both in research and in relation to mental health care. In 1986 McHugh proposed issues for conducting non-sexist research which provide a useful basis for restructuring psychological research. In 1987 Torrey put forward a staged analysis of the phases of revised psychology of personality which has special relevance to the clinical psychologist's job. Indeed there has been considerable literature addressing the methodology of traditional research and many proposals for feminist approaches to research (see, for example, Small 1989).

The main characteristics of feminist theory that apply to research in relation to mental health (as discussed by Ballou and Gabalac 1985) include that women as a gender have less political, social and economic power than men. This power difference accords women an inferior status within a patriarchy. Furthermore, female pathology is caused, essentially, by external as opposed to internal sources in that the social accounts for illness in women rather than the personal. A third point is that women need to attain economic and psychological autonomy. These three principles form critical aspects of feminist orientation to therapy although there is as yet no consensus on a definition of feminist therapy *per se*. Traditional mental health does not acknowledge the phenomenon of oppression of women and though used primarily by women it has a male focus.

As part of their recommendations for change from traditional to feminist approaches, Ballou and Gabalac propound a view of mental health that changes from that of:

"controlling the nonconforming in challenging and changing the power system images, values and structures which are causative to mental illness." p170-171.

There has also been much feminist analysis of the political implications of such change as in Young's 1985 challenge to humanism which echoes in Miriam Greenspan's (1985) review of how traditional psychotherapy fails women. Greenspan suggested a new approach to therapy and the training of therapists based on a feminist model in much the same way that others have proposed (Ballou and Gabalac 1985; Brown 1990; Faunce 1985; Jones and Mahony 1990; Kitzinger 1991; Rudolph 1989; Sang 1989; Williams & Watson1991; Wilson-Schaef, 1985, 1987).

Such proposals are far-reaching in demanding action on policy, roles, functions and knowledge so that new conceptualisations and practices would need to be developed in a way that mental health is completely reviewed. Tradition, power structures, theory and training and practice maintain the status quo and collude with social constraints in the oppression of women and other minorities such as lesbians and gay men. It is in these areas that change must occur and further points on this aspect of the debate are elaborated in the Discussion section of this study.

RESEARCH OBJECTIVES

This study aimed to establish if New Zealand clinicians are influenced by the sex and sexual orientation of the clients in diagnostic assessment. It asked questions relating to a case study where the sex and sexual orientation of the stimulus person were manipulated. It also asked subjects to complete a questionnaire regarding sex-role stereotypes. It aimed to address some of the faulty methodology of previous studies; to address the variable of sexual orientation neglected within the context of sex-role stereotyping by clinicians; and to consider the issues within a New Zealand context.

Broverman et al's study has since been modified many times over. The current study has sought to address some of the faults within the 1970 study and subsequent research. In particular, this research has improved the instrument by including an equal number of male and female valued items that are presented on a continuum rather than a bipolar scale. There was an

attempt to have a very large sample (approximately 50% of the NZ Register of Psychologists was canvassed). The final sample, although only approximately 25% of those canvassed, was still larger than the Broverman et al sample (114 as opposed to the original 79). Furthermore, this sample is approximately 12.5% of NZ registered Psychologists. Another point here is that the current sample used practising psychologists whilst many of the studies since Broverman et al have used student populations. This is considered a major weakness in other studies when the focus is on clinical assessment.

The use of sexual orientation of stimulus persons as an additional variable is considered to be a further improvement on the research to date. As well, the inclusion of a hypothetical case-study was considered to be an improvement on previous studies, as already described. In view of the lack of empirical data regarding sexual orientation and sex-role bias it is emphasised that the hypothesised views expressed in this research are essentially tentative and open to debate. However, the lack of literature on sex-role inversion and homosexuality inspired a focus on the issue in this study.

The male and female valued items were selected using New Zealand norms. It was considered this would add to the reliability of the results as indicative of a true New Zealand clinical picture. In addition to the norms being "home grown" it was considered of interest to have New Zealand clinicians' perspectives given that the majority of the literature is from North America and thus subject to being discounted as not applicable to New Zealand's situation. This would be in much the same vein that the Broverman research had been decried as out of date and thus no longer applicable to clinical practice.

Haines (1986) presented arguments on how psychology categorises women as invisible; being defective men, deficient men, developmentally delayed men, dumb, dutiful, decorative, dependent, domineering, deceitful, domestic, destructive, distressed, demented, disturbed, despondent and depressed. She suggested that an emphasis on difference and distinction would enhance mental health. She cited Max Abbott, 1986, who said that most mental health training

of practitioners in New Zealand is insensitive to other cultures but that the training of clinical psychologists is the worst among such professions. In the Discussion ideas on the issues of training will be discussed and, where possible, related to the New Zealand situation.

The current study has made considerable design improvements: in the instrument, the subject sample and stimulus person variables. It is deemed of importance to address the potential abuse within the mental health system of women generally and of lesbians and gay men and this has been the main theme of this research.

HYPOTHESES OF THIS STUDY

Given the trend in research on clinical stereotyping since the Broverman et al study in 1970 it would seem likely that any research based solely on sex differences would produce an androgynous-type profile as opposed to a sex-role stereotype profile. This is supported in more recent literature (for example, Judd, Ryan & Park 1991) in relation to the complexities of perception with regard to in-group and out-group variability. There has also been a trend for any residue of such stereotyping to be due to male assessors. It is postulated that male and female assessors combined will produce a non-stereotypical result. Thus the first hypothesis of this study is:

Hypothesis 1

Overall, clinical judgments about the characteristics of healthy individuals are based on an androgynous model of mental health (i.e. desirable masculine and feminine characteristics are not differentially attributed to men and women).

However, this hypothesis is qualified by higher order interaction effects.
Given Judd, Ryan & Park's findings in 1991 regarding the complexities of perception of stereotypes and considering the work of Deaux and Kite (1985), cited by Biernat (1991), it would seem that adding the dimension of sexual orientation to the current study would produce an interaction effect. Based on the 1985 research, it is postulated that sex-role stereotypes would be presented as the reverse for homosexual stimulus persons (inversion of traditional assignments by sex). Thus the second hypothesis of this study is:

Hypothesis 2

Clinical judgments about the characteristics of healthy individuals is based on an androgynous model of mental health for heterosexuals and a cross-sex stereotyped model of mental health for homosexuals (i.e. more stereotypically masculine traits are attributed to lesbians and more stereotypically feminine traits are attributed to gays).

As previous research has indicated a tendency for male assessors to give more traditionally stereotyped responses (Hansen 1982) and for females to give more pro-feminist responses (Newman 1989) it is postulated that there would be a reflection of this trend in the results of the present study. Owing to the tendency for males to be more negative than females towards homosexuals (Krulewitz & Nash 1980; Whitley 1987) and given the research supporting hypothesis 2, it is postulated that there would be a reflection of this in the current study. So the third hypothesis is:

Hypothesis 3

Male clinicians have more stereotyped/traditional judgments than female clinicians both in the attribution of sex-consistent traits to healthy heterosexuals and the attribution of cross-sex traits to healthy homosexuals.

TERMINOLOGY OF CURRENT STUDY

Sex Stereotypes

Although the modern trend is to speak of stereotypes based on gender and thus "gender stereotypes" the literature has traditionally referred to these as sex and sex-role stereotypes. For ease of referral to this literature this study will use the terms sex-stereotype and sex-role stereotype. The sex stereotypes in this study are rated using a subscale and these are referred to as the Feminine Subscale and the Masculine Subscale.

Sex

In relation to the person's being male or female, this will be referred to as the person's sex as in Stimulus Person Sex and Clinician Sex.

Sexual Orientation

Similarly, although the modern trend is to speak of sexual orientation in terms of heterosexual or gay male/homosexual or lesbian, it was decided, for ease of reference, to have a single term for each group. These are: heterosexual (female and male) and homosexual (female and male).

Androgyny

This study used Bem's (1974) three typology model of masculine, feminine and mixed (androgynous). Owing to design complexities it was not possible to further differentiate to a four typology model (as described on page 15 of the Introduction). This would entail masculine typed, feminine typed, undifferentiated (low levels of both feminine and masculine traits) and androgynous (high levels of both feminine and masculine traits).

METHOD

SUBJECTS

Subjects were selected from the New Zealand Register of Psychologists. Prior to this selection, all clinicians with a Dip. Ed. qualification (considered to work mainly with children/adolescents) or who were not resident in New Zealand were eliminated from the list. After these deletions the remainder were stratified by sex and 480 were then randomly selected from the register. This amounted to approximately 50% of all New Zealand Registered Psychologists. 114 of those contacted participated in the study (a return rate of 23.75%). This approximated 12.5% of all New Zealand Registered Psychologists.

Of the 114 subjects who took part, 60 were male (52.6%), 50 female (43.86%) and 4 did not specify their sex (3.5%). The mean age of the sample was 41.1 years (S.D. 10.05) with a range from 26-70 years. Time practising ranged from under 1 year to 56 years with the mean being 11.9 years (S.D. 9.04). 91 (79.82%) of subjects described themselves as being NZ European, 20 (17.54%) as being of other race, 2 (1.75%) as Maori, no subjects identified as Pacific Islanders and 1 subject (0.88%) did not specify race.

Clinicians were categorised as either having the Diploma of Clinical Psychology: 61 (53.51%), Masters Degree and above: 38 (33.33%), Other qualifications: 14 (12.28%) and one (0.88%) did not specify qualifications. Types of practice were State Institution: 54 (47.37%), Private Practice: 19 (16.67%), a combination of both State and Private Practice: 39 (34.21%) and two subjects (1.75%) did not specify type of practice. Theoretical orientations preferred were as follows: Psychodynamic 6 (5.3%), Behavioural 13 (11.4%), Cognitive 4 (3.51%), Behavioural/Cognitive 27 (23.68%), Humanistic 1 (.88%), Other orientations 13 (11.4%) and Eclectic 50 (43.86%).

PROCEDURE

A cover letter (Appendix A) was sent outlining the focus of the thesis as clinicians' appraisal processes with no obligation and ensuring anonymity of those who volunteered to participate. Completion of the questionnaire and its return were deemed to be indicative of informed consent and voluntary participation.

Each recipient was asked to complete brief biographical details (Appendix B) including sex, age, race, qualifications, length of time practising, type of practice and theoretical orientation preferred. In addition each subject was asked to respond to a questionnaire which is described below. The cover letter included directions to complete the questionnaire in the order presented.

MATERIALS

Each recipient received the cover letter, biographical details and a questionnaire which consisted of a case study, open-ended questions and a list of sex-stereotyped adjectives. Subjects were asked to rate in relation to the client in the case study.

Four versions of a case study (Appendix C: i, ii, iii, iv) were devised for the purpose of this study. Each version contained identical information with the exception of the client's name and the client's partner's name. These were indicators of the client's sex and sexual orientation. In providing names it was deemed a covert way of providing information about sex and sexual orientation as near as possible as would be provided in the "real" world. In addition, the focus of the study was on the salience of these factors. To state "this is a heterosexual" or "this is a homosexual" could create demand characteristics in the subjects and lack subtlety.

The four versions were female heterosexual, male heterosexual, female lesbian and male homosexual. (Appendix C: i, ii, iii, iv). Attached to each case study were the same 6 open questions about the assessment process (Appendix D). A final section asked for the subject to rate 28 adjectives in relation to what the subject considered descriptive of health and competence in the sample client. There were four versions of this section (Appendix E: i, ii, iii, iv) reflecting sex and sexual orientation in the same way as Appendix C.

The Case Study

The case study was designed to include brief information that might be provided by a G.P. in referral for a psychological appraisal. It included the client's first name, information about where the client lived and for how long; that the client was settled in the city with close relatives living near. It gave the client's age, some symptoms and length of time these had been experienced. It gave details of the client's intake of drugs including alcohol, nicotine and caffeine. The overview provided some details of the client's leisure and sporting interests, that the person's job was demanding but that the client kept regular hours and was in a committed relationship for 3 years (first name of partner provided).

Case Study Exploratory Questions

Six questions were asked of all respondents. These questions were used to gain information on clinicians' responses to sex and sexual orientation of clients. The main focus was on immediate responses to a specific client case-study. The first two questions focused on first impressions, the next two on assessment process and the final two on themes of diagnosis.

The first four questions were a measure of what was salient to the subject and if first impression salience was carried over into the assessment process. Question 5 asked the clinician to identify any specific disorders that might be explored in an assessment

interview with the specific client. This question would be a measure of any sex-specific classification processes. Finally, question 6 asked for the personal characteristics a clinician looked for to determine if the specific client given in the case-study is a healthy, competent person. This question was included as a "should be" question in that it explored any stereotypy in the clinician's view of healthy and competent in relation to the particular version given. These responses were subjected to Content Analysis. The six questions appear in Appendix D. These questions were, along with the next section, designed to test the stated hypotheses.

Ratings of Sex Stereotyped Adjectives

Subjects were presented with 28 positive adjectives, 14 of which were stereotypically feminine and 14 of which were stereotypically masculine. They were asked to indicate a rating based on a 7 point Likert response format ranging from 1 (not at all descriptive of the client) to 7 (extremely descriptive of the client). See Appendix E.

The 14 male stereotyped adjectives and 14 female stereotyped adjectives were randomly selected from focused stereotypes from Williams and Best's Adjective Checklist (ACL) NZ Data (1982) which were adapted from Williams and Bennett (1975). In the previous research each item received an M% score based on assignment of the trait to men or women in New Zealand. This score was computed by dividing the male-associated frequency by the sum of the female associated and male associated frequencies and discarding the decimal. Higher M% scores show adjectives which were highly associated with men and lower M% scores show adjectives which were highly associated with women. Only adjectives which received M% ratings of $\geq$ 66% were included in the focused New Zealand male stereotype. Items which received M% $\leq$ 33% were included in the focused female stereotype.

The favourability ratings for the adjectives were also taken from Williams and Best's

semantic meaning analysis of stereotypic traits in previous research where subjects rated the favourability of ACL items. In the Williams and Best standardization, scores at 500 represented a neutral evaluation with higher scores indicating greater favourability. For the current research, 14 adjectives for each sex were selected that had a relatively high favourability rating (that is, scoring 600 and above).

The 28 selected adjectives appear as part of the questionnaire in Appendix E. These 28 adjectives with the M% Scores for 25 countries, M% Scores for New Zealand and Favourability ratings appear in Appendix F. A complete list of the Focused Sex-Stereotypes appears in Appendix G.

RESEARCH DESIGN

Case study Exploratory Questions

The six responses to the open questions relating to the case study were subjected to a Content Analysis. A Chi Square analysis was to be used on the first five questions to determine if there is a relationship between variables with a specific focus on sex and sexual orientation.

Ratings of Sex Stereotyped Adjectives

A 2x2x2x2 mixed design Anova with repeated measures on one factor was used so that main effects and interaction effects could be considered. The main expectation was for interaction effects. The independent variables were stimulus person sex (female, male) stimulus person sexual orientation (homosexual, heterosexual), subject sex (female, male) and adjective ratings (femininity score, masculinity score). In the latter a within subjects factor was considered in terms of each subject's responses on both feminine and masculine sub-scales.

RESULTS

A two-part questionnaire was completed by participants. Firstly, subjects were asked to respond to six exploratory questions in relation to a case study where sex and sexual orientation of the stimulus persons were manipulated. A content analysis was conducted to determine if these manipulations influenced subjects' responses. In addition, participants rated 28 sex-stereotyped adjectives selected from Williams and Best's (1982) male and female stereotypes. They were asked to rate these items on a seven point scale ranging from Not at all Descriptive (1) to Extremely Descriptive (7). These ratings were used to determine whether subjects' perceptions of mental health were influenced by the sex and sexual orientation of the stimulus persons presented. This section will address first the responses to the sex-stereotyped adjectives and then the case-study exploratory questions.

RATINGS OF SEX-STEREOTYPED ADJECTIVES

Reliability of Femininity and Masculinity Scales

Participants rated sex-stereotyped adjectives selected from Williams and Best's 1982 data. As these adjectives were a random selection of the focused stereotypes it was considered important to check whether the 14 female and 14 male adjectives selected were a reliable measure. Therefore, a reliability analysis was conducted to assess the internal consistency of the femininity and masculinity scales. The masculine version had a Cronbach Alpha value of 0.93 and the feminine version had an Alpha of 0.94.
Thus, it was considered a high level of reliability existed in the selected adjectives.

Analysis of Variance

A 2x2x2x2 mixed design ANOVA with repeated measures on one factor was conducted on the responses. Factors were: Stimulus Person Sex (Male or Female), Stimulus Person Sexual Orientation (Heterosexual or Homosexual), Subject Sex (Male or Female) and Rating (Feminine

or Masculine subscale). The following results emerged:

1. A main effect for Rating:

F (1,113) = 15.51, p< .0001

Overall, stereotypically masculine traits (mean = 65.365, SD 11.060) were perceived as more important characteristics of psychological wellbeing than the stereotypically feminine traits (mean = 61.854, SD 12.147). This is qualified by the following interaction effects:

2. Interaction effects for Stimulus Person Sex by Rating:

F(1, 108) = 9.58, p<.003

Table 1. Means and Standard Deviations of masculine and feminine subscales for male and female stimulus persons.

	Males	Females
Fem Scale	62.62 (10.39)	60.76 (14.00)
Masc Scale	63.26 (8.65)	67.85 (13.09)

The interaction effect indicated that: 1). Stereotypically masculine traits were perceived as more important determinants of mental health than stereotypically feminine traits in women but that masculine and feminine characteristics were deemed equally important for determining psychological wellbeing in men and that 2). stereotypically masculine traits were evaluated as more significant descriptors of mental health in women than in men. This was confirmed by Post Hoc Sheffe analysis (Critical difference= 3.58).

Consequently, a masculine model of mental health is applied to women while an androgynous model of mental health is held for men.

Post-Hoc Sheffe comparisons:

Female SP, Fem Subscale vs. Female SP, Masc Subscale = 7.09
Male SP, Masc Subscale vs. Female SP, Masc Subscale = 4.58

Appendices H and I provide the Anova results for the Masculine and Feminine Subscales respectively.

3. Interaction effects for Sexual Orientation by Rating:

F (1, 108) = 5.77, p<.018

Table 2 Means and Standard Deviations for Masculine and Feminine Subscales for heterosexuals and homosexuals.

	Homosexuals	Heterosexuals
Fem Scale	62.24 (11.45)	60.42 (12.78)
Masc Scale	64.20 (10.19)	66.58 (11.87)

The interaction effect revealed that, 1). stereotypically masculine traits were seen as more important determinants of mental health for heterosexuals but, 2). that masculine and feminine characteristics were seen as equally important for determining psychological well-being in homosexuals. This was confirmed by Post-hoc Scheffe analysis (Critical difference = 3.55). Consequently a masculine model of mental health was deemed appropriate for heterosexuals but an androgynous model was adopted for homosexuals.

Post Hoc Sheffe comparison:

Heterosexual SP, Fem Subscale vs. Masc Subscale = 6.16

A critical difference of 3.55 was found.

Owing to the interaction effects which demonstrated a masculine model of mental health for women and heterosexuals, the question was raised as to whether this reflected desirability in the male and female adjectives, i.e. a method artifact. Comparison of mean favourability ratings of male and female adjectives indicated, however, that female traits were evaluated as more desirable than male traits, t (df 26)= 3.04, $p < 0.001$. The means were: Male 609.86, Female 624.29.

Although the second level interaction effects demonstrated a masculine model of mental health for women and heterosexuals and an androgynous model of mental health for men and homosexuals, a third level interaction effect was not significant. Therefore, mean scores on the masculine and feminine subscales for male and female heterosexuals and homosexuals were

examined further and planned comparisons were conducted to test for the hypothesised inversion effect for clinical assessments of homosexuals.

Table 3
Means for Masculine and Feminine Scale for
Homosexual and Heterosexual Women and Men

Stimulus person	N	M Scale	F Scale
Female Homosexual	24	72.21	64.07
Male Homosexual	34	60.36	62.20
Female Heterosexual	28	65.78	57.92
Male Heterosexual	28	64.59	62.14

Hypothesis 2 predicted an inversion of ratings for homosexuals. This would result in male homosexuals being rated higher on the Feminine Subscale and lower on the Masculine Subscale and it would also result in female homosexuals being rated higher on the Masculine Subscale and lower on the Feminine Subscale.

Data indicate that a masculine model of mental health was adopted for lesbians suggesting some support of the proposed inversion effect. While feminine traits were rated as more important for gays than masculine traits, this difference was not significant and an androgynous model of mental health was applied to gays. Given that a masculine model of mental health also held for heterosexual women, the inversion hypothesis of mental health determinants in homosexuals was not supported.

Table 4
Comparisons to Assess for Inversion Hypothesis

Stimulus person	Masculine	Feminine	Comparison
Female Homosexual	72.21	64.07	8.14 (sig)
Male Homosexual	60.36	62.20	1.84(notsig)
Female Heterosexual	65.78	57.92	7.86 (sig)
Male Heterosexual	64.59	62.14	2.45(notsig)

Critical Difference = 3.54
p = 0.05

The planned comparisons, in conjunction with the anova results, lend support to an androgynous model of mental health for men but a masculine model of mental health for women

which only partially confirms Hypothesis 1. Significance for sexual orientation appears to be a further reflection of this trend rather than an inversion effect, as discussed.

No significant effects for subject sex were found so that Hypothesis 3 was disconfirmed. See Appendices J and K for the complete results for Rating x Within-Subject Effects and Rating x Between-Subject Effects.

Thus a double-standard of mental health is demonstrated by a sample of 12.5% of New Zealand registered psychologists in terms of a model of androgyny for mental health for men but that women are considered healthy relative to a masculine model of mental health which in fact was even more emphasised for lesbians.

CASE STUDY EXPOLORATORY QUESTIONS

A Content Analysis was conducted using the six open questions relating to the case study provided with the questionnaire. The following topics were considered in these questions:

1. First impressions
2. Information influencing impressions
3. Major issues in assessment
4. Hypotheses
5. Possible disorders considered
6. Determinants of health and competence in the client provided in the case-study.

Research questions being considered were: Is there a significant difference in the proportion of answers focusing on sex and/or sexual orientation? Answers for all six questions generated many categories and too small cell numbers for a meaningful analysis of sex and sexual orientation among these categories. The following are data tables representative of the type of answers to each question.

Key for all Tables: MG= Male Gay (N= 34), FL= Female Lesbian (N= 24), FH= Female Heterosexual (N= 28) and MH= Male Heterosexual (N= 28).
The total number of responses to categories may exceed the total Ns owing to subjects offering more than one response.

Table 5
Question 1. First Impressions

Categories	MG	FL	FH	MH
Sex	1	1	1	3
Sexual Orientation	8	2	0	0
Subjective distress	1	2	0	1
Symptoms	11	6	4	8
Lifestyle	7	8	5	12
Instant diagnoses	8	3	8	6
Causal questions	0	1	1	9
Incongruity of functioning vs. symptoms	0	1	2	0
Other (e.g. "troubled", "life stage" etc.)	1	2	3	4
Not answered	0	1	0	0
TOTALS:	37	27	24	43

It is of note that sexual orientation of stimulus person was considered an issue for only homosexuals. Clinicians were not greatly influenced by sex of the stimulus person in relation to a specific category however.

Table 6
Question 2. Information influencing First Impressions

Categories	MG	FL	FH	MH
Sex	0	1	1	0
Sexual Orientation	6	2	0	0
Age	1	1	1	0
Symptoms	16	6	6	5
Lifestyle	4	4	7	13
Incongruity of functioning vs. symptoms	7	6	6	5
Change in functioning	2	2	0	7
Other	4	7	4	2
Not answered	2	2	3	0
TOTALS:	42	31	28	32

Again, sexual orientation but not sex of stimulus person appeared to influence clinicians with regard to homosexuals as opposed to heterosexuals. Within the text of responses comments

were made by clinicians regarding lack of information and yet assessments were made on such a stated lack. One clinician claimed no age was provided and yet this appeared in the text of the case study while another clinician spoke of "immediate help-seeking" by the client who had been described in the text as having had the symptoms for six months.

Table 7
Question 3. Major Issues in Assessment

Categories	MG	FL	FH	MH
Sex	2	0	1	1
Sexual Orientation	8	6	0	0
HIV testing	1	0	0	0
General history	3	3	5	7
Psychosocial history	13	14	7	11
General symptoms and problems	16	11	13	12
Neurological problem	1	3	3	4
Psychiatric problem	9	1	5	4
Other (inc. life stage issues)	3	1	3	4
Relationship issues	12	9	14	19
Not answered	0	1	1	2
TOTALS:	68	49	52	64

It is of note that Sexual Orientation was only offered as a major issue for homosexual men and women in response to question 5. while HIV testing was deemed appropriate for one gay male.

Table 8
Question 4. Hypotheses

Categories	MG	FL	FH	MH
Sexual problem/sexual abuse	1	0	1	2
Sexual orientation as source of problem	5	2	0	0
Relationship problem	7	7	4	6
Work problem	6	2	0	4
Family problem	3	3	3	4
Psychiatric disorder	14	7	8	12
Physiological/organic problem	1	7	6	12
HIV	1	0	0	0
Other	9	6	11	5
Not answered	10	3	3	4
TOTALS:	57	37	36	49

Many clinicians seemed to have difficulty in understanding what a hypothesis is and offered, instead, suggestions for treatment in relation to a hypothesis (for example: "relaxation for the physical problem" and "counselling for anxiety").

In this section the responses of "Obsessional homosexual" and "Defensive homosexual" were offered by subjects and categorised under "Sexual orientation being seen as source of the problem". In addition it is of note that only homosexuals were rated in this category and one homosexual male was assessed as possibly having HIV.

Table 9
Question 5. Possible Disorders

Categories	MG	FL	FH	MH
Sexuality, sexual disorders	4	0	2	1
HIV/Aids	5	0	0	0
Relationship and adjustment problems	6	1	1	6
Mood disorders	21	15	16	16
Addictions	2	2	2	3
Psychoses	8	2	1	5
Anxiety disorders	11	11	5	13
Organicity, brain disorders	11	5	7	8
Personality disorders	2	1	0	0
Sleep disorders	1	0	1	1
Other	6	8	5	3
Not answered	1	4	4	4
TOTALS:	78	49	44	60

It is of note that despite many clinicians stating there was insufficient information to make a statement, they went on to categorise the client. Again HIV was a category deemed exclusive to gay males although issues pertaining to sexuality were not rated with any preference for a specific group and not even mentioned for lesbians.

Table 10
Question 6. Determinants of Health

Categories	MG	FL	FH	MH
Lack of symptoms/disorder/illness	2	2	1	2
Stable, balanced lifestyle, integrated	9	7	3	5
Employable/achiever,financially stable	8	4	3	4
Resolved past issues, upbringing	1	1	0	0
Cognitive functioning, positive attitude	5	1	3	5
Physical fitness	1	2	2	0
Feelings - capacity for emotional range	4	2	6	3
Interpersonal skills	14	7	13	16
Intrapersonal skills	13	11	13	15
Assumed healthiness	0	2	2	0
Other (inc. commitment to change; intelligence; ecological issues)	1	3	4	4
Attitudes to sexuality	2	1	0	0
Not answered	4	1	3	2
TOTALS:	64	44	53	56

It is of note that "attitudes to sexuality" as a determinant of health were only specified for homosexuals (2 ratings for a gay man and 1 for a lesbian). No reference to attitude to sexuality as a determinant of health was made for heterosexuals. One suggestion (placed under the category "Other") was commitment to change for a lesbian client. For male gay responses one subject looked for "attitude to lifestyle" while another for "attitude to women" as determinants of health. No such comments were made regarding heterosexual men.

All of the six questions raised a variety of response categories and the consequent small cell sizes for many of these made a Chi Square analysis meaningless when based on specific content. However, it was noted that there was a systematic trend for more response categories to be generated for males than females for either sexual orientation. Furthermore, there were four out of six questions in which a greater number of responses were generated for homosexuals than for heterosexuals (as demonstrated in Table 11).

Table 11
Responses by sexual orientation and by sex of stimulus person for the six Exploratory Questions.

Question No.	Homosexual N= 56 (MG=32, FL=24)	Heterosexual N= 56 (MH=28, FH=28)	Female N= 52	Male N= 60
Q1	64	67	51	80
Q2	73	60	59	74
Q3	117	116	101	132
Q4	94	85	73	106
Q5	127	104	93	138
Q6	108	109	97	120
Overall totals:	583	541	474	650

Data were computed using the total responses generated by Sexual Orientation and by Sex which were further divided into the totals for Male, Female, Heterosexual and Homosexual. A Chi Square Goodness of Fit was conducted to determine if a difference emerged between Male and Female or Heterosexual and Homosexual but these were not significant (p=0.05).

Chi Square results for Stimulus Person Sex (df = 1) was 0.15 and for Sexual Orientation was (df = 1) 0.03.

DISCUSSION

The Results in Relation to Hypotheses

The three main hypotheses of this study were that an androgynous model would be presented in clinical assessment, qualified by an interaction effect for sexual orientation, whereby stereotyping would be inverted for homosexuals, and clinician sex would influence results in that male clinicians were expected to have more traditional judgments for clients irrespective of sexual orientation. The data demonstrated a trend to androgynous views of clinical assessment for males but a masculine model for mental health for women. Further, the results indicate that women have to be more masculine than men in order to be deemed healthy. An interaction of sexual orientation by rating occurred which appeared to reflect this focus. In addition, content analysis of the six exploratory questions presented a tendency for clinicians to treat homosexual orientation, but not sex of client, as salient. Sex of clinician did not appear to be a significant factor.

Theoretical and Empirical Context of the Results

Sex of Stimulus Person

The findings of this study suggest that women are defined relative to a masculine standard or norm of health which partially supports the findings of the Broverman et al (1970) landmark study so often cited and yet considered to be so out-of-date. This study shows that despite a trend toward androgynous ideals women are still restricted within a sex-typed bias in the clinicians in this study. This still supports the Broverman view that a double-standard of health exists that goes against women.

If the results of this study reflected issues regarding method then some of the modifications need to be noted. Silvern and Ryan (1983) observed the discrepancy in numbers of male and female valued items in the Broverman questionnaire as well as a high number of synonyms within the male valued items thus rendering some of the items redundant. This study sought to address this anomaly. In fact, as reported earlier, female items were more valued than male yet

still produced a finding that indicated a higher valuing of male-typing for women. In addition the design problem of continuous versus forced-choice questions was addressed in the current research and thus made significant findings all the more of interest. Another aspect of change that was addressed was the size of the sample and, as opposed to the Broverman study, only psychologists were used as subjects.

In previous research, a higher masculine model for women compared to males has not been demonstrated. More recent research has tended to result in an androgynous trend for all stimulus persons (Phillips & Gilroy 1985). However, Adler et al (1990) found evidence to support that sex-bias exists in clinical assessment in that clinicians viewing a case-study made global judgments about personality disorders and were influenced by stimulus person sex even when it had no known relevance. Although they acknowledge the finding may not occur in naturalistic settings, the analogue method in which subjects rate a written case study rather than a live interview, is considered a valid test for gender bias. To support this they cite previous literature (Davidson & Abramowitz, 1980; Hare-Mustin 1983; and Loring & Powell, 1988).

It could be speculated that rather than simply presenting an androgynous profile for healthy women, clinicians presented a profile skewed in favour of masculine traits in order to appear liberal in their attitudes to women in particular. Thus the results could be a reflection of demand characteristics as an artifact of attitudinal research.

If this speculation is correct, it implies that these clinicians valued masculine traits more than feminine traits when assessing women. This is off particular interest, given that, in comparing mean favourability ratings of masculine and feminine adjectives, female traits were evaluated as more desirable than male traits.

It is a question of conjecture as to why this happened. It could be that given that this case-study presented a person working out of the home, the results may reflect this. It raises questions if context affects assessment (as raised in research by Poole & Tapley, 1988 and previously

outlined in the introduction of this study). It may be that given the case-study presented in this research, the clinicians responded to a woman working out of the home and that the trend to favour masculine traits for her to be healthy could be an artifact of this. This suggests that future studies could replicate the current work with a manipulation of context within the case-study.

It may be that in terms of the development of the adjectives the issue of context was not attended to and thus masculine and feminine were assessed as favourable relative to a contextual stereotype whereby traits were rated relative to a male in the workforce and a female at home.

Sexual Orientation of Stimulus Person

In terms of previous research in relation to homosexuality and sex-stereotyping, there was no literature that focused specifically on the salience of homosexuality and sex-roles in clinical appraisal that would be comparable to the current research. However, this points to the current research being of value in making some addition to work in this field to date. In terms of sex-role inversion, the previous literature has been mixed so that the current study considered this in an exploratory way. Although the results did not indicate sex-role inversion it is of interest that the clinicians in this study had an apparent androgynous expectation for homosexual men as opposed to homosexual women.

It is a matter of conjecture as to why this occurred. It could be that clinicians believed an androgynous mix of traits was acceptable for gays as for all men and did not perceive sexual orientation to be an issue in global assessment. However, when a specific case-study was presented some indication of sexual orientation being an influence occurred.

Another factor in terms of the results for homosexuals could reflect the rationale used by clinicians to assess minority groups. For example, one male clinician who explained that he had little knowledge of lesbians in his practice and had thus assessed the lesbian in the case-study based on those few lesbians he had met during his life and those who were friends of his

wife. This raises the question as to how clinicians in practice make assessments when confronted with people of minority groups about whom they know relatively little.

Sex of Clinician

Subject (i.e. clinician or judge) sex differences were found in previous literature (for example, McKinney 1987; Silvern & Ryan 1983) but not in others (for example, Thomas 1985 review of 15 previous studies). The current study found no such difference based on subject sex.

As sex of clinician did not appear to influence the results this may be due to a number of variables including cultural aspects of the New Zealand clinicians' assessment processes. It may be, for example, that the focus of clinical training in New Zealand produces a similarity between sexes that does not hold in other countries, especially North America, where previous research in this field has been conducted. This also raises questions regarding method:

Methodology

Although Williams and Best's data was relevant to New Zealand, it was based on non-clinical norms and the results may reflect a discrepancy based on this factor. Adjectives may need to be normed on clinicians' appraisals. It may be of importance to reconsider not only the stereotypes themselves but the issue of favourability within a New Zealand context. In other words, the stereotypes generally in terms of what is masculine and what is feminine may well be assessed differently by clinicians. In addition, the degree of desirability of these traits whether masculine or feminine may be rated differently within the New Zealand culture.

As Matlin (1987) suggested, demand characteristics could occur in studies of this nature in terms of therapists becoming more informed about what is appropriate to present in terms of non-sexist attitudes in assessment processes. Thus the current research may represent the enthusiasm of clinicians to appear unbiased.

Implications of the Results and Questions Raised

The current results have some important implications both within a clinical context and within a broader view of society's expectations of different groups. Of note is Laura Brown's (1988) comments regarding women's multi-roles and how these are affected by an expectation for women (given as heterosexual unless otherwise stated). If a woman has to portray herself as highly masculine to be mentally healthy what does this say for the "traditional" wife and mother? It could explain why a higher number of women present in mental institutions. It could mean that an androgynous man is mentally more healthy than a highly feminine woman and thus ensure that men's non-stereotypical behaviour is not pathologised. Although a masculine model for women implies that women's non-stereotyped behaviour will also not be pathologised it is implicit that female stereotyped behaviour will be. It would seem that pathology based on sex is likely to prevail (see Chesler 1972; Kaplan 1983; Miles 1988; Rosewater 1985).

It is of note that lesbians were rated even higher on the masculine scale than heterosexual women but also received a greater rating for the feminine scale. This suggests that a lesbian has a wider repertoire of clinically prescribed healthy behaviours open to her than a heterosexual woman. However, if heterosexuality is considered a given, does this mean that all women (sexual orientation unspecified) are likely to be assessed using a male stereotype and hence the results of this research? Does it mean that a woman identified as lesbian is likely to be assessed with an even greater emphasis on a masculine model and is thus open to greater bias in assessment? This would suggest that all women would be likely to be categorised as unhealthy if they exhibit feminine as well as masculine traits though this would be open to a further study.

This could mean that a lesbian with only a high level of masculine traits would be deemed unhealthy compared to a heterosexual woman with similar traits. This could reflect discomfort with regard to lesbian "masculinity" being threatening to the status-quo. However, the data do not break down in terms of high and low levels of masculine and feminine traits (the four

typology version of androgyny) and thus further research would be needed to ascertain if these differences occurred.

These results did not present the higher order interaction needed to support the contention that there is a difference between lesbians and heterosexual women in terms of the male-typed model presented for women. Therefore planned comparisons were conducted and revealed that lesbians and heterosexual women are all assessed on a male model of mental health. The current results suggest that women have not only a narrower domain of healthy behaviours but that they also have to aspire to a male domain of healthy behaviours. This would seem to present the double-standard of health that Broverman et al's 1970 study revealed despite the twenty years that have intervened.

With regard to the apparent salience of sexual orientation in the content analysis of the exploratory questions, this suggests clinicians' bias in working with homosexuals. Furthermore, the apparent disregard of HIV/Aids for the heterosexual population suggests the "experts" may level responsibility more to gay men than another group for the spread of this potentially fatal virus. The content analysis suggested bias against gay men despite the apparent androgyny model. It is thus highly likely that androgyny is considered healthy for all men (given as being heterosexual). However, when a man is a known homosexual these clinicians presented a confusing picture: no apparent bias when looking at general descriptors of male mental health versus a direct response to sexual orientation when looking at a specific case-study.

If these results are a reflection of what happens in clinical assessment, the political implications for women in particular are disturbing as suggested by Schur 1984 and by Kitzinger 1991. Referring back to Kimball's statement in 1975 that a woman who changes to being healthy adult becomes sick as a woman and if she is healthy as a woman she is sick as a person, the current results suggest that if a woman is a healthy woman she is not feminine and vice-versa. This would seem contradictory and likely to induce dis-ease in women.

A trend of attitudes to sameness is of some concern in that Taylor and Hall (1982) suggested this masks the imbalances of a society that continues to reward masculine behaviour. Certainly there is an interesting discrepancy in the current results that suggests men are rewarded for a mixture of behaviours but women are not. Of particular note is that women are expected to be more masculine than men to be considered healthy and thus raises questions regarding the likelihood of most women being considered healthy with these criteria. Indeed, Taylor and Hall considered that developing a conceptual scheme that discourages the separate consideration of masculinity and femininity is misleading as:

"such separate consideration reveals that masculinity and femininity differ not only in qualitative essence but also in quantifiable consequences." p363.

In terms of the design, basic issues regarding the operational definition of masculinity and femininity are raised. Consideration of relational androgyny, for example as noted by Brown (1988), challenges concepts of dependency and autonomy as being polarities and that one is not necessarily unhealthy and the other healthy. She stated that a combination of both these traits is desirable and thus the very adjectives that are used in sex-role stereotype research are now questionable relative to interpretation of these concepts. This suggests that a review of the stereotype adjectives and a deconstruction of their meaning is open to further research.

Limitations of this Study

Given that clinicians have been exposed to a wide literature on the topic of sex-role stereotyping over the twenty years since the Broverman (1970) landmark research, a major difficulty in designing this research was the issue of subtlety in terms of the relative sophistication of the subjects. In addition, little research on sex-role stereotyping in clinical assessment has focused on the issue of sexual orientation and this presented the researcher with a problem with regard to subtlety. The possibility of creating demand characteristics was considered an important issue in terms of the wording of the questionnaire and case-study and in terms of its seeking attitudinal responses versus observing actual behaviour in a naturalistic setting.

No data were obtained regarding the sexual orientation of the subjects that could influence their responses. In addition to obtaining this data, a self reported profile of subjects' attitudes could be helpful as a check against their responses in terms of any sexism and heterosexism present.

The adjectives used (from Williams & Best 1982) may not reflect New Zealand clinical populations and the favourability ratings may also be inaccurate representations of New Zealand as they were based on North American data.

No consideration was given to contextual cues and future research could include this as a further manipulation within the case-study as discussed above with regard to home and work settings.

The six exploratory questions did not yield sufficient meaningful data for quantitative analysis. In retrospect it would have been easier to quantify the data by inviting the respondents to rank their responses.

Despite biographical detail regarding clinicians' practice, length of practising and theoretical orientation being obtained, no specific details were gathered regarding the content of training received by clinicians. It is possible that future research with regard to clinical assessment needs to address how clinicians come to assess in the way they do and in what ways client as well as clinician sex and sexual orientation influence this process.

Although the number of respondents exceeded those used in the Broverman research, the sample may still have been too small to draw any definite conclusions with regard to wider clinical populations. The return rate for the questionnaire was below the usual 30% although the sample was 12.5% of all New Zealand registered psychologists.

Strategies and Suggestions for Future Research

All research to date, including this study, has concerned attitudes as opposed to actual practice. This is considered an area begging for research as emphasised by Phillips and Gilroy (1985) and Thomas (1985). To some extent, in vivo research may help to overcome the demand characteristics to which attitude-focused research is vulnerable.
In addition, in vivo research is more likely to address the issue of contextual cues (as espoused by Poole and Tapley in 1988).

More fundamental is the issue of engendering psychological reality, as discussed by Morawski (1985) so that consideration of criteria for knowledge itself need to be challenged and deconstructed. This challenge to knowledge and its perpetuation or sustaining of stereotyping raises questions regarding the training of clinicians: who trains, what they are trained to look for and why. Models for integrating clinical assessment and gender awareness are put forward by Brown 1990. To enhance this approach it may be helpful to assess through pre-training and post-training analysis whether sexism and heterosexism have altered within the trainees as a measure of the effectiveness of issues addressed in training. This could be achieved in the form of self-ratings (as previously cited in Judd et al 1991) to determine accuracy criteria. However, this would be questionably accurate so that, again, the focus would need to be on practice as opposed to attitude. Further questions raised would be who would be assessing these changes and how would they be selected?

Details in terms of replication of studies such as this one would need to include factors such as sexual orientation of clinician as well as some review of training received. Some consideration of contextual cues in the case-study (especially with regard to working environment) may be improvements for future studies. Another point of interest is the larger number of responses generated for males to females in the content analysis. This suggests that clinicians put more time and energy into hypothesising about male clients than female clients. A suggestion for measuring this would be to ask clinicians to report how long they took to complete the questions.

As these results suggest that health is based on an androgyny model for men and a masculine model for women, it would be interesting to present case-studies of androgynous, feminine and masculine descriptions of male and female clients in order to ascertain if the same trends emerge.

Going back to the masculine and feminine adjectives from the focused New Zealand stereotypes, an affective meaning analysis was conducted based on North American data. As favourability ratings were based on North American data, favourability ratings based on New Zealanders would also be helpful in conducting future research in this field.

New Zealand clinicians do not appear to differ by sex compared to previous literature. This could be a cultural difference, reflecting clinical training in New Zealand. This could be tested by presenting the same case-study to two groups: New Zealand trained clinicians and overseas trained clinicians.

In view of the challenges made to the author of this research it may be helpful in future research to include the sexual orientation as well as the sex of the researcher and possibly to manipulate these details using a split-half analysis of the results to determine if any salience is placed on these aspects of the study.

As much of the previous research on homosexuality has emphasised that homosexuality is a source of problems and much of this research has set out to determine what causes homosexuality, it would be of interest to explore the issue of heterosexuality in a similar vein of causality. Further studies would therefore address if heterosexuality is a source of difficulties as well as looking at the determinants of heterosexuality.

With regard to the issue of HIV/Aids a follow-up repeat of the study but with an intervening educational programme for clinicians regarding the issue of HIV would be a way of measuring if clinicians continued to place the focus on homosexual men or if their assessment focus changed. Follow-ups after educational interventions are common ways of evaluating effectiveness of such programmes and such an approach was outlined in the literature, for example, by Rudolph (1989) regarding the effectiveness of a workshop on mental health practitioners' attitudes toward homosexuality.

Conclusions

This study has established that the New Zealand sample it canvassed expect androgynous traits in men but a masculine model of mental health for women. Although an interaction effect was found for sexual orientation, it appeared to reflect the emphasis on the masculine model for lesbian women to a greater extent than heterosexual women. No difference for clinician sex was found in this study. There are clinical and political implications in these findings that point not only to further research to address some of the design issues and conceptual issues raised but to consideration of the training of clinicians in New Zealand. Suggestions regarding such future research have been offered.

The results suggest women must be more masculine than men to be deemed healthy. It is of note that homosexual women were rated even higher on this model. Therefore the expected repercussions of such attitudes could be translated into clinical practice and influence the ratio of women to men in our mental health institutions. No data is available regarding sexual orientation but as previously cited, there is a higher ratio of women to men in New Zealand Mental Health Data (outnumbering men by two to one).

If a masculine model of mental health prevails for women and an androgynous model for men this suggests a complexity of issues with regard to clinical assessment. Thus heterosexual women and lesbians who are predominantly feminine or androgynous; and heterosexual or

homosexual men who are predominantly masculine or feminine would all be deemed unhealthy using the model presented by the clinicians in this study.

Twenty years since Broverman's study, women are assessed as healthy only if they can be more masculine than men and are thus still rated in terms of a male viewpoint. There is still a double-standard for women compared to men. It is a concern if clinicians are creating disparities in mental health statistics and creating pathology itself, and sustaining it, by assessing women based on a male standard. It seems that Adrienne Rich's contention that knowledge must be reinterpreted in terms of women's experience has come of age in the field of clinical assessment.

REFERENCES

Abbott M. (1986) Keeping Psychology White: The Taha Maori Component in New Zealand Health Training Programmes. Paper presented at NZPsS Conference, Dunedin (cited by Hilary Haines, 1986).

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

Adler D. A., R. E. Drake & Teague G. B. (1990) Clinicians' Practices in Personality Assessment: Does Gender Influence the Use of DSMIII Axis II? Comprehensive Psychiatry, 31(2) (March/April): 125-133.

Antoniadis, N. (1984) Trends in Telephone Emergency Services: A New Zealand Study. Community Mental Health in New Zealand 1 (1), 90-95.

Archer J. & Rhodes C. (1989) The relationship between gender-related traits and attitudes, British Journal of Social Psychology, 28, 149-157.

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

Ballou M. & Gabalac N. W. (1985) The Feminist Position on Mental Health, Illinois: Charles Thomas.

Bellezza F. S., Bower G. H. (1981) Person stereotypes and memory of people, Journal of Personality and Social Psychology, 41: 856-865.

Bem S. L. (1974) The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology, 42, 155-162.

Bem S. L. (1976) Probing the promise of androgyny. In Kaplan A. G. & Bean J. P. (Eds) Beyond Sex-Role Stereotypes. Boston: Little, Bron.

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

Biernat M. (1991) Gender Stereotypes and the Relationship Between Masculinity and Femininity: A Developmental Analysis, Journal of Personality and Social Psychology, 61(3): 351-365.

Braude M. (Ed.) (1988) Women, Power & Therapy: Issues for Women, New York: The Haworth Press Inc.

Brooks-Gunn J. & Fisch M. (1980) Psychological Androgyny and College Students' Judgments of Mental Health, Sex Roles, (6)4: 575-580.

Broverman I. K., Broverman D. M., Clarkson F. E., Rosenkrantz P.S. & Vogel S. R. (1970) Sex-Role Stereotypes & Clinical Judgments of Mental Health, Journal of Consulting and Clinical Psychology, 34(1): 1-7.

Brown L. S. (1986) Gender Role Analysis: A Neglected Component of Psychological Assessment, Psychotherapy, 23(2).

Brown L. S. (1989) New Voices, New Visions. Toward a Lesbian/Gay Paradigm for Psychology, Psychology of Women Quarterly, 13, 445-458.

Brown L. S. (1990) Taking Account of Gender in the Clinical Assessment Interview, Professional Psychology: Research and Practice, 21(1), 12-17.

Brown L. S. (1991) Plus ca change...or, Who Writes the Scripts for These Guys Anyway? Feminism & Psychology, 1(1) 89-92.

Bruning J. L., & Kintz B. L. (1977) Computational Handbook of Statistics, Second Ed., London: Scott, Foresman & Co.

Buie, J. (1990) Heterosexual Ethic mentality is decried, The Monitor, American Psychology Association, Vol 21 (3), March, 20.

Bunkle P., & Hughes B. (Eds.) (1980) Women in New Zealand Society, Auckland: Allen & Unwin.

Carroll, L. (1950) Alice Through the Looking Glass, Harmondsworth: Penguin.

Casey E. A. (1990) A comparison of homosexual and heterosexual relationships and an examination of attitudes toward homosexuality, M.A. Thesis, Canterbury University.

Chesler P. (1972) Women and Madness, New York: Avon Books.

Cheung F. M. (1991) Consciousness-raising of Gender Issues in Clinical Psychology Training: A Community Psychology Approach, Feminism & Psychology, 1(1): 93-95.

Collier A. (1977) R. D. Laing: The Philosophy and Politics of Psychotherapy, Sussex, U.K.: Harvester.

Condor S. (1991) Sexism in Psychological Research: A Brief Note, Feminism & Psychology, 1 (1): 430-434.

Cowan G. (1976) Therapist judgments of client's sex-role problems. Psychology of Women Quarterly, 1, 115-124.

Cramer D. (1986) Gay Parents and Their Children: A Review of Research and Practical Implications, Journal of Counseling & Development, 64, 504-507.

Davidson D. & Abramowitz S. (1980) Sex bias in clinical judgment: Later empirical returns, Psychology of Women Quarterly, 4, 377-395.

De Beauvoir S. (1970) The Second Sex, New York: Bantam.

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

Dominy M. D. (1986) Lesbian-Feminist Gender Conceptions: Separatism in Christchurch, New Zealand, Signs, 1(2), Winter, 274-287.

Downey P. G. & Werry J. S. (1980) Psychiatric Care in General Practice. NZ Medical Journal, 87, 305-308.

Dunkle J. H. & Francis P. L. (1990) The Role of Facial Masculinity/Femininity in the Attribution of Homosexuality, Sex Roles, 23, (3/4), 157-167.

Ehrenreich B. & English D. (1973) Complaints and Disorders: The Sexual Politics of Sickness, Old Westbury, New York: The Feminist Press.

Eichenbaum L. & Orbach S. (1983) Understanding Women, Middlesex: Penguin Books.

Ernst S. & Goodison L. (1984) In Our Own Hands: A Book of Self-Help Therapy, London: Women's Press.

Etchegoyen R. H. (1989) The Concept of Perversion in Psychoanalysis, British Journal of Psychiatry, 154 (suppl. 4), 81-83.

Fabrikant B. (1979) The psychotherapist and the female patient. In V. Franks and V. Burtle (Eds) Women in therapy. New York: Brunner/Mazel.

Faunce P. S. (1985) Teaching Feminist Therapies: Integrating Feminist Therapy, Pedagogy & Scholarship, In Handbook of Feminist Therapy - Women's Issues in Psychotherapy, Eds Rosewater L. B. & Walker L. E. A., New York: Springer.

Ferguson A., Zita J. N., & Addelson K. P. (1982) "On Compulsory Heterosexuality and Lesbian Existence": Defining the Issues in Feminist Theory: A Critique of Ideology, (Eds) Keohane N. O. et al, New York: The Harvester Press.

Flaherty J. F., & Dusek J. B. (1980) An investigation of the relationship between psychological androgyny and components of self-concept. Journal of Personality and Social Psychology, 38, 984-999.

Garnets L., Hancock K. A., Cochran S. D., Goodchilds J., & Peplau L. A. Issues in Psychotherapy With Lesbians and Gay Men, A Survey of Psychologists, American Psychologist, 46 (9): 964-972.

Gilbert L. A. (1981) Toward Mental Health: The Benefits of Psychological Androgyny. Professional Psychology,12(1), February, 29-38.

Glasser M. (1977) Homosexuality in adolescence, British Journal of Medical Psychology, 50, 217-225.

Golombok S., Spencer A., & Rutter M. (1983) Children in Lesbian & Single-Parent Households: Psychosexual and Psychiatric Appraisal, Journal of Child Psychology and Psychiatry, 24(4), 551-572.

Gove W. R. (1987) Mental Illness & Psychiatric Treatment Among Women in Walsh M. R. (Ed.) The Psychology of Women: Ongoing Debates, New Haven: Yale University Press.

Grahn J. (1984) Another mother tongue: Gay words, Gay worlds. Boston: Beacon Press.

Green R., Barclay M. J., Hotvedt M. E., Gray J. & Smith L. (1986) Lesbian Mothers and Their Children: A Comparison with Solo Parent Heterosexual Mothers and Their Children, Archives of Sexual Behaviour, 15 (2): 167-183.

Greenspan M. (1985) A New Approach to Women & Therapy, New York: McGraw-Hill.

Haines H. (1986) D For Psychology: Distorts, Devalues, Damns Difference, NZ Women's Studies Journal, August, 2-19.

Haines H. (1987) Mental Health for Women, Auckland: Reed Methuen.

Hansen G. L. (1982) Androgyny, Sex-Role Orientation, and Homosexism, Journal of Psychology, 1 12, 39-45.

Hargreaves, D. J., & Colley, A. M. (1986) The Psychology of Sex Roles, London: Harper & Row.

Harris L. H., & Lucas M. E. (1976) Sex-role stereotyping. Social Work, 21, 390-395.

Hayes K. E., & Wollent P. L. (1978) Effects of sex in judgments of a simulated counseling interview. Journal of Counseling Psychology, 25, 164-168.

Hepburn C. & Gutierrez B. (1988) Alive and Well - A Lesbian Health Guide, California: Crossing Press.

Herek G. M. (1984) Beyond "homophobia": A social psychological perspective on attitudes toward lesbians and gay men. Journal of Homosexuality, 10, (1-2): 1-21.

Herek G. M., Kimmel D. C., Amaro H., & Melton G. B. (1991) Avoiding Heterosexist Bias in Psychological Research, American Psychologist, 46(9):957-963.

Hockey M. (1990) Towards a Feminist Perspective for Counselling Women, Social Work Review, 2(4): 14-20.

Hoeffer B. (1981) Children's Acquisition of Sex-Role Behavior in Lesbian-Mother Families, American Journal of Orthopsychiatry, 5(3): 536-544.

Holland S. (1991) From Private Symptoms to Public Action, Feminism & Psychology, 1(1): 58-62.

Hort B. E., Fagot B. I., & Leinbach M. D. (1990) Are People's Notions of Maleness More Stereotypically Framed Than Their Notions of Femaleness?, Sex Roles, 23(3/4): 197-212.

Horwitz A. V. (1982) The Social Control of Mental Illness, New York: Academic Press.

Howard D. (Ed.) (1986) A Guide to Dynamics of Feminist Therapy, New York: Harrington park.

Janeway E. (1971) Man's World, Woman's Place, New York: Dell.

Johnson M. (1987) Mental Illness & Psychiatric Treatment among Women: A Response, in Walsh M. R. (Ed.) The Psychology of Women: Ongoing Debates, New Haven: Yale University Press.

Jones W., Chernovertz M. E., & Hansson R. O. (1978) The enigma of androgyny: Differential implications for males and females? Journal of Consulting and Clinical Psychology, 46, 298-313.

Jones C., & Mahony P. (Eds.) (1989) Learning Our Lines: Sexuality and Social Control in Education, London: Women's Press

Judd. C. M., Ryan C. S., & Park B. (1991) Accuracy in the Judgment of In-Group and Out-Group Variability, Journal of Personality & Social Psychology, 61(3): 366-379.

Kaplan A. & Sedney M. (1980) Psychology & Sex Roles: An Androgynous Perspective, Boston: Little Brown & Co.

Kaplan M; (1983) A woman's view of DSM-III. American Psychologist, 38, 786-792.

Kimball M. (1975) Women, Sex Role Stereotypes and Mental Health in Smith D. E. & David S. J. (Eds.) Women Look at Psychiatry, Vancouver: Press Gang Publishers.

Kirkpatrick M., Smith C., & Ron R. (1981) Lesbian Mothers and Their Children: A Comparative Survey, American Journal of Orthopsychiatry, 51 (3), July, 545-551.

Kirkpatrick M. (1987) Clinical Implications of Lesbian Mother Studies, Journal of Homosexuality, 14(1-2): 201-211.

Kitzinger C. (1987) The Social Construction of Lesbianism, Bristol U.K.: Sage.

Kitzinger C. (1991) Feminism, Psychology and the Paradox of Power, Feminism & Psychology, 1(1): 111-129.

Kravetz D. F. (1976) Sex-role concepts of women. Journal of Consulting and Clinical Psychology, 44, 437-443.

Krulewitz J. E., & Nash J. E. (1980) Effects of Sex Role Attitudes and Similarity on Men's Rejection of Male Homosexuals, Journal of Personality and Social Psychology, 38(1): 67-74.

Larsen K. S., Reed M., & Hoffman S. (1980) Attitudes of heterosexuals toward homosexuality: A Likert-type scale and construct validity. The Journal of Sex Research, 16 (3): 245-257.

Lee A. G. & Scheurer V. L. (1983) Psychological Androgyny and Aspects of Self Image in Women and Men, Sex Roles 9 (3): 289-306.

Lenskyj H. (1990) On the Treatment of the Sexualities in Research, RFR/DRF 19(3/4): 91-92.

Lipman-Blumen J. (1984) Gender Roles and Power, Englewood, Cliffs: Prentice-Hall.

Locksley A. & Colten M. E. (1979) Psychological Androgyny: A Case of Mistaken Identity? Journal of Personality and Social Psychology , 37(6): 1017-1031.

Lubinski D., Tellegen A. & Butcher J. N. (1981) The Relationship Between Androgyny and Subjective Indicators of Emotional Well-Being, Journal of Personality and Social Psychology, 40(4): 722-730.

Maslin A., & Davis J. L. (1973) Sex-role stereotyping as a factor in mental health standards among counsellors-in-training. Journal of Counseling Psychology, 22, 87-91.

Masters, W. H., & Johnson, V. E. (1979) Homosexuality in Perspective, Boston: Little, Brown & Co.

Matlin M. (1987) Women and Psychiatric Disorders, Chapter 12 of the Psychology of Women, New York: Holt, Rinehart and Winston.

McHugh M. C., Koeske R. D., & Frieze I. H. (1986) Issues to consider in Conducting Nonsexist Psychological Research: A Guide for Researchers. American Psychologist, 41(8): 879-890.

McKinney K. (1987) Age & Gender Differences in College Students' Attitudes Toward Women: A Replication & Extension, Sex Roles, 17(5/6): 353-358.

Mies M. (1983) Towards a Methodology for Feminist Research, in Bowles G. & Klein R. D. (Eds.) Theories of Women's Studies, U.K.: Routledge & Kegan-Paul.

Miles A. (1988) Women and Mental Illness, Brighton U.K.: Wheatsheaf Books.

Miranda J. & Storms M. (1989) Psychological Adjustment of Lesbians and Gay Men, Journal of Counseling & Development, 68, 41-45.

Mischel W. (1986) Introduction to Personality - A New Look, (4th Ed.) New York: CBS.

Morin S. F., & Garfinkle E. M. (1978) Male homophobia. Journal of Social Issues, 34 (1): 29-47.

Morin S. F., & Rothblum E. D. (1991) Removing the Stigma, American Psychologist, 46 (9): 947-949.

Morawski J. G. (1985) The measurement of masculinity and femininity: Engendering categorical realities, Journal of Personality, 53(2): 196-223.

Newman B. S. (1989) The Relative Importance of Gender Role Attitudes to Male and Female Attitudes Toward Lesbians, Sex Roles, 21 (7-8): 451-465.

Nowacki C. M. & Poe C. A. (1973) The concept of mental health as related to sex of person perceived. Journal of Consulting and Clinical Psychology, 40, 160.

Oakley A. (1981) Interviewing Women: a Contradiction in Terms in Roberts H. (Ed.) Doing Feminist Research, U.K.: Routledge & Kegan-Paul.

Oakley A. (1985) Subject Women: a Powerful Analysis of Women's Experience in Society Today, London: Fontana.

Orbach S. & Eichenbaum L. (1988) Bitter Sweet - Love, envy and competition in women's friendships, London: Arrow.

Pedhazur E. J. & Tetenbaum T. J. (1979) Bem Sex Role Inventory: A theoretical and methodological critique. Journal of Personality and Social Psychology, 37, 996-1016.

Perkins R. (1991) Oppression, Inequality and Invisible Lesbians, Feminism & Psychology, 1(3): 427-434.

Perkins R. (1991) Therapy for Lesbians?: The Case Against, Feminism & Psychology, 1(3): 325-338.

Phillips R. D. & Gilroy F. D. (1985) Sex-Role Stereotypes & Clinical Judgments of Mental Health: The Brovermans' Findings Re-examined. Sex Roles, 12(1/2): 1-7.

Plummer K. (1975) Sexual Stigma: an interactionist account, London: Routledge & Kegan Paul.

Poole D. A. & Tapley A. E. (1988) Sex-Roles, Social Roles & Clinical Judgments of Mental Health, Sex Roles, 9(5/6): 265-272.

Reaney P. (1991) Britain's controversial Mental Health Act under challenge, The Press, August 16.

Reinken J, Sparrow M. & Campbell A. J. (1982) The Giving and Taking of Psychotropic Drugs in New Zealand. New Zealand Medical Journal, 95, 489-492.

Rich, A. (1979) On Lies, Secrets and Silence. Selected Prose 1966-78, New York: WW Norton.

Rich A. (1980) Compulsory Heterosexuality and Lesbian Existence, Signs, Summer, 5(41): 631-660.

Robbins J. & Siegel R. (1985) Women Changing Therapy - New Assessments, Values and Strategies in Feminist Therapy, New York: Harrington Park Press.

Rosenkrantz P. S., Vogel S. R., Bee H., Broverman I. & Broverman D. (1968) Sex-role stereotypes in self-concepts in college students. Journal of Consulting and Clinical Psychology, 32, 287-295.

Rosewater L. B. (1985) Feminist interpretation of traditional testing. In L. B. Rosewater and L A Walker (Eds.) Handbook of Feminist Therapy: Women's Issues in Psychotherapy, New York: Springer, 266-273.

Rosewater L. B. (1985) Schizophrenic, Borderline or Battered? In L. B. Rosewater and L. A. Walker (Eds) Handbook of Feminist Therapy: Women's Issues in Psychotherapy, New York: Springer, 215-225.

Ross M. W. (1980) Retrospective distortion in homosexual research. Archives of Sexual Behavior, 9, 523-531.

Rudolph J. (1989) Effects of a Workshop on Mental Health Practitioners' Attitudes Toward Homosexuality and Counseling Effectiveness, Journal of Counseling and Development, 68, 81-85.

Sang B. E. (1989) New Directions in Lesbian Research, Theory and Education, Journal of Counseling and Development, 68, 92-96.

Sayal-Bennett A. (1991) Equal Opportunities - Empty Rhetoric? Feminism & Psychology, 1(1): 74-77.

Scarf M. (1980) Unfinished Business - Pressure Points in the Lives of Women, Glasgow: Fontana.

Schur E. (1984) Producing Female Deviance in Labeling Women Deviant, New York: Random House.

Settin J. M. & Bramel D. (1981) Interaction of Client, Class & Gender in Biasing Clinical Judgment, American Journal of Orthopsychiatry, 51 (3), July 510-520.

Silvern L. E. & Ryan V. L. (1983) A Re-Examination of Masculine and Feminine Sex-Role Ideals and Conflicts Among Ideals for the Man, Woman & Person, Sex Roles, 9(12): 1223-1248.

Small D. (1989) Participatory Research: the Whys and Wherefores in Race, Gender Class, 8, 38-48.

Smith K. T. (1971) Homophobia: A tentative personality profile. Psychological Reports, 29, 1091-1094.

Smith D., Carroll J. L. & Fuller F. B. (1988) Journal of Clinical Psychology, 44(2): 165-174.

Spence J. T. & Helmreich R. L. (1979) The Many Faces of Androgyny: A Reply to Locksley & Colten, Journal of Personality and Social Psychology, 37(6): 1032-1046.

Squire C. (1989) Significant Differences - Feminism in Psychology, London: Routledge.

Storms M. D. (1981) A theory of erotic orientation development. Psychological Review, 88, 340-353.

Sweet G. (1989) The Advantage of Being Useless - The Tao & the Counsellor, Palmerston-North: Dunmore Press.

Taylor M. C. & Hall J. A., (1982) Psychological Androgyny: Theories, Methods and Conclusions, Psychological Bulletin, 92(2): 347-366.

Thomas, C. (1985) The Age of Androgyny: The New views of Psychotherapists, Sex Roles, 3, (7-8): 381-392.

Torrey J. W. (1987) Phases of feminist re-vision in the Psychology of personality. Teaching of Psychology, 14 (3):155-159.

Travis C. B. (1988) Women and Health Psychology - Mental Health Issues, New Jersey: Lawrence Erlbaum.

Ussher J. M. (1991) Clinical Psychology and Sexual Equality: A Contradiction in Terms? Feminism & Psychology, 1(1): 63-68.

Vickers E., Williams J. & Watson G. (1991) Looking Back: Reflections on Clinical Psychology Training, Feminism & Psychology, 1(1): 69-73.

Ward C. (1991) A Cross-cultural Perspective on Theoretical and Methodological Controversies in Psychological Androgyny Research, unpublished paper.

Walsh M. R. (Ed.) (1987) The Psychology of Women: Ongoing Debates, New Haven: Yale University Press.

Wetherell M., & Griffin C. (Eds.) (1991) Feminist Psychology and the Study of Men and Masculinity, Part I: Assumptions and Perspectives, Feminism & Psychology, 1(3): 361-391.

Whitam F. L., & Zent M. (1984) A cross-cultural assessment of early cross-gender behaviour and familial factors in male homosexuality. Archives of Sexual Behavior, 13, 427-439.

Whitley B. E. (1987) The Relationship of Sex-Role Orientation to Heterosexuals' Attitudes Toward Homosexuals, Sex Roles, 17(1/2): 103-113.

Whittlin W. A. (1983) Homosexuality and Child Custody: A Psychiatric Viewpoint, Conciliation Courts Review, 12(1), June.

Widom C. S. (Ed.) (1984) Sex Roles & Psychopathology, New York: Plenum Press.

Williams E. (1977) Notes of a Feminist Therapist, New York: Dell.

Williams J. E. & Best D. L. (1982) Measuring Sex Stereotypes - A 30 Nation Study, California: Sage.

Williams J. & Watson G. (1991) Clinical Psychology Training: Training in Oppression? Feminism & Psychology, 1(1): 55-109.

Williams J. & Watson G. (1991) Oppression, Inequality and Invisible Lesbians: A Reply, Feminism & Psychology, 1(1): 429.

Williams J. & Watson G. (1991) Sexual Inequality and Clinical Psychology Training in Britain: Survey Report, Feminism & Psychology, 1(1): 78-88.

Wilson-Shaef A. (1985) Women's Reality - An Emerging Female System in a White Male Society, San Francisco: Harper & Row.

Wilson-Shaef A. (1987) When Society Becomes An Addict, San Francisco: Harper & Row.

Young I. M. (1985) Humanism, Gynocentrism and Feminist Politics, Women's Studies Int. Forum, 8 (3): 173-183.

Young-Eisendrath P. & Wiedemann F. (1987) Female Authority - Empowering Women Through Psychotherapy, New York: Guilford Press.

Zeldow P. B. (1975) Clinical judgment: A search for sex differences. Psychological Reports, 37, 1135-1142.

Zeldow P. B. (1976) Effects of non-pathological sex-role stereotypes on student evaluations of psychiatric patients. Journal of Consulting and Clinical Psychology, 44, 304.

Zeldow P. B. (1978) Sex differences in psychiatric evaluation and treatment: An empirical review. Archives of General psychiatry, 35, 89-93.

Zeldow P. B. (1984) Sex Roles, Psychological Assessment and Patient Management in Sex Roles and Psychopathology (Ed.) Widom C. S., New York: Plenum.

APPENDIX A

University of Canterbury,
Psychology Department,
Ilam, Christchurch.

To Whom It May Concern

I would value your contribution to my thesis research in the area of clinical appraisal processes. Your responses will be treated in strictest confidence and will be anonymous. Overleaf you will find questions asking for brief information about you. Further to this are the two parts of the study: a case study for you to appraise and answer a few brief questions; and a more general questionnaire.

Please complete all questions in the order in which they are presented and return in the enclosed envelope to me at the address below. Due to my deadlines I would appreciate your prompt reply.

Thank you for your contribution.

Yours faithfully,

Diane Clare
Masters Research Student,
Psychology Department.

Please mail reply to:

APPENDIX B

Brief Information about you

Sex:

Age:

Race: NZ European, Maori, Pacific Island,
Other (please specify).....
(circle your answer)

Qualifications for clinical practice:

Length of time practising (YEARS):

Type of practice (e.g. Private, State
Institution etc.)

Theoretical orientation preferred:
(Please tick)
Psychodynamic
Behavioural
Humanistic
Cognitive
Feminist
Other (please specify):

APPENDIX C (i)
Female heterosexual version

CASE STUDY

Please read the following description then answer the questions which follow overleaf.

Mary has lived in Christchurch for 5 years and is settled in the city with some close relatives living nearby. Mary is 31. She has been suffering from headaches for about 6 months and finds it difficult to get to sleep, often waking early. She does not smoke or take drugs but has the occasional glass of wine. She drinks between 3-5 cups of coffee or tea per day. Her job is demanding but she manages to keep regular 9-5pm hours. Mary has been in a committed relationship with John for 3 years. She enjoys the theatre, reading and gardening and she plays squash. She has been to see her GP about feeling "out of sorts" and not her usual self. She is concerned as she is finding herself confused and irritable regularly which is unusual for her and she finds her moods go up and down. She describes herself as feeling detached from her body, as if she is in a kind of dream. The GP believes she may benefit from a psychological appraisal.

APPENDIX C (ii)
Male heterosexual version

CASE STUDY

Please read the following description then answer the questions which follow overleaf.

Martin has lived in Christchurch for 5 years and is settled in the city with some close relatives living nearby. Martin is 31. He has been suffering from headaches for about 6 months and finds it difficult to get to sleep, often waking early. He does not smoke or take drugs but has the occasional glass of wine. He drinks between 3-5 cups of coffee or tea per day. His job is demanding but he manages to keep regular 9-5pm hours. Martin has been in a committed relationship with Jenny for 3 years. He enjoys the theatre, reading and gardening and he plays squash. He has been to see his GP about feeling "out of sorts" and not his usual self. He is concerned as he is finding himself confused and irritable regularly which is unusual for him and he finds his moods go up and down. He describes himself as feeling detached from his body, as if he is in a kind of dream. The GP believes he may benefit from a psychological appraisal.

APPENDIX C (iii)

Female homosexual version

CASE STUDY

Please read the following description then answer the questions which follow overleaf.

Mary has lived in Christchurch for 5 years and is settled in the city with some close relatives living nearby. Mary is 31. She has been suffering from headaches for about 6 months and finds it difficult to get to sleep, often waking early. She does not smoke or take drugs but has the occasional glass of wine. She drinks between 3-5 cups of coffee or tea per day. Her job is demanding but she manages to keep regular 9-5pm hours. Mary has been in a committed relationship with Jenny for 3 years. She enjoys the theatre, reading and gardening and she plays squash. She has been to see her GP about feeling "out of sorts" and not her usual self. She is concerned as she is finding herself confused and irritable regularly which is unusual for her and she finds her moods go up and down. She describes herself as feeling detached from her body, as if she is in a kind of dream. The GP believes she may benefit from a psychological appraisal.

APPENDIX C (iv)
Male homosexual version

CASE STUDY

Please read the following description then answer the questions which follow overleaf.

Mark has lived in Christchurch for 5 years and is settled in the city with some close relatives living nearby. Mark is 31. He has been suffering from headaches for about 6 months and finds it difficult to get to sleep, often waking early. He does not smoke or take drugs but has the occasional glass of wine. He drinks between 3-5 cups of coffee or tea per day. His job is demanding but he manages to keep regular 9-5pm hours. Mark has been in a committed relationship with James for 3 years. He enjoys the theatre, reading and gardening and he plays squash. He has been to see his GP about feeling "out of sorts" and not his usual self. He is concerned as he is finding himself confused and irritable regularly which is unusual for him and he finds his moods go up and down. He describes himself as feeling detached from his body, as if he is in a kind of dream. The GP believes he may benefit from a psychological appraisal.

APPENDIX D: CASE STUDY QUESTIONS

Questions to explore

Please answer all questions

1. Describe briefly your first impressions of the client from this information (i.e. what is immediately striking for you about this person?)

2. Which information influenced your first impressions?

3. What do you think would be the major issues you would explore in an assessment interview with this client?

4. What hypotheses might you form about this client from this information?

5. Would you explore any disorders in an assessment interview with this client? If so, which?

6. Which personal characteristics would you look for to determine if this client is a healthy, competent person?

APPENDIX E (i)

Questionnaire

Rate the behaviour you would expect of a healthy, competent heterosexual woman. The scale is from 1 to 7 where 1 is not at all descriptive and 7 is extremely descriptive of such a person.

NOT AT ALL EXTREMELY

1----------2----------3----------4----------5----------6----------7

WRITE THE RATING THAT DESCRIBES THIS PERSON BESIDE EACH BEHAVIOUR LISTED.

FOR OFFICE USE ONLY

1. APPRECIATIVE ___
2. AMBITIOUS ___
3. FORGIVING ___
4. ACTIVE ___
5. CONSIDERATE ___
6. GENTLE ___
7. ATTRACTIVE ___
8. COURAGEOUS ___
9. CONFIDENT ___
10. HANDSOME ___
11. CLEARTHINKING ___
12. DETERMINED ___
13. UNDERSTANDING ___
14. ARTISTIC ___
15. KIND ___
16. REALISTIC ___
17. ADVENTUROUS ___
18. INDUSTRIOUS ___
19. SYMPATHETIC ___
20. WARM ___
21. CHARMING ___
22. ENTERPRISING ___
23. PLEASANT ___
24. AFFECTIONATE ___
25. INDEPENDENT ___
26. STRONG ___
27. PEACEABLE ___
28. LOGICAL ___

APPENDIX E (ii)

Questionnaire

Rate the behaviour you would expect of a healthy, competent heterosexual man. The scale is from 1 to 7 where 1 is not at all descriptive and 7 is extremely descriptive of such a person.

NOT AT ALL EXTREMELY

1----------2----------3----------4----------5----------6----------7

WRITE THE RATING THAT DESCRIBES THIS PERSON BESIDE EACH BEHAVIOUR LISTED.

FOR OFFICE USE ONLY

1. APPRECIATIVE ___
2. AMBITIOUS ___
3. FORGIVING ___
4. ACTIVE ___
5. CONSIDERATE ___
6. GENTLE ___
7. ATTRACTIVE ___
8. COURAGEOUS ___
9. CONFIDENT ___
10. HANDSOME ___
11. CLEARTHINKING ___
12. DETERMINED ___
13. UNDERSTANDING ___
14. ARTISTIC ___
15. KIND ___
16. REALISTIC ___
17. ADVENTUROUS ___
18. INDUSTRIOUS ___
19. SYMPATHETIC ___
20. WARM ___
21. CHARMING ___
22. ENTERPRISING ___
23. PLEASANT ___
24. AFFECTIONATE ___
25. INDEPENDENT ___
26. STRONG ___
27. PEACEABLE ___
28. LOGICAL ___

APPENDIX E (iii)

Questionnaire

Rate the behaviour you would expect of a healthy, competent homosexual woman. The scale is from 1 to 7 where 1 is not at all descriptive and 7 is extremely descriptive of such a person.

NOT AT ALL EXTREMELY

1----------2----------3----------4----------5----------6----------7

WRITE THE RATING THAT DESCRIBES THIS PERSON BESIDE EACH BEHAVIOUR LISTED.

FOR OFFICE USE ONLY

1. APPRECIATIVE ___
2. AMBITIOUS ___
3. FORGIVING ___
4. ACTIVE ___
5. CONSIDERATE ___
6. GENTLE ___
7. ATTRACTIVE ___
8. COURAGEOUS ___
9. CONFIDENT ___
10. HANDSOME ___
11. CLEARTHINKING ___
12. DETERMINED ___
13. UNDERSTANDING ___
14. ARTISTIC ___
15. KIND ___
16. REALISTIC ___
17. ADVENTUROUS ___
18. INDUSTRIOUS ___
19. SYMPATHETIC ___
20. WARM ___
21. CHARMING ___
22. ENTERPRISING ___
23. PLEASANT ___
24. AFFECTIONATE ___
25. INDEPENDENT ___
26. STRONG ___
27. PEACEABLE ___
28. LOGICAL ___

APPENDIX E (iv)

Questionnaire

Rate the behaviour you would expect of a healthy, competent homosexual man. The scale is from 1 to 7 where 1 is not at all descriptive and 7 is extremely descriptive of such a person.

NOT AT ALL EXTREMELY

1----------2----------3----------4----------5----------6----------7

WRITE THE RATING THAT DESCRIBES THIS PERSON BESIDE EACH BEHAVIOUR LISTED.

FOR OFFICE USE ONLY

1. APPRECIATIVE ___
2. AMBITIOUS ___
3. FORGIVING ___
4. ACTIVE ___
5. CONSIDERATE ___
6. GENTLE ___
7. ATTRACTIVE ___
8. COURAGEOUS ___
9. CONFIDENT ___
10. HANDSOME ___
11. CLEARTHINKING ___
12. DETERMINED ___
13. UNDERSTANDING ___
14. ARTISTIC ___
15. KIND ___
16. REALISTIC ___
17. ADVENTUROUS ___
18. INDUSTRIOUS ___
19. SYMPATHETIC ___
20. WARM ___
21. CHARMING ___
22. ENTERPRISING ___
23. PLEASANT ___
24. AFFECTIONATE ___
25. INDEPENDENT ___
26. STRONG ___
27. PEACEABLE ___
28. LOGICAL ___

APPENDIX F

28 FEMININE AND MASCULINE ITEMS WITH FAVOURABILITY, M% SCORES (FOR 25 COUNTRIES) AND M% SCORES FOR NEW ZEALAND.

FEMININE ITEMS	FAVOURABILITY	M%SCORE	M%SCORE NZ
1. Affectionate	611	10	08
2. Appreciative	618	26	17
3. Artistic	613	34	31
4. Attractive	620	14	07
5. Charming	610	19	27
6. Considerate	636	35	30
7. Forgiving	632	33	30
8. Gentle	635	21	19
9. Kind	645	29	25
10. Peaceable	630	26	30
12. Sympathetic	603	27	30
13. Understanding	638	33	29
14. Warm	640	27	16
MASCULINE ITEMS			
1. Ambitious	599	82	93
2. Active	629	81	74
3. Adventurous	615	93	96
4. Clearthinking	636	71	76
5. Confident	601	77	85
6. Courageous	608	86	80
7. Determined	603	78	72
8. Enterprising	604	81	79
9. Handsome	606	69	94
10. Independent	612	84	94
11. Industrious	624	60	72
12. Logical	599	79	75
13. Realistic	601	75	74
14. Strong	601	92	72

Favourability Scores
500: relative neutrality
500+: relative favourability
M% Scores
Low M%: female stereotype
High M%: male stereotype

APPENDIX G
NEW ZEALAND DATA (FOCUSED STEREOTYPES)

Male Stereotypes

active
adventurous
aggressive
alert
ambitious
arrogant
assertive
autocratic
boastful
clearthinking
coarse
confident
courageous
cruel
daring
deliberate
determined
disorderly
dominant
easy going
egotistical
energetic
enterprising
forceful
frank
greedy
handsome
hard headed
hard hearted
headstrong
healthy
hostile
humorous
independent
individualistic
industrious
ingenious
initiative
interests wide
inventive
lazy
logical
loud
masculine
noisy
obnoxious
opinionated
opportunistic
outgoing
outspoken
pleasure seeking
progressive
queer
rational
realistic
reasonable
reckless
resourceful
responsible
rigid
robust
rude
self confident
serious
severe
shiftless
show-off
stern
strong
tough
unemotional
unexcitable
unkind
unscrupulous
wise

Female Stereotypes

affected
affectionate
anxious
appreciative
artistic
attractive
changeable
charming
complaining
complicated
confused
considerate
cooperative
dependant
distractable
dreamy
emotional
excitable
faultfinding
fearful
feminine
fickle
flirtatious
foolish
forgiving
frivolous
fussy
gentle
highly strung
imaginative
interests narrow
kind
meek
mild
modest
nagging
nervous
peaceable
pleasant
poised
prudish
rattlebrained
self-denying
sensitive
sentimental
sexy
shy
snobbish
softhearted
submissive
sulky
superstitious
sympathetic
talkative
temperamental
timid
touchy
trusting
unambitious
understanding
unstable
warm
weak
whiny

APPENDIX H

ANOVA Table: Masculine Sub-Scale

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	880.327	3	293.442	2.474	0.066
SPSEX	721.792	1	21.792	6.085	0.015*
SEXOR	77.524	1	77.524	0.654	0.421
SUBSEX	12.763	1	2.763	0.108	0.744
2-Way Interactions	343.050	3	114.350	0.964	0.413
SPSEX SEXOR	185.595	1	185.595	1.565	0.214
SPSEX SUBSEX	46.829	1	46.829	0.395	0.531
SEXOR SUBSEX	190.836	1	190.836	1.609	0.208
3-Way Interactions	189.328	1	189.328	1.596	0.209
SPSEX SEXOR SUBSEX	189.328	1	189.328	1.596	0.209
Explained	1412.705	7	201.815	1.701	0.117
Residual	11980.808	101	118.622		
Total	13393.513	108	124.014		

114 cases were processed
5 cases were missing (4.4%)

*Significant, (p = 0.05)

APPENDIX I

ANOVA Table: Feminine Sub-Scale

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	294.328	3	98.109	0.678	0.568
SPSEX	34.238	1	34.238	0.236	0.628
SEXOR	223.329	1	223.329	1.543	0.217
SUBSEX	0.474	1	0.474	0.003	0.954
2-Way Interactions	773.115	3	257.705	1.780	0.156
SPSEX SEXOR	442.090	1	442.090	3.054	0.084
SPSEX SUBSEX	385.698	1	385.698	2.664	0.106
SEXOR SUBSEX	189.298	1	189.298	1.308	0.256
3-Way Interactions	432.729	1	432.729	2.989	0.087
SPSEX SEXOR SUBSEX	432.729	1	432.729	2.989	0.087
Explained	1500.172	7	214.310	1.480	0.183
Residual	4621.998	101	144.772		
Total	16122.170	108	149.279		

114 cases were processed
5 cases were missing (4.4%)

No significant results

APPENDIX J

ANOVA: Rating Within-Subjects Effect

Source of Variation	SS	DF	MS	F	Sig of F
WITHIN CELLS	4510.60	101	44.66		
RATING	692.49	1	692.49	15.51	0.0001*
SPSEX BY RATING	427.91	1	427.91	9.58	0.003*
SEXOR BY RATING	257.63	1	257.63	5.77	0.018*
SUBSEX BY RATING	7.58	1	7.58	0.17	0.681
SPSEX BY SEXOR BY RATING	29.97	1	29.97	0.67	0.415
SPSEX BY SUBSEX BY RATING	80.30	1	80.30	1.80	0.183
SEXOR BY SUBSEX BY RATING	0.00	1	0.00	0.00	0.994
SPSEX BY SEXOR BY SUBSEX BY RATING	24.80	1	24.80	0.56	0.458

*Significant Results:
Main Effect of Rating
Interaction Effect of SPSEX X RATING
Interaction Effect of SEXOR X RATING

APPENDIX K

ANOVA: Between-Subjects Effects

Source of Variation	SS	DF	MS	F	Sig of F
WITHIN CELLS	22092.20	101	218.73		
SPSEX	326.60	1	326.60	1.49	0.225
SEXOR	41.24	1	41.24	0.19	0.665
SUBSEX	5.39	1	5.39	0.02	0.876
SPSEX BY SEXOR	659.39	1	659.39	3.01	0.086
SPSEX BY SUBSEX	334.94	1	334.94	1.53	0.219
SEXOR BY SUBSEX	378.68	1	378.68	1.73	0.191
SPSEX BY SEXOR BY SUBSEX	597.26	1	597.26	2.73	0.102

No Significant Results

ACKNOWLEDGEMENTS

I would like to thank:

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My supervisor, Dr. Colleen Ward of Canterbury University
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