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Relationship of Counselor Trainees' Gender Role Ideologies on Clinical Judgment with Male Clients

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Clients

Bryce Crapser, MA
University of Connecticut, 2018

Abstract

The purpose of this study is to assess how counselor trainees' gender role conflict, stage of the gender role journey, and emotional stereotype endorsement relates to clinical judgment toward male clients. Participants included counselor trainees enrolled in master's and doctoral level counselor education programs (n=117) recruited via CESNET list serve and email requests. Participants were randomly assigned to receive either a male or female client vignette, identical with the exception for the name and gender pronouns. All participants completed the Gender Role Conflict Scale, Gender Role Journey Measure, and Beliefs About Men's Emotions scale before reading the male or female vignette. Participants then completed the Client Symptoms Severity Scale, Counselor Rating Scale, and Theoretical Domain and Intervention Choice scales. Results indicated that counselor trainees rated male vignette conditions as more severe and chose cognitive interventions more often than with the female vignette. Gender Role Journey Measure phase of Acceptance of Traditional Gender Roles and client vignette emerged as predictors of gender reinforcing counseling interventions, more strongly with male clients. The results provided evidence of counselor trainee gender bias. The limitations of the study and implications are discussed including recommendations for counselor educational and training.

Relationship of Counselor Trainees' Gender Role Ideologies and Clinical Judgment with
Male Clients

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APPROVAL PAGE

Doctor of Philosophy Dissertation

Relationship of Counselor Trainees' Gender Role Ideologies on Clinical Judgment with Male

Clients

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M;klm

‘?’

That was a contribution from my daughter Leah, who at the time of this writing is 10 months old. I hope you grow up in a world a little freer of the restrictive ideologies we have now. I love you!

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CHAPTER I: Introduction

The psychological literature on counseling men has made great progress in the past decade. Research on the prevalence of men's psychological and emotional problems requiring counseling services has been extensive (O'Neil 2015; O'Neil, 2011; O'Neil, 2008; Katz 2006; Cochran, 2005; Kessler & Walters, 2002; Brooks, 2010; Levant, 1998) especially for those men who endorse traditional masculinity (Good, Sherrod, & Dillon, 2000; Hayes & Mahalik, 2000; Kessler & Walters, 2002; Sabo, 2000). Much of the literature also indicates that many men do not receive services to address their problems, often citing resistance to help-seeking as a possible cause (Addis & Mahalik, 2003; Blazina & Watkins, 1996; Mahalik, Good, & Englar-Carlson, 2003; Levant, Wimer, Williams, Smalley, & Noronha, 2009). Recently, literature has emerged to address difficulties associated with help-seeking and other issues related to men in therapy (Addis & Mahalik, 2003; Good & Sherrod, 2001; Good & Mintz, 2005; Rabinowicz & Cochran, 2002). Once men can overcome the barrier of seeking help, they could face other challenges in counseling. Often, research focuses on client factors that contribute to counseling outcomes but therapist factors are overlooked.

Mental health professionals including counselors, social workers, marriage and family therapists, and psychologists need to be aware of the barriers that exist for men, when receiving mental health treatment. Professionals also need to take an active role in identifying and owning their part in contributing to counseling processes that could negatively impact clients. Oftentimes, it seems counselors and other mental health professionals are immune to gender based biases. This immunity; however, is questionable given that therapists bring their own lives and humanity into the counseling room. This identification of biases needs to begin during counselor education to reduce the negative impact on clients.

Statement of the Problem

Practicing counselors and psychologists need to deliver adequate and equitable mental health services according to the ethical codes outlined by both the American Psychological Association (APA) and American Counseling Association (ACA). The ethical codes suggest that counselors need to be aware of how their beliefs and values affect the counseling process. The ACA Ethical code (ACA, 2014) addressing personal values (ACA Code A.4.b) asserts that, “Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants” (p.4). Furthermore, the ACA code addressing nondiscrimination (ACA Code C.5.) states, “Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/ spirituality, gender, gender identity, sexual orientation, marital status/ partnership, language preference, socioeconomic status, or any basis pro-scribed by law. Counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative impact on these persons.” (p. 10)

The APA has established relevant ethical principles that address unfair treatment of clients. APA (2016) Ethical Principle 3.01unfair discrimination states, “In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law” (p. 5). The ethical standards established by the major professional organizations are essential to maintaining the integrity of counseling and psychological services. Counseling and psychological services need to be provided equitably and fairly; so as to not discriminate based on gender, sexual orientation, race, religion, or any other identity variable. The American Psychological Association has specified the importance of providing equitable

psychological services by publishing guidelines specifically addressing psychological practice with girls and women (APA, 2016). While this was an important step in the field, codes specifically addressing men and boys do not currently exist.

Counselor assumptions and stereotypes about clients can bias counselors and therefore produce discriminatory and inadequate services. However, counselors may believe that they are not susceptible to gendered stereotypes within the counseling process (Philpot, Brooks, Lusterman, & Nutt, 1997). Nevertheless, research has demonstrated that counselors in training have different mental health standards for men and women (Seem & Clark, 2006), view men and women as opposites (Trepal, Wester, & Shuler, 2008) and hold more negative stereotypes for men than for women (Feibert & Meyer, 1997). According to Seem and Clark (2006) women's gender role stereotypes have evolved, while male gender role stereotypes have gone unchanged. Moreover, the lack of attention on healthy masculinity has resulted in relatively unchanged male gender stereotypes. Research shows that men desire less gender role conflict in their lives (Liu, Rochlen, & Mohr, 2005). However, much of the psychology of men has focused on the problems associated with male clients (O'Neil, 2008). Often, research focuses on client factors that contribute to counseling outcomes but therapist factors are under-studied.

Counselors need to be aware of how their personal views and beliefs, about gender roles affect clients, so as to mitigate their impact in the counseling processes. Specifically, a counselor's restrictive gender role ideology about men may impact their conduct in counseling sessions (Hayes & Gelso, 2001; Johnson, 2001; Scher 2001). Counseling processes are driven by clinical judgment. A counselor's assessment of symptom severity, treatments, options, and actual interventions can be negatively impacted by gender role stereotypes and counselor gender role conflict, which may result in ineffective counseling services for men. In general, research

investigating clinical outcomes are relatively similar for men and women (Clarkin & Levy, 2004). However, the few times research produced significant findings, outcomes consistently favored female clients (Sue & Lam, 2002). Research is needed to examine the impact of male stereotypes on specific therapeutic processes including therapeutic relationship building, diagnosis, treatment planning, intervention, and termination.

The effects of gender stereotypes on therapy outcomes have been limited (Robertson & Fitzgerald, 1990; Feibert & Meyer, 1997; Vogel, Epting, & Wester, 2003; Seem & Clark, 2006; Trepal, Wester, & Shuler, 2008), and therefore require continued empirical study. Perhaps the most researched area related to therapist stereotypes toward men is therapist's hypo-emotional assumptions of male clients. Hypo-emotionality is defined by Scher (1993) as men "[having] problems with emotions" (pg. 295), having an "inability to express feelings" (Barker & Blackburn, 1992, p. 11), and being "unable to feel emotionally alive" (Brooks & Gilbert, 1995, p. 260). Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, and Goodholm, (1999) conducted six studies which explored therapist assumption of client emotionality. They found that the therapists studied rated women as hyperemotional and men as hypo-emotional. This suggests that counselors may choose interventions that fit emotional stereotypes rather than the needs of the individual client (Wester, Vogel, Pressly, & Heesacker, 2002). In addition, Rencher, (2000) found that counselors used instrumental-focused interventions more with men than with women clients. This instrumental-focus approach could be based on the assumption that males are task-oriented, concrete, and cognitive. Such an assumption could influence therapists to assume men are unemotional which lead to continued avoidance and minimization of affect in therapy. This avoidance can reinforce male restrictive emotionality and increase gender role conflict. Owen, Wong, and Rodolfa (2010) suggest that when working with clients who conform more to

masculine norms, therapists should employ therapeutic approaches that are incongruent with masculine norms, (e.g., warmth and emotional learning). Given the limited research on masculinity and men in therapy, it would be useful to explore the impact that therapist's emotional stereotypes have on men in therapy.

Research has not identified specific counselor characteristics that contribute to biased clinical judgment with male clients. Therapist personal gender-role-ideologies and stereotypes can bias clinical judgment and negatively impact the therapeutic process. A lack of empirical evidence exists documenting the prevalence and effects of male gender bias and no empirically based best practices for providing adequate psychological services with men. This absence could lead to inadequate clinical services for male clients and prevent healthy gender role development.

The purpose of this study is to examine the effects of counselor trainees' gender role ideologies including gender role conflict, gender role journey phases, and emotional stereotype endorsement, and their impact on clinical judgments with male clients. Research on gender bias has primarily addressed bias toward women resulting in APA guidelines for the psychological practice with girls and women but no guidelines exist for boys and men. In addition to a lack of research about gender bias towards men, almost no research has explored the counselor characteristics that predict biased interventions. In order to continue to provide equitable and effective mental health services to men, further research is needed addressing the prevalence and causes of therapists' gender biases against men. Identifying which counselor characteristics contribute to biased intervention with men can lead to targeted educational efforts for counselors in training, and improved clinical services for men.

This dissertation has a prescribed sequence in its presentation. Chapter two presents a critical review of relevant research and theory related to gender bias. The concepts of gender role

restrictiveness from gender role conflict theory (O'Neil, Helms, Gable, David, & Wrightsman, 1986; O'Neil, 1995, 2008, 2015), concepts from gender role journey theory (O'Neil & Egan 1993, O'Neil, 2015), and emotional stereotyping (Heesacker et al., 1999) are reviewed and theoretically linked to gender biases in counseling processes.

Chapter 2 also addresses another issue central to this research, a debate among the gender role researchers regarding the use of gender role complimentary or gender role reinforcing counseling interventions. Gender role complimentary approaches expose clients to coping styles that were not experienced during traditional gender socialization; for example, assertiveness training with women, or increasing emotional intelligence with men (Levant, 1998; Mahalik, Good, & Englar-Carlson, 2003; Ogrodniczuk & John, 2006; O'Neil, 1981). Gender role reinforcing therapeutic techniques align with norms and ideologies typically found within a particular gender socialization; for example drawing on men's value of strength and independence (Heesacker & Prichard, 1992; Robertson & Fitzgerald, 1992; Robertson, Woodford, Lin, Danos, & Hurst, 2001). Relatively little research explores the prevalence of each approach or the counselor gender role characteristics that could influence the clinical decision to use one approach over the other. Theoretical linkages connecting potential counselor gender role ideologies with gender bias and complementary or reinforcing interventions are reviewed.

Chapter three provides a methodological overview of the study, detailing the sample, relevant scale information, research hypotheses, and statistical analyses used in research. Chapter 4 presents the results and the final chapter provides a discussion of the findings with implications for the counselor education and the counseling psychology professions.

CHAPTER II: Review of Literature

This chapter is a critical review of the existing literature and research related to the existence and scope of gender bias toward male clients in counseling. In addition, theoretical links to gender role ideologies that may contribute to gender bias are identified including gender role conflict, gender role journey, and emotional stereotyping. This section provides a rationale and context for the study described, later in chapter three.

Operational Definitions of Gender Bias and Gender Effects in Counseling

Operational definitions of gender biases and effects are needed to conceptualize the research. *Gender effects* include any set of attitudes or behaviors that affect the genders differently, without the implicit or explicit intent of favoritism or discrimination on the part of the counselor (Barak & Fisher, 1989). Betz and Fitzgerald (1987) define a related term, *gender bias* as discriminatory attitudes and beliefs that result in favoring one sex over the other. Furthermore, *gender role bias* is defined as discriminatory attitudes and beliefs that result in preferring sex-congruent behavior and negatively evaluating sex-incongruent behavior (Betz & Fitzgerald, 1987).

More recently, *gender bias* has been defined by the American Psychological Association as, “beliefs, attitudes and/or views that involve stereotypes or preconceived ideas about the roles, abilities and characteristics of women and men...is often modified by and intersects with biases related to race, class, culture, age, ability, and sexual orientation.” (APA, 2007). For the purposes of this research, the term *gender bias* is used to refer to therapist gender role ideologies and gender stereotypes toward clients that result in an observable impact on the therapeutic process.

Bias Against Women

The literature on gender bias has predominantly focused on therapist bias against women. Much of this research culminated in 2007 when the American Psychological Association published guidelines addressing psychological practice with girls and women (APA, 2016). The publication identified biases against women including: (a) diagnosis and labeling (Caplan & Cosgrove, 2004; De Barona & Dutton, 1997; Hartung & Widiger, 1998; Ross, Frances, & Widiger, 1997), (b) underdiagnosis of girls problems because girls are more likely to internalize their distress (Gershon, 2002; Hayward & Sanborn, 2002; Jenkins, Goodness, & Buhrmester, 2002; Quinn, 2005; Seiffge-Krenke & Stemmler, 2002), (c) potential gender sampling biases associated with diagnostic categories (Hartung & Widiger, 1998), (d) more therapist interruptions of female clients compared to male clients (Werner-Wilson, Price, Zimmerman, & Murphy, 1997), (e) higher counselors outcome expectations with male clients, stereotyping women as expressive, and take a more instrumental behavioral approach with men (Fowers, Applegate, Tredinnick, & Slusher, 1996; Klonoff et al., 2000; Rudman & Glick, 2001; Seem & Johnson, 1998) and (f) biased literature from male-only samples generalized to women and girls (APA, 2016). These biases provided a justification for the development of the APA guidelines for women and girls because, "...gender bias has been observed to be more covert but still a detectable and powerful force in psychological practice" (APA, 2016, p. 7). While psychologist and counselor gender bias against women is well-established in the literature, therapist biases against boys and men have been inadequately identified, described and studied.

Research Addressing Bias Toward Men

Research addressing bias against males has elicited mixed results and appears inconclusive. Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) is widely accepted as one of

the most influential and frequently cited studies on the impact of sex bias (Sankis, Corbitt, & Widiger, 1995). Broverman et al. (1970) asserted that mental health was more likely to be associated with masculinity than femininity, thus skewing mental health professionals' clinical judgment toward males as "the norm." Although a seminal work, the results in Broverman et al. (1970) have been disputed with the following claims: (a) findings were the result of an imbalanced ratio of male-valued to female-valued items in the dependent measures (Widiger & Settle, 1987); (b) results reflected a biased instrument, rather than a biased sample (Thorn, 2004); and (c) incorrect statistical analysis of the data (Phillips & Gilroy, 1985). Despite the legitimate criticism, Broverman et al., (1970) continues to be used to empirically support the existence of gender bias (Kelly & Blashfield, 2009).

Fiebert and Meyer (1997) found that undergraduate college students reported significantly more negative stereotypes against men compared to women. Individuals having negative stereotypes of males could easily lead to negative biases toward men and further polarize a counselor's views of male and female clients. Evidence of this polarization has been found in the counselor education field. In a replication of Broverman et al., (1970), Seem and Clark (2006) found that counselors-in-training have different standards for mental health for men and women. These findings indicated that some counselors-in-training have a *gendered* definition of mental health. These predetermined and gendered definitions could translate to gender-specific counseling processes and stereotyped expectations for therapeutic outcomes.

In an analogue study, Seem and Johnson (1998) explored the prevalence of gender bias among counseling trainees. The researchers presented counseling trainees with four case descriptions of male and female clients and asked participants to provide free response questions regarding speculation of underlying psychological issues, clinical issues to explore, and

treatment goals. Using a category derivation procedure (Holsti, 1969), 26 mutually exclusive content categories were produced, then analyzed using chi-square analysis. Results indicated that gender bias continues to exist, especially in cases where traditional gender roles are violated. These findings must be interpreted carefully, as the results had reduced statistical power due to the many chi-square analyses conducted in the study.

Vogel, Epting, and Wester (2003) studied counselors perceptions of female and male clients by reviewing intake reports (n=59) randomly chosen from a university counseling center consisting of female clients (n=37), male clients (n=22), and a third set without identified sex. The review found observed difference in topic emphasis within intake reports. Specifically, female client intakes showed more emphasis on “vulnerability” and “assertiveness” while male client intakes emphasized clients feeling “stuck” and experiencing difficulty with “connection to others.” This study added to the gender bias literature however, no explanatory variables or counselor characteristics were studied and the relatively small sample size (n=59) was a limitation of the study.

In a qualitative study, Trepal, Wester, and Shuler (2008) found that counselors in training (n=29) adhered to traditional stereotypic views of gender. However, in addition to the small sample size, this non-empirical study utilized a Q methodology and therefore, the results cannot be generalized. In addition, this study did not investigate the characteristics of the counselors in training that contributed to their views on gender. Still, these results confirm the findings of existing research about counselor bias (Seem & Clark, 2006).

In another study, Rencher (2000) explored the intervention choices among counseling psychology and clinical psychology doctoral students (n=92). Results indicated that therapists used instrumental-focused interventions more with men than with women clients and viewed

men and women in accordance with gender stereotypes. Assuming that men are hypo-emotional and non-expressive, more task-oriented or instrumental, could influence therapeutic techniques that reinforce problematic masculine norms. These techniques designed to help men could in fact further restrict men's gender expression and solidify hegemonic views of gender role behavior.

More recently, Boyson, Ebersole, Casner, and Coston, (2014) studied gendered mental disorders and relationship to stigma. Researchers presented non-clinical participants (n=242) with brief name and description of a total of 52 disorders in DSM 5. Each participant rated whether the disorder seemed more masculine or feminine. Results indicated that participants found Antisocial Personality Disorder, addictions, and paraphilias to be "more masculine" and histrionic personality disorder, eating disorders, body dysmorphia and orgasmic disorders as "more feminine." A second study with new participants (n= 229) were asked to rate disorders on pity/fear scales, and the results indicated significantly more fear associated with "masculine disorders." In the second study, Boyson and Logan (2017) replicated these findings that traditional masculinity was associated with increased stigma toward mental disorders.

None of the aforementioned studies investigated the factors that contributed to the biases presented. Other studies have investigated contributing counselor characteristics related to counseling biases. For example, Wisch (1998) conducted a study to examine the interaction of male counselor gender role conflict on clinical judgments of male clients. Male therapists completed the Gender Role Conflict Scale (O'Neil, et al., 1986) and were presented with male client case vignettes focused on sexual orientations and levels of emotional expression. Correlational analyses confirmed the interaction of gender role conflict in influencing counselor attitudes towards homosexual male clients. Male therapists with higher GRC were more likely to have a negative view of male homosexual male client vignettes and judged them differently

compared to therapists with low GRC. These findings suggest bias exists due to an interaction between GRC and clinical judgment with homosexual clients. Although an interaction was found, more critical and well-developed male bias studies are needed that address diverse identity variables and therapeutic processes.

Some research has shown a lack of support for therapist bias toward male clients. For example, McClain (1998) surveyed doctoral counseling students and found that self-perceived knowledge of gender issues was not related to ratings of gender bias on a series of counseling vignettes. McClain concluded that the students appeared to be “more sophisticated about gender issues than students in past studies” (pg. iv). These findings are consistent with research by Thomas (1985) who found that male and female therapists do not engage in sexual stereotyping in their views of mental health; and instead hold an androgynous standard. These studies about a lack of counselor bias are in the minority, but may reflect the complexity in studying gender bias and the counseling process.

Few theoretical models exist that identify male biases, and the ones that do are anecdotal. For example, Gilbert and Scher (1999) identified the following biases in a therapeutic relationship: (a) encouraging clients' independence and discouraging emotions in relationships; (b) failing to recognize the costs of equating personal power with sexual power over women; (c) alienating men from their children by associating caring with weakness; (d) encouraging and modeling autonomy, success, and competition; (e) leaving unchallenged the exaggerated importance of male sexual power in terms of personal meaning; and (f) reinforcing homophobia and heterosexism. This list more completely defines male gender bias but the list does not have any empirical support. Additional research is needed to identify specific biases against men and their

impact on therapy. In particular, it is important to focus not only on the clinical impact of gender bias, but the counselor's gender role ideologies that are most associated with the bias.

Summary of Bias Toward Men Research. The effects of gender stereotypes on counseling and therapy have been generally investigated (Robertson & Fitzgerald, 1990; Feibert & Meyer, 1997; Vogel, Epting, & Wester, 2003; Seem & Clark, 2006; Trepal, Wester, & Shuler, 2008), but continued empirical study is needed. In summary, it seems clear that gender bias toward men in therapy is present. Feibert and Meyer (1997) found that undergraduate college students reported significantly more negative stereotypes against men compared to women; counselors-in-training have different standards for mental health for men and women (Seem & Clark, 2006). Furthermore, Trepal, Wester, and Shuler (2008) found that counselors in training adhere to traditional stereotypic views of gender especially in cases where traditional gender roles are violated (Seem & Johnson, 1998). Counselors and college students consistently stereotyped men as hypoemotional including biased counseling-relevant judgments (Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, & Goodholm, 1999). Rencher (2000) found that therapists used instrumental-focused interventions more with men than with women clients and viewed men and women in accordance with gender stereotypes.

Perhaps the most researched area related to therapist stereotypes toward men is therapist's hypoemotional assumptions of male clients. Hypo-emotionality is defined by Scher (1993) as men "[having] problems with emotions" (p. 295), having an "inability to express feelings" (Barker and Blackburn, 1992, p. 11), and "unable to feel emotionally alive" (Brooks & Gilbert, 1995, p. 260). Heesacker et al., (1999) conducted six studies, which explored therapist assumption of client emotionality. They found that the therapists studied tended to rate women as hyperemotional and men hypoemotional. This could suggest that counselors may choose

interventions that fit emotional stereotypes rather than the needs of the individual client (Wester, Vogel, Pressly, & Heesacker, 2002). In addition, Rencher, (2000) found that counselors used instrumental-focused interventions more with men than with women clients. This instrumental-focus approach could be based on the assumption that males are task-oriented, concrete, and cognitive. Such an assumption could influence therapists to assume men are unemotional, leading to avoidance and minimization of affect in therapy. This avoidance can reinforce male restrictive emotionality and maintain or increase gender role conflict. Owen, Wong, and Rodolfa (2010) suggest that when working with clients who conform more to masculine norms, therapists should employ therapeutic approaches that are incongruent with masculine norms, (e.g., warmth and emotional learning). Given the limited research on masculinity and men in therapy, it would be useful to explore the impact that therapist emotional stereotypes have on men and outcomes in therapy.

The few studies that specifically addressed the prevalence and impact of therapist male gender bias (Trepal, Wester, & Shuler, 2008; Wester et al., 2002; Rencher, 2000; Heesacker, et al., 1999; Wisch, 1998) have produced mixed or partial results. Many of the studies reviewed were related to therapist assumptions and clinical judgment; however, the research has not directly identified bias as the area of study. Some studies were vague, tangential, or inconclusive. There is a lack of research and attention given to the existence and clinical impact of stereotypes against men. While the “bias literature” with women is plentiful and has resulted in APA guidelines, research on gender bias toward male clients is needed. More specific research on masculinity constructs could help explore the existence of biased counselor’s attitudes and behaviors.

Counselor Characteristics and Constructs Explaining Biases Against Men

Counselors are trained to provide non-judgmental and equitable mental health services to male and female clients. Even though counselors gain experience and training through years of coursework and supervised clinical placements, counselors bring a variety of human characteristics that can impact the process and outcome of therapy. A counselor's gender role restrictiveness, emotional stereotypes, and challenges with their own gender roles could lead to unfair influences, judgments, and decision making processes in counseling.

Masculine Gender Role Socialization. Men's socialization process and the impact of learned gender roles (O'Neil, 2008; Pleck, 1995) and gender norms (Mahalik, Locke, Ludlow, Diemer, Scott, & Gottfried, 2003) have been studied for decades and provide insights into possible values and assumptions that counselors learn. Western society provides men a constricted constellation of traditional masculinity characteristics. This narrow constellation effectively restricts not only a man's definition of self, but how others view masculinity as well. Masculinity is considered to be socially constructed, (David & Brannon, 1976; Pleck 1981, 1995; Levant, Hirsch, Celentano, Cozza, Hill, MacEachern, Marty, & Schnedeker, 1992; Mahalik et al., 2003) and reflects a societal belief system about gender roles. Violence prevention educator Tony Porter called this "the collective socialization of men" and stated that "men see themselves as separate but they are very much a part of it." (Porter, 2010)

Clinicians need to be aware that men are constantly exposed to role-defining pressures, which restrict individual's self-expression. Harris and Edwards (2010) asserted that men experience external pressures to perform hegemonic masculinity: to be competitive, respected, in control, aggressive, tough, and pursue positions of authority. These pressures could reflect a social belief system of masculinity, which is maintained and perpetrated by institutional and personal systems

of sexism and patriarchy. Societal definitions of traditional masculinity create internalized rules and gender roles, which have been a central focus for the psychological study of men.

Current theoretical models about men can demonize and negatively stereotype both boys and men. The study of male client gender effects presents an important research area for counselor educators and helping professionals. Recent research suggests that societal definitions of acceptable feminine and masculine traits have shifted somewhat in North America (Seem & Clark, 2006), which challenges the currently defined gender norms in psychological literature. As gender roles shift and are redefined, so must the field of counseling and psychology. It is essential for therapists to critically evaluate the impacts that gender has on the therapeutic process and become aware of their own values and assumptions about gender. Wester (2008) asserted that without understanding gender- role attitudes, counselors may have difficulty providing culturally sensitive service to diverse clients. Addis and Cohane (2005) claim that,

Understanding the social context of masculinity (and gender more broadly) is similar to understanding the social context of race and ethnicity. Approaching important questions from only one perspective of difference is a bit like assuming we can only understand one racial, cultural, or ethnic group by comparing it with another. . . . Gender is about much more than sex differences between men and women on interesting dependent variables (p. 635).

While knowledge of men's socialization process is important for working with men in therapy (Mahalik et al., 2003), the balance between understanding and endorsing traditional masculinity must be carefully negotiated. Similar to having counselors possess cultural knowledge (Sue, Sue, & Sue 2003), knowledge related to gender needs to be used to inform but not restrict a clinician's work with their client.

Within the psychology of men, a number of theoretical paradigms have dominated the literature, beginning with David and Brannon (1976), “rules of masculinity” which included: (a) no sissy stuff: Antifemininity, homophobia, avoiding emotions, (b) be a big wheel: achievement, success, focus on competition, (c) be a sturdy oak: Avoid vulnerability, stay composed and in control, toughness, and (d) give em hell: Act aggressively to become dominant (1976). Brannon and David’s initial definitions lead to theories related to traditional definitions of masculinity including: masculine ideology (Thompson & Pleck, 1986), male norms (Mahalik, et al., 2003), gender role conflict and strain (Pleck, 1981; O’Neil, et al., 1986), and masculine scripts (Mahalik, Good, & Englar-Carlson, 2003). A review of research on masculinity can be used to support masculinity theories that could have utility for the purposes of identifying biases.

Gender Role Conflict Theory. One of the most frequently studied construct within the psychology of men is Gender Role Conflict (GRC) (O’Neil, Good, & Holmes, 1995; O’Neil 2008; 2015). GRC is defined by O’Neil et al., (1995) as, “a psychological state in which socialized gender roles have negative consequences for an individual or others. GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self” (O’Neil, Good, & Holmes, 1995). GRC is theorized to present itself on cognitive, affective, behavioral and unconscious levels when one deviates from a gender norm, tries to meet an unrealistic or restrictive gender norm, or experiences dissonance between a norm and one’s authentic self. GRC can be experienced through gender role restrictions, devaluations, and/or violations and occurs in four situational contexts; (a) within the person (intrapersonal), (b) toward others (interpersonal), (c) from others (interpersonal) and (d) during gender role transitions. The outcome of GRC is restrictive humanity; in other words, when individuals attempt to manage, adhere to, or resist socialized gender roles, their authentic humanity is

restricted. GRC is measured using O'Neil et al.'s (1995) Gender Role Conflict Scale (GRCS). GRCS measures men's problems related to their experience with gender roles. O'Neil (1981, 2008, 2015) empirically identified four patterns where men experience GRC, which are summarized below:

1. Conflict Between Work and Family Behavior (CBWFB) relates to problems individuals can experience related to work/school and personal life balance due to restrictive gender roles. O'Neil, et al., (1995) described this pattern as, "experiencing difficulties balancing work-school and family relations, resulting in health problems, overwork, stress, and a lack of leisure and relaxation. (p. 176)
2. Restrictive Affectionate Behavior Between Men (RABBM) describes problems men have expressing feelings with and physically touching other men.
3. Restrictive Emotionality (RE) represents problems identifying, labeling/naming, and expressing or sharing emotions.
4. Success, Power, Competition (SPC) reflects attitudes about achieving success in life through competition and use of power. Specifically, this can include: "persistent worries about personal achievement, competence, failure, status, upward mobility and wealth, and career success, worries about obtaining authority, dominance, influence or ascendancy over others, striving against others to gain. (p.174)

The empirically derived patterns identified in the GRCS indicate possible patterns for biases and could influence therapists' assessment of men.

The GRCS remains among the most widely used and cited scale within the psychology of gender, and has been used in more than 350 studies (O'Neil, 2015). GRC has been correlated with many important mental health topic including thirty three studies on depression, thirty-two

studies on anxiety and stress, twenty studies on low self-esteem, twelve studies on the relationship between GRC and personality, nine studies on body image problems, eight studies on self-destructiveness, hopelessness, suicide, seven studies of shame and guilt, seven studies on substance use, and six studies on alexithymia (See O'Neil, 2015 for a comprehensive review). The research overwhelmingly indicates that higher GRC is positively correlated with men's psychological and health problems.

Much of the GRC research has been completed on undergraduate students and the non-clinical population, with only two studies exploring therapist GRC and the effect on clinical judgment (Hayes, 1985; Wisch & Mahalik, 1999). Results indicated that therapists with high RABBM reported significantly less liking of male clients, less empathy with nontraditional male clients, and more maladjustment for nontraditional male clients (Hayes, 1985). Therapists reporting SPC and RABBM had significantly less liking for, empathy with, and comfort with male clients and were less willing to see clients who were homosexuals, and angry (Wisch & Mahalik, 1999). In addition, therapists with significantly less RABBM were more comfortable seeing a homosexual client and reported better prognosis for him in therapy. In both of these studies, RABBM related to therapists' feelings and thoughts about clients who were nontraditional or homosexual. These studies suggest that training or other educational efforts may be necessary to help some therapists resolve their RABBM and biases about men who deviate from traditional masculinity ideology.

Other theoretical and empirical constructs within the psychology of men support and expand upon the impacts of men's gender socialization. Helping men identify the patterns of GRC can facilitate the process of journeying with one's gender roles. In addition, these constructs can help explore the possible gender role ideologies that contribute to gender bias among clinicians and

counselors in training.

Gender Role Journey. The Gender Role Journey (GRJ) is a metaphor used to explain men and women's gender role development and growth (O'Neil, 2015; O'Neil et al., 1995; O'Neil & Egan, 1992; O'Neil & Roberts Carroll, 1988). The GRJ provides a way to conceptualize an individual's gender role ideology. An individual's gender role journey encompasses their gender socialization, transitions, and gender role integration. The GRJ theory was initially broken into five phases that demonstrate cognitive, affective, and behavioral integration of gender roles over an individual's life span. The five phases were: (1) acceptance of traditional gender roles; (2) ambivalence, (3) anger, (4) Activism, and (5) Celebration and Integration of Gender roles (O'Neil & Egan, 1992b). The five phases were empirically reduced to the following three phases; (1) acceptance of traditional gender roles (ATGR); (2) gender role ambivalence, confusion, anger, and fear (GRACAF); (3) personal and professional activism (PPA) (O'Neil, Egan, Owen, & Murray, 1993). The GRJ model provides a framework for clinicians and clients to conceptualize an individual's gender role ideology and gender role conflict from a developmental perspective.

Empirical Research on the GRJ and GRJ-M. GRJ is measured using the Gender Role Journey Measure (GRJ-M) created by O'Neil et al., (1993) to assist men and women in resolving their GRC and productively facilitate their gender role transitions. The GRJ-M has been studied empirically by a few studies. For men, different phases of the GRJ-M have been significantly correlated with GRC, hypermasculinity, hostility toward women, sexually aggressive experiences, and likelihood of forcing sex (O'Neil et al., 1993). The different phases of the gender role journey with adult women have been significantly correlated with positive and negative affect, depression, religious well-being, and emotional distress (Mock, 1995). The

Gender Role Ambivalence, Confusion, Anger and Fear (GRACAF) subscale of the GRJ-M has been found to be a significant predictor of maladaptive anger management strategies and negative attributions (McDermott, Schwartz, & Trevathan-Minnis, 2012). Other research has found support for the different subscales in terms of various contextual variables (McDermott & Schwartz, 2013). Research has also found that Personal-Professional Activism subscale of the GRJ-M is a predictor of feminist activism (White, 2006), and adaptive anger management strategies (McDermott, et al., 2012).

The gender role journey relates to the present study in that counselor's gender role socialization, gender role transitions, gender role integration, and gender role ideology can influence their clinical judgment with male and female clients. How a clinician constructs their own gender identity could alter their perceptions of clients gender identities.

Male Emotional Expression. Perhaps the most researched area related to therapist stereotypes toward men is therapists' own-hypo-emotional assumption of male clients (Hessacker & Bradley, 1997; Heesacker & Prichard, 1992; Skovholt, 1993; Wilcox & Forrest, 1992). Heesacker et. al., (1999) theorized that therapists tend to rate women as hyper-emotional and men as hypo-emotional. This could suggest that counselors may choose interventions that fit emotional stereotypes rather than the needs of the individual client (Wester et al., 2002). In an analogue study, Rencher, (2000) examined the impact of gender on therapists' interventions with depressed individuals. Respondents reported that they used instrumental focused interventions more with men than with women clients. This instrumental focus could indicate an assumption that males are task-oriented, concrete, and cognitive. Such assumption could lead therapists to assume men are unemotional. Given the limited research on masculinity and men in therapy, therapist's emotional stereotypes about male clients are a critical variable to be studied.

Emotional processes are an integral component to productive therapeutic experiences. According to Heesacker and Bradley (1997), “emotion and emotional related processes lie at the heart of” therapy (p. 201). Greenberg (2012) stresses the importance of emotional activation in therapy in achieving optimally productive therapeutic processes and provides a comprehensive review of research in the affective and cognitive neurosciences regarding the importance of emotions in counseling processes. Specifically, Greenberg outlined six principles for emotional change in therapy: awareness, expression, regulation, reflection, transformation, and corrective emotional experience. These processes are central to effective counseling and can be overlooked, minimized, or avoided if male clients are judged in a biased way to be hypo-emotional or alexithymic (Levant, 1998).

Clinical Judgment: Counselor Reaction, Symptom Severity, and Theoretical Domains

The effects of gender bias with male clients can be observed during the counseling processes within therapy. While many differences exist among counselors theoretical orientation and treatment approaches, all therapists react to clients, assess for symptom severity, and focus on domains of treatment with their clinical work.

One important counselor characteristic related to clinical judgment includes a counselor’s initial reaction and feelings toward their client. Counselors form impressions of their clients within moments after meeting them (Vogel, Epting, & Wester, 2003). These impressions can impact counseling processes in a variety of ways and could include unresolved GRC within the counselor. For example, in one study mental health trainees were found to overestimated sex differences in emotional expression 50 to 67% of the time (Vogel, Wester, Heesacker, Boysen, & Seeman 2006).

Another important clinical task involves the assessment of the severity of a client's symptoms, which can help determine an appropriate level of care, potential prognosis, and possible referrals. Research conducted by Boyson, Ebersole, Casner, and Coston, (2014), found that masculine disorders had higher levels of stigma, that could indicate a counselor's biased assessment. Here, gender bias can present in over or underestimating a client's symptoms due to gender-based assumptions.

Clinical assessment and treatment of clients can be broken into three theoretical domains: thoughts, feelings, and behaviors. These domains represent both areas of evaluation and foci for clinical intervention and are defined below.

Emotion-Focused Interventions. Emotion Focused Interventions (EFIs) can include process-experiential, Emotion-Focused Therapy, Psychodynamic therapy, and other affect-focused approaches. EFIs typically integrate Rogerian person-centered and Gestalt theory and emphasize the importance of the therapeutic relationship, and reflection on aroused emotions to create new meaning. Treatment relies on identification and expression of emotions as the primary vehicle for change (Elliott, Greenberg, Watson, Timulak, & Feire, 2013; Greenberg 2012).

Cognitively-Focused Interventions. These kinds of interventions include Cognitive Therapy (CT), Rational Emotive Behavior Therapy (REBT), Cognitive Behavior Therapy (CBT) and other related cognitively focused approaches. Bergen and Garfield's (Lambert, 2013) handbook of psychotherapy and behavior change defines cognitively focused interventions as a therapeutic approach based on the assumption that thoughts and cognitions play a role in the etiology or maintenance of psychological disorders. Treatment relies on focusing on increasing coping by changing maladaptive beliefs and teaching new information-processing skills. Cognitive

Behavioral intervention focuses on the role that cognition plays on changing feelings and behaviors. (Hollon & Beck, 2013)

Behaviorally-Focused Interventions. These include: Applied Behavior Analysis, Behavioral Activation, Problem-solving Training, Relaxation Training, Modeling, and Functional Behavioral Analysis. Behaviorally focused interventions emphasize learning theory and measurable behaviors as the intervention target. Behaviorally-Focused Interventions often use concrete, structured, task-oriented and practical interventions which prioritize observable behaviors as the focus of both the intervention and desired outcome (Emmelkamp, 2013).

Gendered Approaches to Therapeutic Interventions

Currently, there are two hypotheses for treating male clients on the basis of their endorsement or conformity to masculine norms; the complementary hypothesis and reinforcing hypothesis. The *complementary hypothesis* asserts that counselors should expose clients to coping styles that were not experienced during their restrictive gender socialization (Levant, 1998; Mahalik, Good, & Englar-Carlson, 2003; Ogrodniczuk, 2006; O'Neil, 1981). This could include an emphasis on emotional expression with men or assertiveness training with women. The *reinforcing hypothesis* suggests that counselors align therapeutic techniques with norms and ideologies typically found within a particular gender socialization (Heesacker & Prichard, 1992; Robertson & Fitzgerald, 1992; Robertson et al., 2001). This could include commending men on their strength or supporting women's emotional expression. Owen, Wong, and Rodolfa (2010) suggest that counselors be adaptive when working with clients who conform more to masculine norms. They encourage counselors to balance validation of clients socialized norms with exposure to different norms.

Biases and stereotypes perpetuate restrictive socially defined definitions of gender for both men and women. Clinical judgment, intervention decisions, and outcome expectations can be filtered through biased lenses and can sabotage potential therapeutic productivity. Mental health professionals need to provide productive and ethical services to male and female clients. Men and women often live out their restrictive and confining gender roles. Therefore, within the counseling process critical evaluation and deconstruction of gender roles needs to occur. Research focused on the prevalence of implicit and explicit existence of gender bias with counselors-in-training, new professionals, and experienced mental health professionals is supported by the published literature.

Research has not identified specific gender role ideologies that contribute to biased clinical judgment with male clients. Therapist personal gender-role stereotypes can bias clinical judgment and negatively impact the therapeutic process. There is a lack of empirical evidence documenting the prevalence and effects of male gender bias. Therefore, there are currently no empirically based best practices for providing adequate psychological services with men. This absence could lead to inadequate clinical services with male clients and prevent healthy gender role development.

Current Study

This purpose of this study is to examine counselor trainees' gender role ideologies including GRC, phases of the gender role journey, and emotional stereotyping on clinical judgment of male clients. Clinicians can minimize the importance of men's emotions in counseling by assuming they are hypo-emotional (Heesacker, 1999) or alexithymic (Levant, 1995) which may conflict with the ethical and professional standards set by the ACA and APA. Identifying counselor's

restrictive gender role ideologies that contribute to biased intervention with men can lead to targeted educational efforts for counselors in training, and improve clinical services for men.

This study explores how gender role ideologies and gender-based emotional stereotypes of counselor trainees relate to the assessment of male and female clients (Aspel, Willis, & Faust, 1998). Specifically, this study addresses how counselor's attitudes and beliefs about gender roles (gender role ideologies), and emotional stereotyping (Heesacker, 1999) of men's emotional expression affects clinical judgment, treatment expectations, and intervention choice.

CHAPTER III: Methods

Participants

The participant pool was comprised of male and female master's level counselor trainees enrolled in counselor education, marriage and family therapy, and clinical mental health counseling programs. Emails were sent out to the department chairs of four counselor education programs in the Northeast, and these contacts served as the primary source for obtaining the sample. A listserv post on CESNET-L (a counselor educator listserv) was used to recruit graduate trainees.

A total of 117 participants completed the survey (25 men, 92 women). The mean age of the sample was 28.9 years old, with a range from 22-57 years old. CESNET listserv utilizing Qualtrics survey software yielded 72 participants; 45 participants were obtained through counselor education programs in the Northeast. Eight paper surveys and forty-two electronic surveys were omitted due to incomplete data, with the majority of omitted surveys only having demographic data completed.

Instrumentation and Scales

Men's Gender Role Conflict Scale (GRCS-M). Gender role conflict (GRC) is assessed using the Gender Role Conflict Scale (GRCS) (O'Neil, et al., 1986), which consists of 37 statements concerning men's thoughts and feelings about their gender role behaviors. Respondents report the degree that they agree or disagree with each statement on a 6-point scale ranging from 1 (strongly disagree) to 6 (strongly agree). On the basis of the mathematical average of their responses, respondents receive a mean gender role conflict score. Higher scores indicate more restrictive gender roles and greater GRC.

The GRCS was originally developed using a sample of college men (O'Neil, et al., 1986). Through exploratory factor analysis, four empirically derived factors were identified, which explained 36% of the total variance. Assessment of the scales' reliabilities found internal consistency reliabilities scores ranged from .75 to .85 and test-retest reliability scores ranging from .72-.86 for each subscale. Success, Power, Competition (SPC) subscale is defined as having personal attitudes about achieving success through competition and power. SPC subscale was reported to have a mean factor loading of .5, internal consistency reliability of .85, test-retest reliabilities of .84. Restrictive Emotionality (RE) subscale is defined as having difficulty and fears about expressing one's feelings and difficulty finding words to express basic emotions. The RE subscale has a mean loading factor of .55, internal reliability of .82, test-retest reliability of .76. Restrictive Affectionate Behavior Between Men (RABBM) subscale is defined as having limited ways to express one's feelings and thoughts with other men and difficulty touching other men. The RABBM subscale has a mean loading factor of .60, internal reliability of .83, test-retest reliability of .86. When women take the GRCS, this scale is called the Restrictive Affectionate Behavior Between Women (RABBW), and "other men" terminology is changed to "other women" in the scale items. Conflict Between Work and Family Relations (CBWFB) relates to individuals experiencing difficulties balancing occupational, and/or school and family relations resulting in health problems, overwork, stress, and a lack of leisure and self-care. CBWFB subscale has a mean loading factor of .57, internal reliability of .75, test-retest reliability of .76.

Women's Gender Role Conflict Scale-F (GRCS-F). The GRCS was initially constructed to measure *male* GRC, but women are also significantly influenced by male norms in a patriarchal society. In eleven studies, (Borthwick, et al., 1997; Eicken, 2003; Harishfeger,

1998; Hernandez, 2006; Newman, 1997; Schwartz, Higgins, & He, 2003; Silva, 2002; Zamarippa, Wampold, & Gregory, 2003), women have been given a slightly modified version of the GRCS where the male pronouns have been changed to female. Women reported lower GRC compared to men on three of the four subscales: Restrictive Emotionality, (RE), Success, Power, Competition (SPC), and Restrictive Affectionate Behavior Between Women (RABBW). In six studies, no differences were found in Conflict Between Work and Family Relationships (CBWFR) subscale between men and women. In two other studies, women reported significantly higher CBWFR than men (Eicken, 2003; Schwartz, et al., 2003).

The psychometric evaluation of the GRCS-F showed that the factor structure of the revised scale was similar to the male version (Borthick, Knox, Taylor, & Dietrich, 1997). All the items loaded in the same way as the male version and all exceeded .40 with their factor loadings. Therefore, it is appropriate to utilize the GRCS-F in this study to assess women's gender role conflict. The reliability alpha score for this sample for the GRCS-F was .92 (alpha scores for SPC was .883, RE was .928, RABBW was .913, and CBWFR was .863) and for the GRCS-M, alpha was .97. Further justification for using the GRCS with women is found in Appendix L.

Gender Role Journey Measure (GRJM). Gender role development and growth occurs over the course of an individual's lifetime and can be viewed using the GRJ construct. As discussed in the previous chapter, Gender Role Journey consists of three phases, and an individual's current phase is determined by the 34-item Gender Role Journey Measure (GRJM; O'Neil et al., 1993). The GRJM assesses men's and women's gender role ideology, that is, their endorsement of gender role attitudes and beliefs, ranging from traditional gender roles to more integrated, progressive, and liberated gender role perspectives.

Empirical validation of the GRJM yielded three subscales representing three distinct phases of attitudes and beliefs toward gender role socialization (O’Neil et al., 1993): Acceptance of Traditional Gender Roles (ATGR, 10 items; e.g., “Men should be in charge at work.” [phase 1]); Gender Role Ambivalence, Confusion, Anger, and Fear (GRACAF, 11 items; e.g., I sometimes want to change my gender roles, but I am afraid to” [phase 2, phase 3]); and Personal–Professional Activism (PPA, 13 items; e.g., “I am responsible for changing restrictive gender roles [phase 4, phase 5]”). Items are rated on a 6-point Likert scale ranging from 1 (strongly *disagree*) to 6 (strongly *agree*) and then averaged for each subscale. Higher scores indicate greater identification with attitudes of each phase. O’Neil et al. (1993) reported that androgynous men and women had higher PPA scores as compared with masculine or undifferentiated individuals, and that masculine or undifferentiated men reported the highest levels of ATGR. O’Neil et al. (1993) reported internal consistency estimates Cronbach’s alphas of .87 for ATGR, .76 for GRA, and .89 for PPA. Test–retest reliability of subscale scores have ranged from .53 to .77 (O’Neil et al., 1993). In the current study, the reliability alphas were .94 for ATGR, .67 for GRACAF, and .86 for PPA.

Beliefs About Men’s Emotions Scale (BAME). The (BAME) Scale is an 8–item, measure of the degree to which people endorse emotion–based gender stereotypes. Participants are asked to rate statements about emotionality and gender using the following a likert scale from (1) strongly agree to (6) strongly disagree. Scores range from 8 to 48, and higher scores indicate the presence of stronger gender stereotypes.

The BAME has small–to–moderate correlation with two sub–scales (RABBM $r = .47$; RE $r = .46$) on the Gender Role Conflict Scale (GRCS–I; O’Neil et al., 1986). BAME was found to have adequate test/retest reliability indicating a moderate degree of stability of scores across a 2-week

interval. The Cronbach's alpha for the first administration of the BAME was .73, suggesting that the BAME possesses adequate measurement precision. Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, and Goodholm, (1999) found that the BAME showed good internal consistency, was stable across a 2-week interval ($r = .70$), and reliable across several different participant samples (coefficient $\alpha = 0.71$ and 0.76). The reliability alpha was .85 in this sample surveyed for the current study.

Counselor's Client Rating Scale (CCS). Hayes (1987) developed a six-item scale to assess the extent to which a therapist experiences comfort and liking for a client. The scale utilizes an eleven-point Likert type scale ranging from "extremely uncomfortable" to "extremely comfortable." Internal consistency for the CCS was .78 for this sample. Hayes found the scale to report reliable scores and vary in predictable ways with client behavior, such that counseling trainees with high gender role conflict tended to rate clients who violate gender norms as less likable. An example item is: "How much do you like this client?" Wisch and Mahalik (1999) utilized the same scale with an abbreviated six-point Likert scale and additionally found the scale scores to be both reliable and valid.

Whetstine-Richel (2014) conducted a factor analysis forcing the six items of the CCS onto one factor. All but item 6 loaded onto one factor with adequate factor loadings as outlined by Field (2005), who posited that a factor is reliable if it has four or more item loadings of at least 0.6. Consequentially, item six "How would you rate this client's level of psychological adjustment?" was omitted and the other five items were retained.

Client Symptom Severity Scale. The Client Symptom Severity Scale (CSS-S) was developed for this study to measure how trainees rate the severity of client symptoms. The CSS-S is comprised of six items on a five point Likert-type scale with items such as "How would you

rate this client's level of social, psychological, or occupational impairment?" and "How long would you anticipate client's duration of treatment?" The internal consistency for the CSS-S was .84 for the sample surveyed in the current study.

Theoretical Domain and Intervention Choice (TDIC) An innumerable amount of counseling interventions exist currently, however; this study will focus on three types, organized into emotion, cognitive, and behavioral interventions. These represent three important domains, on which counselors focus to assess, conceptualize, and intervene with their clients. A scale was developed for this study Theoretical Domain and Intervention Choice (TDIC), which can be found in the appendix. The TDIC scale contains 6 items and uses a 5 point likert scale where counseling trainees rate the importance of emotional, cognitive, and behavioral domains and the effectiveness of emotionally, cognitive, and behaviorally focused interventions. The alphas for each scale were .73, emotional, .85 cognitive, and .77 behavioral, indicating good internal consistency. The cognitive and behavioral scales were significantly correlated ($r = .369, p < .01$), however no other significant correlations existed among these three scales.

Procedure

An email was sent out to department chairs and faculty in three CACREP-accredited counselor education programs in the Northeast with an overview of the study, request for their students' participation, and a link to participate in the study. Once students clicked on the link, they read appropriate informed consent documentation and chose whether or not to participate.

This study was implemented by the counselor education faculty who gave specific written instructions and collected informed consent forms. The study was also implemented electronically through the CESNET list-serv. The survey was distributed during the spring and summer semesters 2016. Once the informed consent forms were signed, participants completed

the GRCS, GRJ-M, and BAME then the subjects were randomly assigned to read one of two client vignettes. The vignettes described either a male or female client expressing strong feelings of sadness and loss (both versions can be found in Appendix G). Participants then completed the CCS (5 items) and responded to a series of clinical questions addressing symptom severity, clinical domain, anticipated duration of treatment, medication referral, and intervention choice. The study was piloted in October of 2015 by three pre-licensed master's level counselors who averaged approximately 17 minutes to complete the online version of the study.

Given equal participant groups, each with three independent (GRCS, GRJM, BAME) and three dependent variables (CCS, CSSS, and Theoretical Domain/Intervention Choice), an adequate sample size is needed to bring sufficient power for a multiple regression analysis. Two studies with similar methodologies (Rencher, 2000; Whetstone-Richel, 2014) suggested a minimum sample size of 100 participants. Tabachnick and Fidell (2007) suggest using the equation $50+8(n)$, when using a full regression, which would set a minimum sample of 106 participants. Consultation with an expert research methodologist UConn faculty member yielded a minimum sample of 114 members $58 + 8(n)$, with n =the number of predictors in the statistical model, with a small effect size $f^2=.15$). Therefore, $58 + 8(7) = 114$). To ensure statistical power, the second equation was used given that the minimum is slightly higher ($N=117$).

Variables

Hypothesis testing included the following independent variables: Counselor trainees demographic information (age, sex, school status, theoretical orientation, personal ideology), gender role restrictiveness measured using the Gender Role Conflict Scale (GRCS, O'Neil et al., 1986), views on gender roles and sexism measured by the Gender Role Journey Measure (GRJ-M, O'Neil, et al., 1993) and emotional stereotyping (Beliefs About Men's Emotionality Scale).

The dependent variables include: Counselor reaction to clients (Counselor Rating Scale, Hayes, 1987) Client Symptom Severity Scale (CSS-S, created by author for this study), and Theoretical Domain/Intervention Choice Questionnaire (TD/IC, created by author for this study). Scale reliability coefficients were calculated for all variables and reliability scores were at acceptable levels to conduct meaningful interpretations of the results. See general summary of variables in Table 1, with additional information about the reliability estimates for this sample in Table 2.

Table 1

Summary of Study Variables

Variable	Measure	Variable Type
Summary of Demographic and Control Variables		
Sex, Education Level	Demographic Questionnaire	Categorical
Age	Demographic Questionnaire	Ratio
Theoretical Orientation	Demographic Questionnaire	Interval
Personal Ideology	Demographic Questionnaire	Interval
Summary of Independent Variables		
Gender Role Restrictiveness	Gender Role Conflict Scale	Interval
Gender Role Ideology	Gender Role Journey Measure	Interval
Emotional Stereotype	Belief About Men's Emotions Scale	Interval
Summary of Dependent Variables		
Counselor Reaction to Client	Client Rating Scale	Interval
Client Symptom Severity	Client Symptom Severity Scale	Interval
Intervention Choice	Theoretical Domain/Intervention Choice	Interval, Categorical

Table 2
Summary and Reliability Scores of Independent and Independent Variables

Instrument	Source	Scales	Coefficient alphas for present sample
Beliefs About Men's Emotions (BAME)	Heesacker et al, 1999	BAME (7 items)	.85
Gender Role Conflict Scale (GRC-S)	O'Neil, et al., 1986		.92 (GRCS-F); .97 GRCS-M; .93 Combined
		SPC (13 items)	.90
		RE (10 items)	.93
		RABBM/W (8 items)	.91
Gender Role Journey Scale (GRJ-M)	O'Neil, et al., 1993	CBWFR (6 items)	.89
		ATGR (10 items)	.94
		GRACAF (11 items)	.67
		PPA (13 items)	.86
Client Rating Scale (CCS)	Hayes, 1987	CCS (5 items)	.78
Client Symptom Severity Scale (CSS-S)	Author, 2017	CSS-S (6 items)	.87
Theoretical Domain	Author, 2017	Cognitive (2 items)	.73
		Behavioral (2 items)	.85
		Emotional (2 items)	.77
Intervention Choice	Author, 2017	Cog/Beh, Emot	Categorical scale (no alpha)

Client Vignette Construction and Review

The case vignette portrays a 34-year-old client presenting to an appointment expressing strong feelings of sadness and loss. The vignette describes an individual presenting with depressed mood, excessive guilt, increased substance use, and social isolation following a job loss and end of a significant romantic relationship. The vignette ends describing the client sobbing uncontrollably, and asking the reader, presumably a counselor, for help.

So as to not over-emphasize one type of symptom domain, equal numbers of cognitive, affective, and behavioral symptoms are incorporated into the vignette. A gender-neutral vignette was created; the gender of the individual was not identified, nor were gender pronouns used. This gender neutral vignette was reviewed by four practicing masters and doctoral level mental health professionals. Reviewers assessed the vignette for appropriateness and applicability to clinical settings and accurate portrayal of a client expressing strong emotional reactions to sadness and loss. Questions were also aimed at ensuring: a) the vignette is realistic, a balanced number of cognitive/affective/behavioral symptoms (so as to not weigh one symptom domain more heavily and potentially lead participants to choose interventions or value one domain more heavily), and b) adequate information in the vignette that a person would be able to make a clinical decision about symptom severity and intervention. After each review, feedback was analyzed and minor alterations to the vignette were completed until symptom domain equality, clinical applicability, and adequate information was achieved. After the initial review, a second review was conducted with each male and female vignettes. A new set of six masters level clinicians reviewed each vignette and rated clinical applicability, accuracy, equal number of symptoms, and sufficient information. The vignettes applicability, number of symptoms, and

amount of information was confirmed by consensus of the six mental health trainees, using the review survey. The final case vignette and review survey is found in Appendix G.

Statistical Analyses and Hypotheses

This study focuses on how the gender role ideologies of counselors in training are related to counseling processes and clinical decision making with male and female clients. Specifically, the hypotheses are related to using either reinforcing counseling approaches, congruent with socialized gender roles; or complementary counseling approaches, incongruent with socialized gender roles. Interventions consistent with the *reinforcing hypothesis* would imply with male clients, trainees rate behavior and cognitive domains as more important compared with affective domain, have a higher average of medication referral likelihood, and rate cognitive and behavioral interventions as more effective. With female clients, trainees would rate affective domain as more important and identify affective interventions are more effective. These will be considered the *gender role reinforcing* counseling approach; the counselor trainees would prioritize client domains and chose interventions that align with and reinforce socialized gender roles. Clinical judgment consistent with *complementary* hypotheses would include rating affective domains higher and affective intervention as more likely to be successful with male clients. This is labeled the *gender role complementary* counseling approach.

Multiple linear regression and logistic regression analyses were used to examine the predictive strength of gender role ideologies (measured using GRJ-M), gender role restrictiveness (measured using GRCS), and emotional stereotyping (using the BAME) on counselor rating of liking and having comfort with a client (CCS), counselor assessment of severity (CSS-S), and intervention choice (TD/IC), with male and female clients. SPSS Statistics software was used to complete all statistical analyses.

Means for all variables items on the BAME, CCS, CSS-S and Treatment Domain were obtained. Items on the GRCS (SPC, RE, RABBM, CBWFR) and GRJM (ATGR, GRACAF, PPA) were computed to obtain subscale scores. Also, all continuous variables (BAME, SPC, RE, RABBM, CBWFR, ATGR, GRACAF, PPA, CCR, and CSS-S) were computed into standardized Z-scores, using SPSS, to be used in regression analyses. Dummy codes were created for intervention choice (0=Emotional intervention, 1= Cognitive/Behavioral Intervention), and client vignette (female vignette=0, male vignette =1).

To more effectively analyze the prevalence and relationship of gender role interventions, a new categorical variable was created: Gender role intervention approach, which could be either a gender role complementary or gender role reinforcing intervention choice. A gender role reinforcing intervention occurs when a cognitive/behavioral intervention was chosen for the male client vignette, or an emotional intervention was chosen for the female vignette. A gender role complementary intervention occurs when an emotional intervention was chosen for the male vignette, or a cognitive/behavioral intervention was chosen for the female vignette.

Within the treatment domain scale, two likert scale items were combined into Treatment Domain scales: Cognitive/Behavioral and Affective. Behavioral and cognitive intervention choices were combined for two reasons. First, only four participants chose a behavioral intervention and second, many clinicians do not differentiate between cognitive and behavioral interventions, given the similarities in their clinical processes. In fact, the separation between cognitive and behavioral therapies has been, “rather artificial.” (Emmelkamp, 2013, p. 343) In addition, meta-analyses found behavior therapy to be as effective as cognitive therapy (Cuijpers et al., 2007a; Emmelkamp, 2004; Cucherat & Blackburn, 1998; Longmore & Worrel, 2007).

Hypotheses

Research has demonstrated that higher GRC (indicating more restrictive gender roles, O'Neil, et al.1986) is associated with lower CCS scores (indicating less liking of clients, Hayes, 1985). Higher BAME scores (indicating stereotypic beliefs about men and women's emotional expression,) plays a role in influencing an individual's judgment (Heesacker et al., 1999). Also, early phases of GRJ-M (ATGR and GRACAF) indicate more traditional attitudes and beliefs about gender roles, or confusion and fear about gender roles (O'Neil et al., 1993).

Fiebert and Meyer (1997) found that undergraduate college students reported significantly more negative stereotypes against men compared to women, which could suggest that counselor trainees would rate men as more severe compared with women. These gender role ideology factors (GRC, GRJ, and BAME) were predicted to impact gender based decision making processes of counselor trainees (CCS, CSS-S, and TD/IC). The following hypotheses were tested:

Hypothesis 1:

Counselor trainees randomized into the male client condition will choose different ratings of symptom importance/effectiveness and intervention choices, compared to the female vignette. Counselor trainees randomized into the male client vignette condition will rate cognitive and behavioral symptoms significantly higher compared to participants in the female condition. To test this hypothesis, a t-test analysis was used to compare cognitive and behavioral ratings between male and female client vignette conditions. Counselor trainees randomized into the male client vignette condition will choose cognitive/behavioral interventions significantly more as compared to participants in the female client condition. To test this hypothesis, a non-parametric

chi-square analysis was used to determine whether intervention choice differs significantly as a function of group membership (male/female client vignette).

Hypothesis 2:

Counselor trainee GRC will have a positive relationship with gender reinforcing counseling approaches with male clients. Higher GRC, indicating more restrictive gender roles, will have a positive relationship with symptom severity and gender role reinforcing interventions. A logistic regression analysis was used to test this hypothesis.

Theoretically, RE is related to restricted capacity for emotional expression (O'Neil, 2008) and therefore would purportedly correlate negatively with emotional intervention choices with men and women. Therefore, it was hypothesized that higher RE scores predict the use of cognitive and behavioral interventions in both conditions, however, more so in the male vignette.

Hypothesis 3:

It was hypothesized that higher BAME scores, indicating stronger endorsement of emotional gender stereotypes, predict a positive relationship with gender role reinforcing interventions with the male and female vignette; however more strongly with the male vignette. Research by Heesacker, et al., (1999) indicated that higher BAME scores were related to beliefs that male clients tend to be hypoemotional, and female clients hyperemotional. This research hypothesis suggested that higher BAME scores would translate to emotional interventions with the female vignette and cognitive/behavioral intervention choices with the male vignette. A multiple regression analysis with interactions was conducted to examine the predictive power of BAME and vignette gender on intervention choice, and symptom severity.

Hypothesis 4:

Theoretically there should be a connection between GRJ and clinical judgment, although no such research exists. GRJ measures an individual's beliefs, attitudes, and experience with gender roles, from traditional through progressive ideology. It seems likely that one's GRJ would be related to their opinions and judgment toward male and female clients. Developmental phase on the GRJ-M was hypothesized to predict significant differences in clinical judgment of symptom severity. A multiple regression analysis was used to test this hypothesis. It was hypothesized that GRJ-M of phase 1 or 2 (ATGR or GRACAF) would predict gender role reinforcing intervention choices (cognitive and behavioral with male clients, emotional with female client vignettes) and higher severity ratings in male vignette. Phase 3 of GRJ-M (PPA, indicating more progressive gender role beliefs, O'Neil et al., 1993) will predict gender role complimentary intervention choices and lower severity ratings in the male and female vignette.

Hypothesis 5:

Higher GRC and BAME scores will be negatively related to CCS, indicating more restrictive gender roles and emotional stereotype endorsement will be correlated with lower ratings of both male and female client vignettes. This hypothesis can expand the findings of Wisch and Mahalik (1999) who found higher GRC scores are negatively correlated with CCS. A multiple regression analysis with interaction was used to test this hypothesis. GRC and BAME relationship will be more strongly negatively related to CCS in the male vignette than in the female vignette.

Hypothesis 6:

Lower CCS scores, indicating negative counselor reactions to clients, and higher CSS-S scores, indicating more severe symptom ratings, were hypothesized to predict gender role reinforcing counseling approaches with male and female client vignettes. A multiple regression

analysis was used to test this hypothesis. Lower CCS scores was posited to predict gender role reinforcing counseling more strongly for the male vignette compared to the female vignette; male vignette.

Hypothesis 7:

The final hypothesis examined the relationships between the three independent variables and subscales (GRC, BAME, and GRJM) and the three dependent variables (CCS, CSS-S, and TD/IC). Based on the literature reviewed in Chapter 2, it was hypothesized that higher GRC scores, higher BAME scores, and higher ATGR or GRACAF scores, would predict lower CCS scores, higher symptom severity (CSS-S) ratings, and cognitive/behavioral clinical judgment moderated by the gender of the client vignette. Three multiple regression analyses were used to test this hypothesis. All independent variables were entered in simultaneously and significant predictors were identified, and non-significant variables were dropped. A final trimmed model was used to identify significant predictors of the three outcome variables.

CHAPTER IV: Results

This chapter presents the results of the study, describes the statistical analyses, and findings. The correlational data is first reported followed by the results for each hypothesis presented in chapter three.

Hypothesis Testing

Zero-order correlations were calculated for all variables to assess the strength of the relationship. Means and standard deviations were also computed for all variables. Descriptive and correlational results from the data sets are displayed in Table 3. Effect size magnitude was computed using R^2 and interpreted using method suggested by Cohen (1992). Results indicated a number of significant correlations ($p < .01$). The Gender Role Journey Measure (GRJM) phases correlated with both dependent and independent variables. Attitudes Toward Traditional gender Roles (ATGR) was positively correlated with three of the Gender Role Conflict Scale (GRCS) subscales (Restrictive Emotions (RE), Restrictive Affectionate Behavior Between Men (RABBM) and Conflict Between Work and Family Relations (CBWFR), and negatively correlated with Counselor Rating Scale (CCS), Emotional Theoretical Domain (TxDomEmot), and Behavioral Treatment Domain (TxDomBeh). GRACAF was positively correlated with three GRCS subscales (RE, RABBM, and CBWFR) and negatively correlated with Behavioral Theoretical Domain. PPAC, the third GRJ-M phase was negatively correlated with Behavioral Theoretical Domain and three GRCS subscales (RE, RABBM, CBWFR). GRCS was not significantly correlated with any of the dependent variables, with the exception of a negative correlation with Behavioral Theoretical Domain.

Table 3

Pearson's Correlations, Means, and Standard Deviations of Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	M	SD
1. BAME	-	.536**	.178	-.394**	.128	-.298**	.218*	.380**	.192*	-.160	.073	-.102	-.152	-.205*	3.57	.82
2. ATGR		-	.224*	-.636**	.482**	-.198*	.615**	.700**	.374**	-.271**	-.050	-.193*	-.259**	-.517**	2.17	1.12
3. GRACAF			-	-.019	.424**	.093	.367**	.506**	.300**	-.016	-.232*	.046	-.100	-.264**	2.45	.58
4. PPA				-	-.319**	.021	-.339**	-.403**	-.245**	.270**	-.072	.126	.215*	.274**	3.59	.79
5. GRCS					-	.558**	.838**	.745**	.718**	-.116	-.068	-.001	-.176	-.305**	3.15	.74
6. SPC						-	.137	.049	.222*	.044	.039	.109	.008	.172	3.28	.90
7. RE							-	.713**	.550**	-.194*	-.073	-.089	-.271**	-.467**	2.94	1.17
8. RABBM								-	.472**	-.116	-.121	-.059	-.187*	-.372**	2.34	1.03
9. CBWFR									-	-.067	-.068	.033	-.029	-.272**	4.33	1.11
10. CCS										-	-.158	-.170	.508**	.069	8.05	1.35
11. CSSS											-	.274**	-.053	.324**	3.05	.65
12. TxDomCog												-	-.134	.369**	4.36	.58
13. TxDomEmot													-	.162	4.21	.72
14. TxDomBeh														-	3.62	.90

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed)

* Note: BAME = Beliefs About Men's Emotions, ATGR = Acceptance of Traditional Gender Roles, GRACAF = Gender Role Ambivalence, Confusion, Anger, and Fear, PPA = Personal and Professional Activism, GRCS = Gender Role Conflict Scale, SPC=Success, Power, Competition, RE = Restrictive Emotionality, RABBM = Restrictive Affectionate Behavior Between Men/Women, CBWFR = Conflict Between Work and Family Relationships, CCS = Client Rating Scale, CSSS = Client Symptom Severity Scale, TxDomCog = Cognitive theoretical domain, TxDomEmot = Emotional theoretical domain, TxDomBeh = Behavioral theoretical domain

Table 4

Means, and Standard Deviations of Independent Variables by Vignette

	Male Vignette (N=57)		Female Vignette (N=60)	
	M	SD	M	SD
BAME	3.6	.76	3.54	.87
ATGR	2.24	.56	2.11	1.13
GRACAF	2.42	.56	2.49	.60
PPA	3.44	.69	3.73	.87
GRCS	3.18	.77	3.12	.71
SPC	3.31	.95	3.25	.86
RE	3.01	1.16	2.86	1.18
RABBM	2.37	1.08	2.31	1.00
CBWFR	4.28	1.05	4.37	1.17

* Note: BAME = Beliefs About Men's Emotions, ATGR = Acceptance of Traditional Gender Roles, GRACAF = Gender Role Ambivalence, Confusion, Anger, and Fear, PPA = Personal and Professional Activism, GRCS = Gender Role Conflict Scale, SPC=Success, Power, Competition, RE = Restrictive Emotionality, RABBM = Restrictive Affectionate Behavior Between Men/Women, CBWFR = Conflict Between Work and Family Relationships

Hypothesis One: Significant Differences in Symptom Severity, Counselor Rating, Theoretical Domain and Intervention Choice

The first hypothesis tested the main effects of the dependent variables for the study. Specifically, whether Counselor Rating (CCS), Symptom Severity (CSS-S), and Theoretical Domain/Intervention Choice (TD/IC) scores differed significantly between male and female vignette condition was calculated using t-tests. CSS-S scores differed significantly with the male vignette (M=3.18, SD = .65) receiving higher CSS-S scores compared to the female vignette (M=2.93, SD=.64); $t(115)=-2.1$, $p=.037$, $d=.389$ indicating statistically significant higher symptom severity ratings.

The results also indicated that although the female vignette received higher CCS scores (M=8.28, SD=1.18), compared to the male vignette (M=7.8, SD=1.47), $t(115)=1.96$, $p=.052$, $d=.359$ the difference was not statistically significant. Results of these differences are found on Table 5.

Emotional treatment domain rating differed significantly with higher importance and effectiveness scores in female vignette (M=4.38, SD =.64) compared to the male vignette (M= 4.04 SD=.78), $t(115) =2.533$, $p=.013$, $d=.473$. No statistically significant differences were found between cognitive and behavioral treatment domain rating, supporting the decision to combine these two domains. Counselor trainees were hypothesized to rate cognitive and behavioral theoretical domain importance and intervention effectiveness at significantly higher levels compared to participants in the female client condition. To test this hypothesis, t-test analyses compared cognitive and behavioral ratings between the male and female vignette groups. Results indicated no statistical differences in counselor trainee ratings of cognitive treatment domain with the male vignette (M= 4.45, SD=.506), compared to the female vignette condition (M=4.275, SD=.627), $t(115) = -1.631$, $p= .106$, $d= .316$. Results indicated that emotional treatment domain was lower in the male vignette

($M=4.04$, $SD=.775$) compared to the female vignette ($M=4.375$, $SD=.635$), $t(115) = 2.53$, $p = .013$, $d=.473$.

Table 5
Mean Differences in Outcome Variables

Variable	Male Vignette		Female Vignette		t	sig	Cohen's d
	M	SD	M	SD			
CCS	7.80	1.468	8.28	1.188	1.96	.052	.359
CSSS	3.18	.647	2.93	.638	-2.11	.037	.389
IntChoice	1.19	.398	1.40	.494	2.501	.014	.468
TxDomain Cog	4.45	.506	4.27	.627	-1.631	.106	.316
TxDomain Emot	4.04	.775	4.375	.635	2.53	.013	.473
TxDomain Beh	3.68	.869	3.558	.935	-.753	.452	.135

*Note: CCS = client rating scale, CSSS = Symptom Severity Scale, IntChoice = Intervention Choice, and TxDomain = Cognitive, Emotional, and Behavioral Theoretical Domains

Counselor trainees were hypothesized to choose cognitive and behavioral interventions more often with male vignettes. In the male vignette condition, participants chose 46 cognitive/behavioral interventions compared to 11 emotional interventions. Participants in the female vignette condition chose cognitive/behavioral interventions 36 times compared to 24 emotional interventions.

Considering that intervention choice is categorical data, to test this hypothesis, a chi-square test for independence was conducted. Results indicated statistically significant differences of intervention choices, between male and female vignette groups $\chi^2(N=117) = 5.975$, $p = .014$. These results replicate findings by Rencher (2000), that counselors in training choose instrumental interventions

statistically significantly more with male clients compared to female clients. Relevant data for this hypothesis is displayed in Table 6 and Figure 1.

Table 6

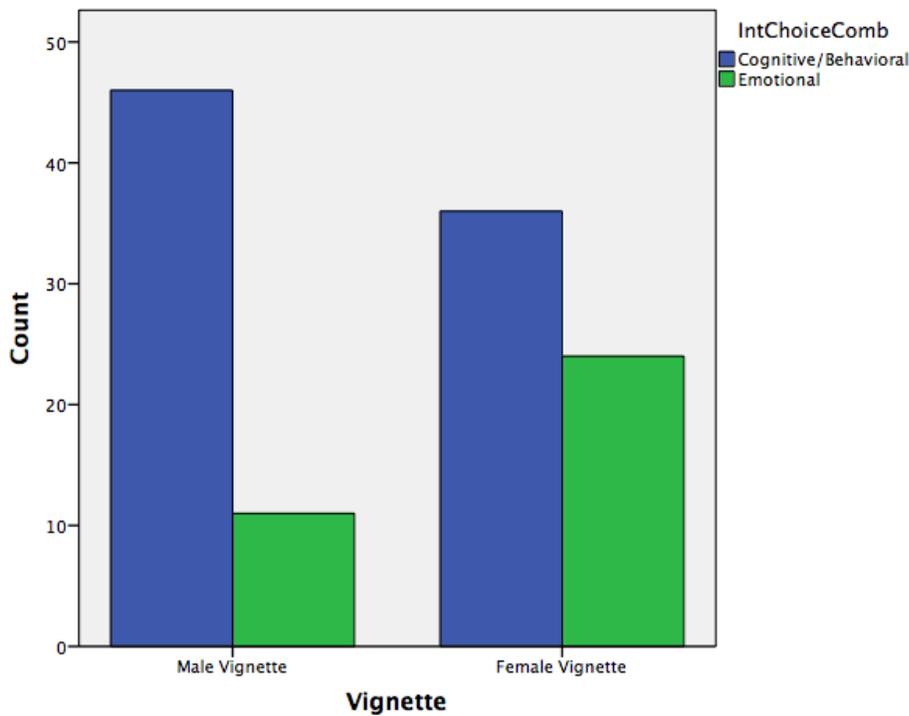
Intervention Choices with Male and Female Vignette

Intervention	Female Vignette	Male Vignette	Total
Cognitive/Behavioral	36	46	82
Emotional	24	11	35
Total	60	57	117

**Client vignette group differences significant at the $p = .014$ level

Figure 1

Male and Female Vignette Intervention Choices



Gender Reinforcing Intervention Predicting GRC, BAME, GRJ

Before testing the remaining hypotheses investigating the relationships of GRC, BAME, and GRJ on the outcome variables CCR, CSS-S, and TD/IC, it may be useful to explore whether Gender Role Reinforcing Intervention would predict GRC, BAME, and GRJ scores. A t-test for independent samples was used to test whether Gender Role Reinforcing Intervention relates to scores on the GRCS, BAME, and GRJ-M. Results indicated that BAME ($p=.007$ level), ATGR ($p < .001$ level), PPA ($p = .032$), and RABBM ($p = .01$) scores differed significantly between counselor trainees who choose reinforcing interventions compared to complimentary interventions. These results suggest that Gender Role Reinforcing Intervention choice significantly relates to scores on the BAME, two GRJ-M subscales (ATGR and PPA), and one GRC-S subscale (RABBM). Results for this analysis are displayed on Table 7.

Table 7
Gender Role Reinforcing Intervention as a Predictor of BAME, GRJ, and GRC

Dependent Variable	Mean Square	F	Sig.
BAME	4.807	7.611	.007
ATGR	15.496	13.718	.000
GRACAF	.125	.365	.547
PPA	2.894	4.690	.032
SPC	1.390	1.720	.192
RE	4.184	3.118	.080
RABBM	6.938	6.818	.010
CBWFR	.001	.001	.977

*Independent Variable: GR Reinforcing Intervention

* Note: BAME = Beliefs About Men's Emotions, ATGR = Acceptance of Traditional Gender Roles, GRACAF = Gender Role Ambivalence, Confusion, Anger, and Fear, PPA = Personal and Professional Activism, GRCS = Gender Role Conflict Scale, SPC=Success, Power, Competition, RE = Restrictive Emotionality, RABBM = Restrictive Affectionate Behavior Between Men/Women, CBWFR = Conflict Between Work/Family Relationships

Hypothesis Two: GRC and Gender Role Intervention

The second hypothesis tested whether counselor trainee GRC would predict gender reinforcing counseling approaches with male clients. Descriptive data for this hypothesis is displayed on Table 8. Counselor trainees appeared far more likely to choose reinforcing interventions with the male vignette, which was confirmed by a chi-squared analysis of independence $\chi^2(N=117) = 20.148, p < .001$.

Table 8

Gender Role Intervention Choices by Client Vignette

Gender Role Intervention	Female Vignette	Male Vignette	Total
Complementary	36	11	47
Reinforcing	24	46	70
Total	60	57	117

To test this hypothesis, all GRCS subscales (RE, RABBM, SPC, and CBWFR) and a dummy variable coded for vignette type, were regressed into Gender Role Intervention using a logistic regression analysis with interaction. One GRC subscale, RE was of particular interest. Higher RE scores were hypothesized to predict the use of cognitive and behavioral interventions in both conditions, however, more strongly with the male vignette. However, RE was not found to be a statistically significant predictor of the gender reinforcing interventions with the male client vignette. The regression was run again without client vignette variable (as this was used to create the gender role intervention variable), and RABBM ($p=.051$) emerged just outside of the acceptable limit for statistical significance. When client vignette was included in the regression, RABBM ($p=.029$) and the client vignette type ($p < .001$) emerged as significant positive predictors of gender

role reinforcing intervention for the male client vignette. The results of these analyses are displayed in Table 9 and Table 10.

Table 9

Gender Role Conflict as a Predictor of Gender Role Reinforcing Intervention

Variable					
	B	S.E.	Wald	Sig.	Exp(B)
SPC	-.276	.229	1.461	.227	.759
RE	.137	.254	.290	.590	1.147
RABBM	.551	.282	3.824	.051	1.734
CBWFR	-.260	.223	1.364	.243	.771
Constant	.438	.199	4.845	.028	1.550

Model Summary		
	Cox & Snell R Square	Nagelkerke R Square
-2 Log likelihood		
147.139	.086	.116

* Note: SPC=Success, Power, Competition, RE = Restrictive Emotionality, RABBM = Restrictive Affectionate Behavior Between Men/Women, CBWFR = Conflict Between Work and Family Relationships

Table 10

Gender Role Conflict and Client Vignette Predictors of Gender Role Reinforcing Intervention

Variable	B	S.E.	Wald	Sig.	Exp(B)
SPC	-.365	.262	1.943	.163	.694
RE	.039	.286	.018	.893	1.039
RABBM	.706	.323	4.786	.029	2.025
CBWFR	-.218	.256	.727	.394	.804
Male Vignette	2.006	.464	18.721	.000	7.436
Constant	-.439	.283	2.404	.121	.645

Model Summary			
	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
	125.175	.242	.327

* Note: SPC = Success, Power, Competition, RE = Restrictive Emotionality, RABBM = Restrictive Affectionate Behavior Between Men/Women, CBWFR = Conflict Between Work/Family Relationships

Hypothesis Three: BAME and Gender Role Reinforcing Intervention

The third hypothesis tested whether higher BAME scores, indicating stronger endorsement of emotional gender stereotypes, had a positive relationship with gender role reinforcing interventions for both the male and female vignette conditions.

A logistic regression analysis with interactions was conducted to examine the predictive power of BAME and vignette gender on intervention choice. Given that client vignette variable was used to create the gender role intervention choice variable, two regressions were conducted to isolate BAME as a possible predictor. Each computation resulted with BAME as a significant predictor of gender role reinforcing intervention choice, however both pseudo-R square indicators Cox & Snell

R square and Nagelkerke R square scores indicated a weak relationship of 29.5% between BAME, Client Vignette, and Gender Role Intervention. Results for the second logistic regression indicate an even weaker relationship of 8% suggesting that much of the variance may be accounted for by Client Vignette, which shares variance with Gender Role Intervention. Results for this hypothesis are displayed on Tables 11 and 12.

Table 11

Emotional Stereotype as Predictor of Gender Role Reinforcing Intervention

Variable	B	S.E.	Wald	Sig.	Exp(B)
BAME	.655	.250	6.845	.009	1.925
Constant	.423	.195	4.692	.030	1.527

Model Summary

-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
150.229	.061	.08

*Note: BAME = Beliefs About Men's Emotions

Table 12

Emotional Stereotype and Client Vignette as Predictors of Gender Role Intervention Choice

Variable	B	S.E.	Wald	Sig.	Exp(B)
Male Vignette	1.929	.448	18.501	.000	6.882
BAME	.744	.280	7.050	.008	2.104
Constant	-.425	.276	2.372	.124	.654

Model Summary

-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
128.860	.218	.295

*Note: BAME = Beliefs About Men's Emotions

Hypothesis Four: Gender Role Journey and Symptom Severity

The fourth hypothesis posited that the developmental phase on the GRJ-M significant differences in clinical judgment of symptom severity (CSS-S). A multiple regression analysis was used to test this hypothesis. GRJ-M of phase 1 or 2 (ATGR, GRACAF) was hypothesized to predict higher severity (CSS-S) ratings in male vignette. The male vignette received significantly higher CSS-S scores, GRAFAC emerged as the only predictor for CSS-S (.041 level), as a negative predictor. Higher GRAFAC scores were related to lower CSS-S scores; an opposite finding to the initial hypothesis. Phase 3 of the GRJ-M (PPAC) was hypothesized to predict lower severity ratings in the male and female vignette. These relationships were not significantly correlated nor did they emerge from the regression analysis therefore, this hypothesis was not supported. The results can be found on Tables 13 and 14.

Table 13

GRJ-M Predictors of Client Symptom Severity

Variable	B	SE B	Beta	t	Sig		
Constant	.003	.059		.057	.954		
ATGR	-.049	.072	-.085	-.689	.492		
GRACAF	-.241	.106	-.216	-2.277	.025		
PPA	-.107	.098	-.130	-1.090	.278		
R	.252	Adjusted R2	.039	R2	.064	F Change	2.563*

**Note: ATGR = Acceptance of Traditional Gender Roles, GRACAF = Gender Role Ambivalence, Confusion, Anger, and Fear, PPA = Personal and Professional Activism.

*p ≤ .058, Dependent Variable: Client Symptom Severity

Table 14

Statistically Significant Predictors of Client Symptom Severity

Variable	B	SE B	Beta	t	Sig		
Constant	-.110	.081		-1.358	.177		
GRACAF	-.248	.100	-.222	-2.472	.015		
Male Vignette	.234	.117	.180	2.009	.047		
R	.294	Adjusted R2	.07	R2	.086	F Change	4.036*

*Note: GRACAF = Gender Role Ambivalence, Confusion, Anger, and Fear

* $p \leq .05$, ** $p \leq .01$; Dependent Variable: Client Symptom Severity

Hypothesis Five: GRC, BAME as Predictors for Client Rating

The fifth hypothesis examined whether higher GRC and BAME scores were negatively related to CCS, indicating more restrictive gender roles and emotional stereotype endorsement will be correlated with lower ratings of both male and female client vignettes. A multiple regression analysis with interaction was used to test this hypothesis. Neither GRC nor BAME emerged as significant predictors of CCS, however RE had a significance of .08, also not statistically significant. The overall model was not significant (F change of .120 and an Adjusted R2 score of .036) and therefore, this hypothesis was not supported. None of the predictors (GRC, BAME, or Client Vignette) alone or in combination predicted CCS. The results for this hypothesis are found in table 15.

Table 15

BAME and GRC as Predictors of Client Rating

Variable	B	SE B	Beta	t	Sig
Constant	.208	.172		1.212	.228
BAME	-.224	.175	-.136	-1.370	.173
SPC	.045	.150	.030	-.301	.764
RE	-.285	.161	-.247	-1.767	.080
RABBM	.127	.181	.97	.703	.484
CBWFR	.044	.138	.036	.316	.753
Client Vignette	-.432	.247	-.161	-1.750	.083
R	.294	Adjusted R2	.036		
R2	.086	F Change	1.32343*		

* Note: BAME = Beliefs About Men's Emotions, SPC=Success, Power, Competition, RE = Restrictive Emotionality, RABBM = Restrictive Affectionate Behavior Between Men/Women, CBWFR = Conflict Between Work and Family Relationships

*Note: Sig at .120 level

Hypothesis Six - CCS and Gender Role Intervention

The sixth hypothesis tested whether lower CCS scores, indicating negative counselor reactions to clients, would predict gender role reinforcing counseling approaches with male and female client vignettes. A logistic regression analysis was used to test this hypothesis but CCS did not emerge as a significant predictor of Gender Role Intervention. Results for this hypothesis can be found in Table 16.

Table 16

CCS as a Predictor of Gender Role Reinforcing Intervention

Variable	B	S.E.	Wald	Sig.	Exp(B)
CCS	-.015	.141	.011	.916	.985
Constant	.398	.189	4.462	.035	1.489

Model Summary			
	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
	150.229	.061	.08

*Note: CCS = Client Rating Scale

Hypothesis Seven - Final Prediction Model

Logistic regression analyses were used to develop a model for predicting counselor in training's tendency to choose gender role reinforcing interventions from their GRJ phase and randomly assigned vignette. RE, SPC, RABBM, CBWFR, BAME, ATGR, and GRACAF were regressed onto the dichotomous variable, gender role intervention using a logistic regression procedure. All predictors were entered simultaneously into the equation, and then only statistically significant predictors were used to create a trimmed regression equation. The first phase of the GRJ-M, ATGR and vignette type emerged as predictors for gender role reinforcing interventions (cognitive/behavioral interventions with male vignette condition, emotional interventions with female vignette condition).

Results indicated that ATGR (the first phase of the GRJ-M) and Client Vignette were the two variables with significance, as was the interaction of Client Vignette and ATGR. Client Vignette and ATGR were then entered into regression equation with the dependent variables (CCS), and they showed significance. Basic descriptive statistics and regression coefficients are shown in Table 15.

Each of the predictor variables had a significant ($p < .01$) zero-order correlation with Gender Role Intervention but only the ATGR and Client Vignette predictors had significant ($p < .05$) partial effects in the full model. This suggests that gender of the client vignette alone, predicted gender role reinforcing interventions. Table 17 display regression results from the initial analysis.

Statistically significant predictors in the final trimmed prediction model are found in Table 18.

Table 17

Hypothesized Predictors of Gender Role Reinforcing Intervention

Variables	B	S.E.	Wald	Sig	Exp(B)
BAME	.277	.339	.664	.415	1.139
ATGR	.709	.381	3.468	.063	2.032
GRACAF	.123	.447	.076	.783	1.131
SPC	-.099	.283	.121	.728	.906
RE	-.109	.305	.128	.721	.897
RABBM	.272	.391	.484	.487	1.313
CBWFR	-.294	.258	1.296	.255	.746
Male Vignette	2.036	.475	18.099	.000	7.661
Constant	-.392	.299	1.717	.190	.676

Model Summary

-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
118.724	.283	.382

* Note: BAME = Beliefs About Men's Emotions, ATGR = Acceptance of Traditional Gender Roles, GRACAF = Gender Role Ambivalence, Confusion, Anger, and Fear, PPA = Personal and Professional Activism, GRCS = Gender Role Conflict Scale, SPC=Success, Power, Competition, RE = Restrictive Emotionality, RABBM = Restrictive Affectionate Behavior Between Men/Women, CBWFR = Conflict Between Work and Family Relationships

Table 18

Statistically Significant Predictors of Gender Role Reinforcing Interventions

Variable	B	S.E.	Wald	Sig	Exp(B)
ATGR	.826	.235	10.66	.001	2.283
Male Vignette	1.935	.456	18.335	.00	7.047
Constant	-.356	.291	1.501	.221	.700

--2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
122.381	.261	.352

*Note: ATGR = Acceptance of Traditional Gender Roles.

Counselor Trainee Outcome Comparisons by Gender

Given that this study examined the relationship of gender variables (role ideology, gender role conflict), it would make sense to consider the gender differences between counselor trainees. The sample had 97 female counselor trainees and 25 male counselor trainees, so comparisons were not equal, but nonetheless important to consider. Results from these analyses showed that male counselor trainees had no significant differences in outcome measures. Female counselor trainees reported significantly higher client rating scores (CCS) in the female vignette ($M=8.244$, $SD=19.1$) compared to the male vignette ($M=7.685$, $SD=1.413$) $p=.045$, $d=.330$. Female counselor trainees also reported significantly higher symptom severity scores (CSS-S) in the male vignette ($M=3.241$, $SD=.631$) compared to the female vignette ($M=2.911$, $SD=.6129$), $p=.013$, $d=.5306$. Female counselor trainees reported significantly higher ratings of effectiveness and usefulness in cognitive theoretical domain scores in the male vignette ($M=4.521$, $SD=.786$) compared to the female vignette ($M=4.2778$, $SD=.5988$), $p=.037$, $d=.441$ and lower ratings of effectiveness and usefulness

in emotional theoretical domain scores in the male vignette ($M=4.02$, $SD=.7868$) compared to the female vignette ($M=4.355$, $SD=.636$), $p=.028$, $d=.467$. Results for this analysis can be found in Tables 19 and 20.

Table 19

Male Counselor Trainee Mean Differences in Outcome Variables

Variable	Male Vignette		Female Vignette		t	sig	Cohen's d
	M	SD	M	SD			
CCS	8.34	1.56	8.4	1.211	-.103	.920	.043
CSSS	2.90	.681	2.988	.730	-.306	.759	.124
TxDomain Cog	4.10	.394	4.27	.627	-.738	.468	.324
TxDomain Emot	4.15	.7472	4.433	.651	-1.005	.325	.404
TxDomain Beh	3.65	.883	3.533	1.043	.301	.767	.121

**Note: CCS = client rating scale, CSSS = Symptom Severity Scale, IntChoice = Intervention Choice, and TxDomain = Cognitive, Emotional, and Behavioral Theoretical Domains

Table 20

Female Counselor Trainee Mean Differences in Outcome Variables

Variable	Male Vignette		Female Vignette		t	sig	Cohen's d
	M	SD	M	SD			
CCS	7.685	1.438	8.244	1.915	-2.026	.045	.330
CSSS	3.241	.631	2.911	.6129	2.543	.013	.5306
TxDomain Cog	4.521	.786	4.2778	.598	2.122	.037	.441
TxDomain Emot	4.02	.786	4.355	.636	-2.235	.027	.467
TxDomain Beh	3.69	.8757	3.566	.908	.671	.504	.1398

*Note: CCS = client rating scale, CSSS = Symptom Severity Scale, and TxDomain = Cognitive, Emotional, and Behavioral Theoretical Domains

Counselor trainees also showed differences in intervention choices with male and female client vignettes. To explore this, a Chi-square test for independence was conducted for male and female counselor trainees. Results indicated that female counseling trainees chose significantly different interventions between male and female client vignettes $\chi^2 (N=97) = 4.096, p = .043$. Male counselor trainees did not choose significantly different interventions between male and female client vignettes $\chi^2 (N=25)=1.326, p=.250$, with results are displayed on Figures 2 and 3.

Figure 2

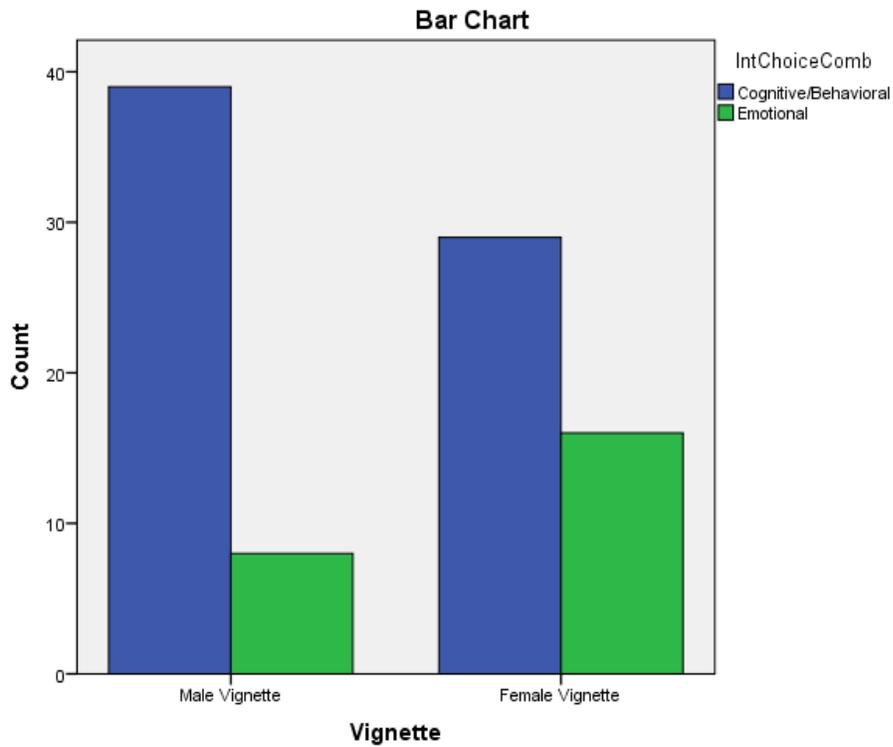
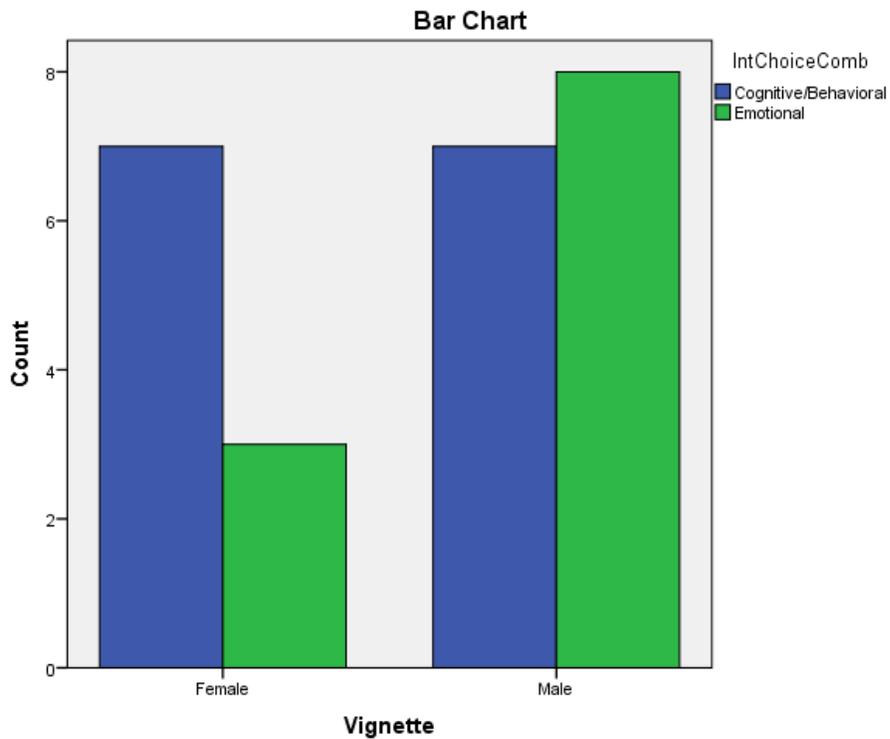
Female Counselor Trainee Intervention Choice

Figure 3

Male Counselor Trainee Intervention Choice

CHAPTER V: Discussion, Limitations, and Conclusions

The goal of this research was to assess whether counselor trainees express gender bias, or approaches that reinforce or challenge traditional gender roles. Counselor trainees assessed two therapy vignettes on male and female clients with identical presenting problems. Bias was defined as liking or not liking the client, being comfortable or uncomfortable with the client, and symptom severity that implies assessing various degrees of psychological, emotional, and behavioral problems. Bias was also defined as choosing a theoretical approach (cognitive-behavioral or emotional) based on sex of the client. Choosing a cognitive-behavioral intervention for a male client over an emotional approach was assumed to be a sign of gender effects and could suggest gender bias and was supported by research (Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, & Goodholm, 1999; Rencher, 2000).

Some of these criteria for bias were labeled theoretically as reinforcing or complementary approaches to the therapy process. These approaches imply that some gender role ideologies and therapy processes could reinforce restrictive gender roles with clients and others could be complementary by challenging the stereotypes and using non stereotypic therapeutic processes.

The trainees' gender role ideology was defined by the three phases of the gender role journey including phase 1: accepting traditional gender roles (ATGR), phase 2: gender role ambivalence, confusion, anger, and fear (GRACAF), and phase 3: personal and professional activism (PPA). Gender role conflict (GRC) was defined as a psychological state where restrictive gender roles have negative consequences on self or others and included four patterns: success, power, and competition (SPC), restrictive emotionality (RE), restrictive affectionate behavior between men (RABBM), and conflict between work and family relations (CBWFR). Emotion-based stereotyping was defined as the degree that trainees endorsed emotion-based gender stereotypes in their assessment of the two

clinical vignettes. The sex of the client vignette was one way to determine whether trainees assessed the male and female clients differentially.

Overall, the research assessed whether gender role ideology using the phases of the gender role journey, patterns of gender role conflict, emotion-based stereotyping, and the sex of the client vignettes would differentially affect the clinical appraisal of the male and female clients and indicate gender effects or gender bias. In the following sections, the results are discussed by reviewing the study's hypotheses and the overall question of whether there was bias or clinical prejudice in how the trainees evaluated the two therapy vignettes.

Correlational Analysis

The first question with the correlational data was whether GRC patterns significantly related to trainees' gender role ideology defined by the three phases of the gender role journey. A second question addressed whether any phase of the gender role journey for the trainees predicted potential bias or prejudice in assessment. The final question assessed whether any pattern of GRC, GRJ phase, or BAME scores significantly related to attitudes toward the client vignettes for symptom severity and choice of theoretical approach in therapy.

For the first question, results indicated that counselor trainees' phase of the gender role journey and patterns of GRC were significantly related. Those trainees who had higher scores in Phase 1 (Acceptance of Traditional Gender Roles) reported significantly higher levels of RE, RABBM, and CBWFR. Also, trainees with higher scores in Personal and Professional Activism phase of the gender role journey were not significantly related to the GRC patterns of RE, RABBM, and CBWFR.

The correlational data also indicates that trainees with higher Phase 2 scores (Gender Role Ambivalence, Anger, Confusion, and Fear) were significantly related to discomfort-dislike with the male client vignette and negative attitudes towards both emotional and behavioral theoretical

approaches. Furthermore, none of the GRC patterns correlated in any way with liking-comfort with the client, symptom severity and choice of theoretical approach with the exception of the behavioral approach option.

These results provide new information about those trainees in all three phases of the gender role journey. The results suggest that trainees' gender role ideology is related to patterns of GRC that have been empirically related to psychological effects for both men and women (O'Neil, 2008, 2015). Trainees who report higher GRC, specifically RE, RABBM, and CBWFR also endorsed a gender role ideology of accepting traditional gender roles (ATGR). This finding raises questions about whether trainees' GRC and endorsement of traditional gender roles negatively affecting trainees' biased assessment and therapy processes. Furthermore, counseling trainees with higher GRACAF scores (GRJ Phase 2) reported significantly lower symptom severity scores overall. Based on these results, the trainees in the ambivalent phase of the gender role journey may be more vulnerable to under estimate symptom severity because of their emotional ambivalence, anger, fear, and/or confusion with their gender role ideology. These findings have implications for counselor training and support the inclusion of a graduate curriculum that focuses on consciousness raising and exploration of on gender role ideologies and GRC during counselor training.

The results that the patterns of GRC did not significantly relate to trainees' liking/comfort with a client, symptom severity, or treatment choice raises numerous questions. The lack of relationship suggests that with this sample of trainees, GRC is unrelated to potentially biased assessment of the client vignettes. One possible explanation for this lack of significance could be that counselor trainees endorse less restrictive gender role ideology than other normative groups ("Normative Data on Diverse Men" O'Neil, 2017) and this more limited GRC may affect their appraisal of clients overall. Additional research on GRC in counselor trainees and the relationship between GRC and counselor clinical assessment would be useful.

Discussion of Hypotheses and Regression Analyses

Two additional findings provide additional support for documenting potential gender bias when comparing trainees' assessment of the two clinical vignettes for each sex. The t-tests used to test hypothesis one indicated that trainees rating scores of client likeability, willingness to work with them, and ability to empathize did not differ significantly between male and female vignette conditions. However, counselor trainees reported significantly higher symptom severity (CSS-S) scores when assessing the male vignette condition, despite having identical clinical information in the female condition. These results indicate that counselor trainees evaluated female clients to have less severe symptoms, compared to identical male clients. Furthermore, counselor trainees rated emotional theoretical domain as significantly more important and effective with the female vignette compared to the male vignette.

The results related to hypothesis two suggest that trainees report different theoretical approaches choices when assessing the male versus the female clients. The differences in choice of theoretical intervention combined with symptom severity findings raise concerns about whether bias may exist with the trainees. In other words, counselor trainees are more likely to assess male clients as having more severe problems. Trainees who also use interventions can reinforce restrictive gender roles by choosing cognitive and behavioral interventions over emotional interventions with male clients. If counselor trainees responded equally to the male and female vignette, similar levels of symptom severity and more equal intervention choices would be expected. Therefore, this result indicates that counselor trainees use different clinical assessment processes with male compared to female clients.

Hypotheses 2 and 3 focused on whether the trainees endorsed reinforcing versus complementary approaches when assessing the vignettes. Results indicated that trainees with restrictions in expressing one feelings and thoughts with others and difficulty touching others of the same sex (RABBM) endorsed gender role reinforcing approaches rather than complementary approaches.

Furthermore, trainees with high emotional stereotyping reported they were more likely to use reinforcing approaches compared to complementary approaches.

These findings suggest that those trainees with restrictive affectionate behavior with either men or women (RABBM) and who endorse emotional stereotyping are more likely to reinforce traditional masculine norms with clients rather than challenge those norms with more non-traditional or complementary, non-stereotypic approaches. Counselor trainees who have restrictive affectionate behavior with same sex individuals are more likely to endorse more traditional gender norms with clients. Complementary approaches to counseling may require a more progressive and open-minded approach with clients, as they typically go contrary to socialized gender role ideology. This more liberal approach may be difficult for counselors in training with more restrictive gender roles. The endorsement of emotionally based stereotyping as a reinforcing approach to clients makes sense because emotion based stereotyping is part of masculine traditional gender role ideology of society. Therefore, these results provide evidence that RABBM contributes to potential gender bias with counselors in training.

For hypothesis 4, the relationship between trainees' phase of the gender role journey and their assessment of the male and female client's symptom severity was tested. Counselor trainees with higher phase 2 scores (Gender Role Ambivalence, Fear, Anger, and Confusion) reported lower symptom severity. These results make sense because counselor trainees with greater gender role ambivalence, anger, and confusion could be vulnerable to dismiss, minimize or under-estimate an individual's symptom severity. This means a counselor trainee's unstable gender role ideology may negatively affect an important counseling process.

The relationship between the GRC patterns, emotional stereotyping, and comfort and liking the client was assessed with Hypothesis 5. Results indicated that GRC patterns and emotional stereotyping did not predict greater comfort and liking of the client in either vignette. The

correlational data did not support this hypothesis, given that comfort and liking of the client was not significantly correlated with BAME for almost all GRCS patterns. A significant negative correlation was found with RE and CCS suggesting that individuals with high restrictive emotionality have lower CCS. This finding makes sense since liking and ability to relate to a client requires an emotional experience, and individuals with high restrictive emotionality would find such a process difficult.

The results of hypothesis six indicated that trainees' comfort-liking scores did not have any significant relationship to the reinforcing counseling approaches. This suggests that client liking did not appear to relate to or influence a counselor trainees counseling decision-making regarding intervention choice. This finding is positive in that it suggests counselor liking of a client may not relate to differences in clinical judgment between male and female clients.

Somewhat less evidence was found related to the counselor trainees' gender role ideology contributing to the observed differences in symptom severity, and treatment choice but there were some positive results. ATGR and vignette type emerged as predictors for gender role reinforcing interventions. Past theory has suggested that individuals who report higher traditional attitudes towards gender roles have more stereotypic gender role attitudes and beliefs (O'Neil et al., 1993). This may support a counselor's decision to use clinical interventions that reinforce a client's gender role socialization. This could reflect a clinical bias within the field and combined with the fact that women seek help more than men, be a significant problem for effective service delivery.

The results also indicated some surprising findings. For example, Personal and Professional Activism, (PPA) indicating more progressive gender role ideology was not predictive of gender role complementary interventions. One possible explanation for this finding could be having more progressive gender role ideology, like being a feminist, may stimulate a wider range of interventions. Exploring the empirical relationship between gender role journey and counseling

processes could provide additional insights into this relationship. Surprisingly, neither GRC nor BAME accounted for any significant variance in client ratings, symptom severity, or intervention choice. This suggests that some other variables may contribute to the differences found in these clinical judgment areas. The most consistent and strongest predictor of gender role reinforcing intervention choices was the client vignette. This suggests that a client's gender is the most significant predictor of the clinical judgments identified in this study. Gender plays an important role in clinical decision making, and can influence counseling decisions, even when client symptoms are identical. This suggests that when considering clinical judgment with clients, counselor trainees need to be aware of the potential impact of client gender on their assessment and intervention choices.

An interesting set of findings related to the gender of counselor trainees was the difference in outcome variables. Female counselor trainees rated male and female clients differently in almost every outcome variable measured. With female counselor trainees, the male vignette condition received higher symptom severity scores, lower client rating scores, and were more likely to choose cognitive/behavioral interventions compared to the female vignette. This finding could suggest that counselor trainee gender may play a role in clinical judgment, and may warrant further study.

The purpose of this study was to investigate whether gender bias exists among counselor trainees and what counselor trainee gender role ideology traits predict gender bias. Overall results indicate three findings that provide evidence for gender bias in the counseling assessment process, and two findings that identify predictors of gender bias. First, t-test analyses indicated significant differences between assessment measures with male clients receiving significantly higher symptom severity ratings. Chi-squared analyses confirmed that male client vignette also received significantly more cognitive/behavior intervention choices than the female client vignette. Chi-squared analysis also confirmed significantly more gender role reinforcing interventions were chosen for the male

vignette, compared to the female vignette. In addition, regression analysis showed that restrictive affectionate behavior between same sex individuals predicted reinforcing gender role interventions with male clients. Regression analysis also showed that higher scores in traditional acceptance of gender roles for counselor trainees predicted gender role reinforcing interventions, more strongly with the male client vignette.

The results of this study suggest that counselors in training assess male clients' symptom severity, theoretical domain, and intervention choice significantly differently than female client vignettes, and more often through gender role reinforcing counseling approaches. Endorsement of traditional gender role ideology and restrictive affectionate behavior between same sex individuals predicted gender role reinforcing interventions more strongly with the male client vignette. These results provides evidence for gender bias and suggests that counselors in training are more willing to reinforce male client gender role norms, possibly contributing to sexism in the counseling room. These findings are of particular interest to the counselor education profession and other mental health trainees working hard to practice without bias or stereotypic judgments. The limitations, implications of this study and possible future directions for research are discussed in the next section.

Limitations, Conclusion, and Future Directions

This study examined counselor trainees' gender role ideology (emotional stereotyping, gender role journey phases, and patterns of gender role conflict) that could contribute to gender bias with male clients. The purpose of this section is to present the limitations and conclusions of the study and future directions for counselor education, training, and research.

There are numerous limitations to the research that need to be addressed. These limitations include the use of self-report measures, unequal gender composition in the sample, use of a convenience sample, generalizability issues, and difficulties researching the complex process of

counseling. First, this study used self-report measures that are vulnerable to social desirability. Participants may have reported what they perceive to be more favorable counselor characteristics like being non-judgmental, warm and empathic, accepting of gender roles to look good. The trainees may have reported lower GRC or BAME than they actually possess. On the other hand, counselor trainees may possess lower GRC or emotional stereotypes; the type of person who enters into helping professions may inherently have more progressive and less restrictive gender role ideologies. This could be an area for further study. In addition, the vignette review was conducted by master's level counselors and counseling trainees who could have themselves been biased, however this was not assessed.

This study surveyed both male and female counselors in training that could have threatened the homogeneity assumption necessary for many of the regression computations completed. Comparing male and female counseling trainees, ad-hoc analyses showed no significant statistical differences in the means of almost every scale between male and female trainees. The two exceptions were the mean scores of one GRCS subscale; male counseling trainees had significantly lower CBWFR compared to female trainees. Male counselors and other helping professionals may be less likely to endorse restrictive traditional masculine norms. The total number of male counselor trainees (n=25 or 21% of the sample population) may be a limitation, however, the gender breakdown among the sample, accurately reflects the gender proportions in the counselor education field.

The sample was a convenience sample, from small counselor-education programs in the northeast. This calls into question the representativeness of the sample, and therefore potential difficulty to generalizing the findings to the general population of counselors-in training. To address this potential limitation, counselor-education list-serves were used to populate the sample and reduce the likelihood of a biased sample. Still, non-responders may somehow have been

systematically different from responders, for example, responders may have been more interested in the topic of the study than non-responders.

Another limitation to the study is the dependability and generalizability of the counseling assessment process studied. In other words, do the measures and the vignettes used have adequate reliability and validity and are they generalizable real therapy practice. Furthermore, although scores on the GRCS-F have shown adequate reliability and validity with three factor analyses of the GRCS-F having been completed. Nonetheless, there are still significant questions about the face/content validity of the male items of the GRCS-F for women. Limited research has been completed on whether the item meanings of the GRCS-F are the same for men women. The major limitation to using the GRCS-F is a lack of research on the face/content validity of the items for women and whether the male patterns of GRC patterns mean exactly the same for women compared to men. Future research should pursue these validity issues to better understand whether GRC patterns of men and women are the same or different constructs. Qualitative research and focus groups with women of all ages and races could determine the content/face validity of the GRCS-F. Additional information about using GRCS with women can be found in Appendix L.

Furthermore, as with most analogue studies, external validity is a challenge when applying conclusions elicited from a brief vignettes to actual clinical situations. In this study counselors in training read and respond to a vignette depicting a client, rather than an actual clinical experience. This methodology although common, stimulates questions on whether the vignettes were an accurate portrayal of real-life counseling processes. To compensate for this limitation, the vignettes underwent numerous revisions with practicing master's and doctoral level clinicians until a consensus was reached that the vignettes had realistic content.

In addition, therapy is a dynamic exchange with many variables and there is considerable diversity of client responsiveness (Stiles, Honos-Webb, & Surko, 1998). Both counselor and client

each contribute to the therapeutic processes in a multitude of ways (Baldwin, Wampold, & Imel, 2007) making therapeutic assessments challenging and multidimensional. This creates a complex context to study the counseling process empirically and higher-level statistical and methodological approaches are needed.

Conclusions and Future Directions

The results of this study suggest that gender role bias continues to exist among counselor trainees. The results corroborate and expand upon the current literature and address important gaps in the research. This study supports research by Seem and Clark (2006) who found that counselors-in-training have different standards for mental health for men and women. For example, the current study found the male vignette condition received higher symptom severity scores, which supports research suggesting that counselor trainees hold more negative stereotypes for men than for women (Feibert & Meyer, 1997). This study also found that counselor trainees choose significantly different intervention choices with the male vignette compared to the female vignette. More specifically, counselor trainees chose cognitive/behavioral interventions for the male client vignette, supporting research that therapists use instrumental-focused interventions more with men than with women clients (Rencher, 2000). Furthermore, the findings supported past research that counselor trainees do not choose emotional interventions with male clients (Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, & Goodholm, 1999).

Although this study confirms and adds to the literature about gender bias, additional research is needed to identify the possible factors that contribute to biased clinical judgment. For example, research should further explore how class, ethnicity, age, race, religion, political affiliation, and other diversity indices affect both clients and counselors. Studies that explore how the counseling processes impacts diverse male identities are needed. Just as with any identity component, gender cannot exist in a vacuum and needs to be considered within the context of intersecting identities.

Masculinity is not a stagnant or singular concept; multiple masculinities have been identified that have varying degrees of social power in diverse social contexts (Connell, 2005). While working with clients, it is important that clinicians consider how race, age, culture, ethnicity, class, religion, and sexual orientation interact with and impact how males define themselves. Given the importance of intersecting identity variables with masculinity, more research is needed to explore the clinical impact of multiple masculinities. For example, investigation of how therapists' GRC has clinical impact on men of color, immigrant men, privileged men, or racist men is needed. Given that this study used mental health trainees in various stages of graduate training it could be useful to examine whether these results can be found in practicing mental health professionals. Research focused on the prevalence of implicit and explicit existence of gender bias is needed with counselors-in-training, new professionals, and experienced mental health professionals.

Biases and stereotypes perpetuate restrictive socially defined definitions of gender for both men and women. Clinical judgment, intervention decisions, and outcome expectations can be filtered through biased lenses and can sabotage potential therapeutic effectiveness. Mental health professionals need to provide unbiased services to male and female clients who may live their lives from restrictive and dysfunctional gender roles. Therefore, during the counseling process critical evaluation and deconstruction of gender roles should be a priority.

Research that leads to trainings, programming, and educational efforts toward understanding gender roles, gender role journey, and masculinity need to be developed in an effort to better serve male clients. For example, research suggests that educational interventions can help change a student's GRJ phase (Gertner, 1994), therefore, implementing psychoeducational interventions with counseling students could be an important research area for the future. The curriculum in the Gender Role Journey Workshop (O'Neil, 1995, 2015; O'Neil, Robert, & Carroll, 1988) could serve as a pedagogical example for counselor education training programs. Courses that address gender

bias could bring increased awareness, knowledge, and skill development (Sue & Sue, 2003) to counseling both men and women. Specifically, research and efforts toward developing APA guidelines regarding psychological treatment of male clients (similar to 2006 code for women) would also be very useful.

The potential biases held by counselors are a product of the collective societal socialization and educational system and has serious consequences for both women and men. Restrictive and harmful bias is not a men's problem or a women's problem, it's a human problem, an attitude best captured by Lilla Watson who said, "If you have come here to help me you are wasting your time. But, if you have come here because you realize your liberation is bound with mine, than let us work together." Men, women, educators, researchers, clinicians, and students need to work together toward positive change to eradicate sexism in clinical practice and the larger society.

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APPENDIX A

Doctoral Dissertation Request for Participation – Listserve

Hello. My name is Bryce Crapser and I am a doctoral candidate at the University of Connecticut. I am inviting you to participate in my dissertation research study about counseling decisions and counselor gender characteristics. If you are not eligible to participate in this study, I would greatly appreciate if you would inform potential participants who may be eligible and are interested in this opportunity.

The purpose of this study is to explore the relationships between counselor gender roles and counseling decisions; specifically intervention choice and assessment of symptom severity. Participation in this study has no direct benefit to participants of the study. The results of this study may be published in scientific research journals or presented at professional conferences. However, your name and identity will not be revealed and your record will remain anonymous. Your participation may benefit others in the knowledge gained about counselors in training and how gender roles impact counseling processes.

There are no risks to you as a participant. Some questions may make participants uncomfortable and participants may choose not to answer a question or withdraw from the study at any time. To assure confidentiality, the on-line survey will not gather names, medical information, or addresses. I ask that participants take the survey in a private setting on a private computer, and ensure that the window is closed on the screen once the survey is completed in order to protect responses.

To participate in this study, individuals:

Must be a student in a Counselor Education program or similar (Clinical Mental Health Counseling, Community Counseling, Clinical Psychology, Counseling Psychology, Marriage and Family Therapy, Social Work, etc...)

To participate in this 15-20 minute survey, please click the link below:

https://uconn.co1.qualtrics.com/jfe3/preview/SV_7TyEks8d3QG6Pyt

Thank you for your time and help.

Questions? Please contact the researcher, Bryce Crapser, by email at Bryce.crapser@uconn.edu.

If you have questions about your rights as a research participant, you can call the University of Connecticut Institutional Review Board and reference IRB # .

University of Connecticut IRB # Approved (date) ; Board #1

Bryce Crapser, LPC, NCC

Doctoral Candidate, Counselor Education, Counseling Psychology

Educational Psychology, Neag School of Education

University of Connecticut

Storrs, CT 06226

Informed Consent for Participation in the Relationship Between Counselor Characteristics and Intervention Choice Research Study

Principle Investigator: James O’Neil, PhD **Doctoral Student:** Bryce Crapser, MA
Study Title: Relationship between counselor characteristics and intervention choice

You are invited to participate in a research study to investigate the relationship of gender characteristics of counselors in training and intervention choice. The purpose of this research study is to see if counselor attitudes about gender roles and their own gender roles are related to how counselors judgment and decision making with clients.

If you agree to take part in this study, you will be asked to complete a survey, read a case vignette, and answer some questions. This survey will ask you questions about your attitudes and beliefs about gender roles (e.g. “I sometimes feel confused about gender roles”) and beliefs about emotional expression (e.g. “men are afraid of their feelings”). You will also be asked to provide demographic information (e.g. race, gender, age, etc...). This study should only take about 15-20 minutes to complete.

The survey will ask participants about issues related to their gender roles, beliefs about emotions, and professional orientation, and read a vignette portraying a hypothetical client, which may be emotionally upsetting to some people. Still, given that the survey is studying counselors in training, the study does not include any content that participants would not encounter in their graduate training. There are no known benefits to you as a participant. However, the study will let us know how participants are affected by their gender roles and if this can influence decision-making in counseling. There are no costs and you will not be paid for this study.

The following procedures will be used to protect the confidentiality of your data. The researcher will keep all study records locked in a secure location and no identifying information will be collected. At the conclusion of this study, the researchers may publish the findings, however information will be presented in a summary format and you will not be identified in any publications or presentations. You should know that the Uconn Institutional Review Board (IRB) and the Office of Research Compliance may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate. You may skip any question that you do not want to answer. Take as long as you’d like before you make a decision. Please contact Bryce Crapser regarding any questions you may have about this study. I have read this form and decided that I will participate in the study described above. Its general purposes, the particulars of involvement, and possible hazards and inconveniences have been explained to my satisfaction. I understand I can withdraw at any time.

I _____ (printed name) agree to participate in the study described above.

(Signature)

(Date)

APPENDIX B Study Survey Items

Demographic Data Collected

1. What is your Age:
2. What is your Sex:
 - Male
 - Female
 - Other: _____
3. Graduate credit hours /Years experience (?)
 - 1-4 semesters counselor education program
 - 4+ semesters counselor education program without practicum
 - Started Practicum
 - Advanced practicum
 - Post-master's, unlicensed

4. Where would you rate your personal ideology:

Very Conservative					Very Liberal
1	2	3	4		5

5. In the space to the left of each sentence below, write the number that most closely represents the degree that you ascribe to the following theoretical orientations.

Not at all					Very Strongly
1	2	3	4		5
___ Cognitive	___ Behavioral	___ Existential-humanistic			
___ Interpersonal-process	___ Psychodynamic				

6. In general, how effective do you find the following interventions?

Cognitive-Focused Interventions

Not at all effective	Not very effective	Somewhat effective	Effective	Very effective
1	2	3	4	5

Emotion-Focused Interventions

Not at all effective	Not very effective	Somewhat effective	Effective	Very effective
1	2	3	4	5

Behavioral Interventions

Not at all effective	Not very effective	Somewhat effective	Effective	Very effective
1	2	3	4	5

APPENDIX C

Beliefs About Men's Emotion's (BAME)

Please circle the number that best reflects your opinion.

1. When it comes to emotion, men and women are quite different.

Strongly Disagree						Strongly Agree
1	2	3	4	5		6

2. Men don't express their emotions very much.

Strongly Disagree						Strongly Agree
1	2	3	4	5		6

3. Women have more awareness than men of their own emotions.

Strongly Disagree						Strongly Agree
1	2	3	4	5		6

4. Women are better at expressing their emotions than men.

Strongly Disagree						Strongly Agree
1	2	3	4	5		6

5. Men are afraid of their feelings.

Strongly Disagree						Strongly Agree	1
2	3	4	5		6		

6. Men don't connect their emotions to sex as much as women do.

Strongly Disagree						Strongly Agree
1	2	3	4	5		6

7. Female counseling clients usually don't need as much work as men on expressing their emotions.

Strongly Disagree						Strongly Agree
1	2	3	4	5		6

8. Men rely on intellectualization more than women do to cope with threatening feelings.

Strongly Disagree						Strongly Agree
1	2	3	4	5		6

APPENDIX D

Gender Role Journey Measure

Instructions: Below you will find a series of statements about men and women. Please read each statement carefully and decide to what extent you agree or disagree with the statement. Please answer with your opinion, not what society says.

All responses are confidential and there are no “right or wrong” answers. Please answer in the way that best describes your opinion your name

Please do not omit any statement. Remember to select only one answer for the six possible choices.

In the space to the left of each sentence below, write the number that most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

Strongly Disagree						Strongly Agree
1	2	3	4	5	6	

- ___ 1. I sometimes feel confused about my role as a man or woman.
- ___ 2. I can face my personal pain about sexism and act on it.
- ___ 3. It is not masculine for men to show weakness.
- ___ 4. I reflect on my feelings about gender role conflict and then act on them.
- ___ 5. Sexism hurts people and it must stop now. *
- ___ 6. I use my knowledge about sexism to make difference in my life.
- ___ 7. Sometimes I want to change my gender role but I am afraid to.
- ___ 8. Men should make the major money decisions for the family.
- ___ 9. I am afraid to question why I am restricted from doing things because of being male or female.
- ___ 10. I use my anger about sexism in positive ways.
- ___ 11. I feel inner strength and power because of my gender role freedom
- ___ 12. I cannot always pinpoint why I am angry about sexism

- ___13. Feminists have caused the problems between men and women.
- ___14. I feel angry when sexist remarks are made. *
- ___15. I want to do something about sexism, but I am unsure how to.
- ___16. I express my anger and frustration due to sexism
- ___17. I need help from people who are stronger than I am to change my gender role.
- ___18. I feel less restricted because of gender role changes I am making.
- ___19. When I express my anger over sexism, I experience more conflict.
- ___20. I sometimes feel confused about gender roles.
- ___21. I am responsible for changing restrictive gender roles.
- ___22. I feel gender role freedom in my relationships.*
- ___23. Men should be in charge at work.
- ___24. I feel powerless to do anything to prevent sexism. *
- ___25. Women should be the primary caretakers of children
- ___26. It is not feminine for women to be aggressive.
- ___27. I have taken some actions in my personal life to reduce sexism.
- ___28. I teach people ways to overcome gender role conflict and sexism.
- ___29. I feel consumed by my anger about sexism.
- ___30. I structure my life to be free of gender role stereotypes.
- ___31. I feel upset when people don't accept men as superior to women.
- ___32. I feel angry that women are discriminated against. *
- ___33. Sexism is not a problem for me. *
- ___34. When I get angry about sexism, I want to fight back.

APPENDIX E

Gender Role Conflict Scale for Females (GRCS-F)

Instructions: In the space to the left of each sentence below, write the number which most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

Strongly Disagree			Strongly Agree
1	2	3	5 6

1. ____ Moving up the career ladder is important to me.
2. ____ I have difficulty telling others I care about them.
3. ____ Verbally expressing my love to another woman is difficult for me.
4. ____ I feel torn between my hectic work schedule and caring for my health.
5. ____ Making money is part of my idea of being a successful woman.
6. ____ Strong emotions are difficult for me to understand.
7. ____ Affection with other women makes me tense.
8. ____ I sometimes define my personal value by my career success.
9. ____ Expressing feelings makes me feel open to attack by other people.
10. ____ Expressing my emotions to other women is risky.
11. ____ My career, job or school affects the quality of my leisure or family life.
12. ____ I evaluate other people's value by their level of achievement and success
13. ____ Talking (about my feelings) during sexual relations is difficult for me.
14. ____ I worry about failing and how it affects my doing well as a woman.
15. ____ I have difficulty expressing my emotional needs to my partner.
16. ____ Women who touch other women make me uncomfortable.
17. ____ Finding time to relax is difficult for me.
18. ____ Doing well all the time is important for me.

19. ____ I have difficulty expressing my tender feelings.
20. ____ Hugging other women is difficult for me.
21. ____ I often feel that I need to be in charge of those around me.
22. ____ Telling others of my strong feelings is not part of my sexual behavior.
23. ____ Competing with others is the best way to succeed.
24. ____ Winning is a measure of my value and personal worth.
25. ____ I often have trouble finding words that describe how I am feeling.
26. ____ I am sometimes hesitant to show my affection to women because of how others might perceive me.
27. ____ My needs to work or study keep me from my family or leisure more than I would like.
28. ____ I strive to be more successful than others.
29. ____ I do not like to show my emotions to other people.
30. ____ Telling my partner my feelings about him/her during sex is difficult for me.
31. ____ My work or school often disrupts other parts of my life.
32. ____ I am often concerned about how others evaluate my performance at work or school.
33. ____ Being very personal with other women makes me feel uncomfortable.
34. ____ Being smarter or physically stronger than other women is important to me.
35. ____ Women who are overly friendly to me make me wonder about their sexual orientation (men or women).
36. ____ Overwork and stress, caused by a need to achieve on the job or in school, affects/hurts my life.
37. ____ I like to feel superior to other people.

APPENDIX F

Gender Role Conflict Scale for Males (GRCS-M)

Instructions: In the space to the left of each sentence below, write the number which most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

Strongly Disagree							Strongly Agree
1	2	3	4	5	6	6	

1. ____ Moving up the career ladder is important to me.
2. ____ I have difficulty telling others I care about them.
3. ____ Verbally expressing my love to another man is difficult for me.
4. ____ I feel torn between my hectic work schedule and caring for my health.
5. ____ Making money is part of my idea of being a successful man.
6. ____ Strong emotions are difficult for me to understand.
7. ____ Affection with other men makes me tense.
8. ____ I sometimes define my personal value by my career success.
9. ____ Expressing feelings makes me feel open to attack by other people.
10. ____ Expressing my emotions to other men is risky.
11. ____ My career, job or school affects the quality of my leisure or family life.
12. ____ I evaluate other people's value by their level of achievement and success.
13. ____ Talking (about my feelings) during sexual relations is difficult for me.
14. ____ I worry about failing and how it affects my doing well as a man.
15. ____ I have difficulty expressing my emotional needs to my partner.
16. ____ Men who touch other men make me uncomfortable.
17. ____ Finding time to relax is difficult for me.
18. ____ Doing well all the time is important for me.

19. ____ I have difficulty expressing my tender feelings.
20. ____ Hugging other men is difficult for me.
21. ____ I often feel that I need to be in charge of those around me.
22. ____ Telling others of my strong feelings is not part of my sexual behavior.
23. ____ Competing with others is the best way to succeed.
24. ____ Winning is a measure of my value and personal worth.
25. ____ I often have trouble finding words that describe how I am feeling.
26. ____ I am sometimes hesitant to show my affection to men because of how others might perceive me.
27. ____ My needs to work or study keep me from my family or leisure more than I would like.
28. ____ I strive to be more successful than others.
29. ____ I do not like to show my emotions to other people.
30. ____ Telling my partner my feelings about him/her during sex is difficult for me.
31. ____ My work or school often disrupts other parts of my life.
32. ____ I am often concerned about how others evaluate my performance at work or school.
33. ____ Being very personal with other men makes me feel uncomfortable.
34. ____ Being smarter or physically stronger than other men is important to me.
35. ____ Men who are overly friendly to me make me wonder about their sexual orientation (men or women).
36. ____ Overwork and stress, caused by a need to achieve on the job or in school, affects/hurts my life.
37. ____ I like to feel superior to other people.

APPENDIX G

Client Vignettes

Male Vignette

Michael is a 34 year old male presenting to your counseling practice with depressive symptoms; referred by his mother and general practitioner. Michael has no known family history of mental illness including mood disorders, substance use disorders, or other known mental disorders. He has attended individual therapy briefly during college to help with relationship difficulties, which he reported was “somewhat helpful.” Michael lost his job approximately 6 months ago, about the time his significant long-term romantic relationship ended. Since then, he has been experiencing worsening symptoms including excessive feelings of guilt, sadness, and reported feeling “helpless” and “weak.” Michael has been finding it increasingly difficult to leave the house or get out of bed in the morning and doesn’t feel motivated to socialize or search for a job. He has been having daily tearful spells, becoming more socially isolated, and drinking 3-4 glasses of wine daily.

During today’s intake session, Michael began sobbing while sharing the details of his life over the past year. With his head in his hands, Michael exclaimed “I’m just a worthless loser! Nothing I do is working out and I am no good.” He expresses his feelings clearly and directly but can’t seem to improve his mood. Michael is close with his mother and said that she is very worried about him. He said he often gets stuck in his head and ruminates about his losses and failures. Michael continued to sob uncontrollably and explain that “I just hurt so much” and “I’m so tired of feeling sad.” He looks to you to help, asking what he can do to start feeling better.

Female Vignette

Jennifer is a 34 year old female presenting to your counseling practice with depressive symptoms; referred by her mother and general practitioner. Jennifer has no known family history of mental illness including mood disorders, substance use disorders, or other known mental disorders. She has attended individual therapy briefly during college to help with relationship difficulties, which she reported was “somewhat helpful.” Jennifer lost her job approximately 6 months ago, about the time her significant long-term romantic relationship ended. Since then, she has been experiencing worsening symptoms including excessive feelings of guilt, sadness, and reported feeling “helpless” and “weak.” Jennifer has been finding it increasingly difficult to leave the house or get out of bed in the morning and doesn’t feel motivated to socialize or search for a job. She has been having daily tearful spells, becoming more socially isolated, and drinking 3-4 glasses of wine daily.

During today’s intake session, Jennifer began sobbing while sharing the details of her life over the past year. With her head in her hands, Jennifer exclaimed “I’m just a worthless loser! Nothing I do is working out and I am no good.” She expresses her feelings clearly and directly but can’t seem to improve her mood. Jennifer is close with her mother and said that she is very worried about her. She said she often gets stuck in her head and ruminates about her losses and failures. Jennifer continued to sob uncontrollably and explain that “I just hurt so much” and “I’m so tired of feeling sad.” She looks to you to help, asking what she can do to start feeling better.

APPENDIX H

Post-Vignette Survey Items

Client Rating Scale (CCS)

Instructions: The following are a number of questions regarding the case vignette that you just read. Answer each question by circling the number that best corresponds to your answer and respond quickly, without spending a lot of time on any one question.

1) How much do you like this client?

1	2	3	4	5	6	7	8	9	10	11
Not at all									Very Much	

2) How much do you empathize with this client?

1	2	3	4	5	6	7	8	9	10	11
Not at all									Very Much	

3) To what degree do you see the client as being similar to yourself?

1	2	3	4	5	6	7	8	9	10	11
Not at all									Very Much	

4) How comfortable would you feel in dealing with this client?

1	2	3	4	5	6	7	8	9	10	11
Not at all									Very Much	

5) How willing would you be to take this person as your client ?

1	2	3	4	5	6	7	8	9	10	11
Not at all									Very Much	

APPENDIX I

Client Symptom Severity Scale (CSS-S)

1. How would you rate the clients symptoms?

Very Mild				Very Severe
1	2	3	4	5

2. How long would you anticipate client's duration of treatment?

0-5 sessions	6-10 sessions	11-15 sessions	16-20 sessions	20+ sessions
1	2	3	4	5

3. What is the likelihood that you would consider referring this client for a medication evaluation?

Unlikely		Neutral		Very Likely
1	2	3	4	5

4. What is the likelihood that you would refer this client for a higher level of care (hospitalization for example)?

Unlikely		Neutral		Very Likely
1	2	3	4	5

5. How would you rate this client's suicide risk?

No Risk				Very High Risk
1	2	3	4	5

6. How would you rate this client's level of social, psychological, or occupational impairment?

No Impairment				Severely Impaired
1	2	3	4	5

Total Severity Score:

APPENDIX J

Theoretical Domain and Intervention Choice (TDIC)

How would you rate the importance of the following clinical domains with the client described in the vignette?

1. Cognition (thoughts, beliefs)

Not at all important 1	Not very Important 2	Somewhat Important 3	Important 4	Very Important 5
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2. Affect (feelings, mood)

Not at all important 1	Not very Important 2	Somewhat Important 3	Important 4	Very Important 5
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3. Behavior (actions)

Not at all important 1	Not very Important 2	Somewhat Important 3	Important 4	Very Important 5
-------------------------------------	-----------------------------------	-----------------------------------	-----------------------	-------------------------------

How effective would you rate the following interventions with the client described in the vignette?

1. Cognitive-Focused Intervention

Not at all effective 1	Not very effective 2	Somewhat effective 3	Effective 4	Very effective 5
----------------------------------	--------------------------------	--------------------------------	-----------------------	----------------------------

2. Emotion-Focused Intervention

Not at all effective 1	Not very effective 2	Somewhat effective 3	Effective 4	Very effective 5
----------------------------------	--------------------------------	--------------------------------	-----------------------	----------------------------

3. Behavioral Intervention

Not at all effective 1	Not very effective 2	Somewhat effective 3	Effective 4	Very effective 5
----------------------------------	--------------------------------	--------------------------------	-----------------------	----------------------------

What intervention would be most effective with this client (Choose one):

Cognitive-Focused
 Emotion-Focused
 Behavior Focused

Intervention Definitions

Emotion-Focused Intervention (also known as process-experiential); Typically integrates person-centered and Gestalt therapy tenants emphasizing the relationship, and process of reflection on aroused emotions to create new meaning. Treatment relies on identification and expression of emotions as the primary vehicle for change (Elliott, Greenberg, Watson, Timulak, Feire, 2013; Greenberg 2012)

Cognitively-Focused Intervention: (CT, REBT) is defined by Bergen and Garfield's (2013) as a therapeutic approach based on the assumption that thoughts and cognitions play a role in the etiology or maintenance of psychological disorders. Treatment relies on focusing on increasing coping by changing maladaptive beliefs and teaching new information-processing skills. Cognitive Behavioral intervention focuses on the role that cognition plays on feelings and behaviors. (Hollon & Beck, 2013)

Behaviorally-Focused Intervention (Applied Behavior Analysis, Behavioral Activation, Problem-solving Training, Relaxation Training, Modeling) Interventions emphasize learning theory and measurable behaviors as the intervention target. Uses concrete, structured, task-oriented and practical interventions.

APPENDIX K**Vignette Review Survey**

1. How many of the following symptoms can you identify?

Cognitive:

Behavioral:

Affective:

2. How realistic is this vignette?

1
Not Realistic

2

3

4

5
Very Realistic

3. What additional information would you need to make a general assessment of the level of symptom severity?

4. What additional information would you need to make a clinical decision regarding treatment?

5. What would you guess is the gender of this client?

5a. How confident are you in your guess?

1
Not Confident

2

3

4
Very Confident

5

APPENDIX L

Using the Gender Role Conflict Scale for Men With Women: A Brief Review of the Literature

James M. O'Neil, University of Connecticut

I have been asked to provide a rationale for using the men's Gender Role Conflict Scale (GRCS, O'Neil, Helms, Gable, David, & Wrightman, 1986) with women. Originally, the GRCS was created to assess four patterns of men's gender role conflict (GRC), but over the years women's GRC has emerged as a relevant topic of empirical research and theoretical inquiry (Enns, 2008; O'Neil, 1981, 2015; O'Neil & Egan, 1993; Nutt, 1999, Zamariippa, Wampold, & Gregory, 2003). First, the early definitions of women's GRC are reviewed and provide a historical context for using the GRCS with women. Second, the creation of the Gender Role Conflict Scale for Females (GRCS-F) is discussed and the past psychometric research using the GRCS-F is briefly summarized. A short review of the literature of studies using the GRCS for women is given and future steps to further validate the GRCS-F and understand women's GRC are specified.

Early Definitions of GRC

My early theory hypothesized that GRC existed for both sexes (O'Neil, 1981a, b) resulting in devaluations, restrictions, and violations of self and others because of restrictive gender roles. GRC was described as a human problem for each sex and a critical variable in men and women's interpersonal interactions (Nutt, 1999; O'Neil, 1981, a, b; O'Neil & Egan, 1994). Furthermore, from its inception, GRC has implied both sexes experience gender role conflict in their work and family roles (Pleck, 1981; O'Neil, 1981). Pleck's (1981) break through gender role strain paradigm focused on men, but he also stated three propositions that discussed women's gender role conflict including: a) Both men and women experience conflict because of gender role conflict and strain, b) overconformity to the stereotypes has more severe consequences for males than females, c) prescribed gender roles are psychologically dysfunctional for both sexes in their work and family

roles. These propositions support the position that both sexes have GRC, but men's GRC has been given the most attention over the last four decades and women's GRC is only now being discussed in Feminist circles. Some Women feminists (Enns, 2008; Nutt, 1999) have viewed women's GRC as an important psychological construct. Enns (2004) indicates "that the literature on male GRC is not integrated with work on women's gender role conflict and may subtly support the exaggeration of differences between women's and men's gender related conflicts" (p. 94). In Nutt's (1999) analysis she discusses women's GRC as a major predisposing factor for domestic violence that includes gender role devaluations, restrictions, and violations between the sexes. In summary, women's GRC has been discussed in the psychological literature for many years, but full conceptualization of the construct for females and how it relates to men's GRC, is under developed.

Theoretical Justification

Women's GRC can be conceptualized using men's GRC patterns because the same oppressive, masculine, patriarchal ideologies that harm men can also harm women. Like men, women are also socialized to patriarchal male norms that are sexist and that cause GRC. Women in many cases are forced to endorse restrictive masculine norms that produce distortions about power, emotions, same sex interactions, and conflict between work and family relationships.

What this means is that women can also pay a price for Success, Power, and Competition (SPC), restrictive emotionality (RE), restrictive affectionate behavior between men (RABBM), and conflict between work and family relations (CBWFR). For men, SPC, RE, RABBM, and CBWFR have been the empirically derived patterns of men's GRC but these same conflictual patterns can also affect women. For example, restrictive masculine norms can negatively affect women's need for power and success, discourage emotional expression, devalue human touching, and promote work-family conflicts.

Whether women experience these patterns of GRC the same way that men do is an empirical question. There is vast amount s of literature in psychology that support the existence of SPC, RE, RABBM, and CBWFR as realities in women's lives. Patriarchy, sexist interactions, and GRC are most likely experienced differentially by each sex and what those differences are need further research and conceptualizing. The question of whether women experience GRC is not the most critical question. The more important question is whether women bring different meaning to the GRCS items when filling it out compared to men? In other words, is the validity of items on the GRCS similar for both men and women?

Evidence on the Psychometric Properties of the Gender Role Conflict Scale for Females (GRCS-F)

Even though the GRCS was created for men, the measure was modified to use with women (Borthick, Knox, Taylor, Dietrich, 1997). This modification was completed by changing the pronouns for each GRCS items. Research was conducted to see whether the revised GRCS for women had reliable and valid psychometric qualities like had been found for men (O'Neil, 2105). A female sample (n=462) were given the revised scale, and all items except one loaded on the appropriate factor that explained 38% of the total variance. Factor analysis of the GRCS-F indicated that the scale items loaded in a way similar to the men's version. Internal consistency reliabilities for each factor were as follows: .84 for SPC, .86 for RE, .83 for RABBM, and .81 for CBWFR. In another psychometric analysis of the GRCS-F (Garcia-Sanchez, 2015), a Spanish version of the GRCS was given to two samples of Spanish women (n=281 and n=439). Both exploratory and confirmatory factor analyses were conducted. Internal consistencies reliability for the two samples ranged from .68- .81 for sample one and .75 -.81 for sample two. The results of both of these studies indicate acceptable reliability and validity for the GRCS-F and replication of the original factor structure of GRCS for men (O'Neil et al., 1986).

One of the current limitations to using the GRCS-F is a lack of face/content validity of the GRCS items. Do women interpret the items in the same way as men do when filling out the scale? There has been no research assessing whether the items in the male version of the GRCs mean the same for women. Even though the factor structure and internal consistency reliabilities of the GRCS-F has psychometric support, future research should investigate whether the items have the same meaning for men and women.

Empirical Research on GRCS for Females

Research has been completed on the GRCS for females in eleven studies, (Borthwick, et al., 1997; Eicken, 2003; Harishfeger, 1998; Hernandez, 2006; Newman, 1997; Schwartz, Higgins, & He, 2003; Silva, 2002; Zamarippa, Wampold, & Gregory, 2003). Four studies have found that GRC is related to women's psychological symptoms and problems. Daltry (2009) found that women athletes' identity distress tolerance and quality of athletic life correlated with total GRC score. Butler (2005) studied Australian women and found their SPC, RE, CBWFR correlated with stress, anxiety, and depression. Newman (1998) found that GRC did not correlate to self-silencing for women nor did it moderate the relationship between GRC and depression. Schwartz, Higgins, and He (2003) found low CBWFR and RE were associated with positive feelings toward their weight and physical conditions.

Research has documented that sex differences exist with men's and women's GRC. In the eleven studies using the GRCS-F, significant sex differences have been found on three of the GRC factors. Men reported significantly more GRC on three patterns of GRC (RE, SPC, RABBM) compared to women (Borthwick, et al., 1997; Eicken, 2003; Harishfeger, 1998; Hanson & Yanico, 2003; Hernandez, 2006; Newman, 1997; Schwartz, Higgins, & He, 2003; Silva, 2002; Zamarippa, et al., 2003). Across six studies, Conflict Between Work and Family Relationships (CBWFR) had consistently shown no differences between men and women but in two other studies, women

reported significantly higher CBWFR than men (Eicken, 2003; Schwartz, et al., 2003

In the last fifteen years researchers have conducted studies on how men's GRC relates to couple dynamics and psychological functioning (Breiding, 2003, 2004; Breiding & Smith, 2002; Celentana, 2000; Rochlen & Mahalik, 2004). These findings are important because not only is GRC thought to be a problem for both sexes, it also is believed to interact with men's and women's interpersonal interactions. For example, SPC, RE, RABBM, and total GRC scores have significantly related to decreased marital adjustment, lower daily marital happiness, greater depressive symptomatology, and greater negative affect for both men and women (Breiding, 2003, 2004; Breiding & Smith, 2002; Celentana, 2000). Two studies have assessed how women's perception of men's GRC relates to the women's relationship satisfaction and psychological health (Breiding & Smith, 2002; Rochlen & Mahalik, 2004). Wives' assessments of husbands' GRC significantly correlated with wives' decreased marital adjustment and happiness, increased depressive symptomatology, and negative affect (Breiding & Smith, 2002). Furthermore, women's reports of their partners' high RE and SPC significantly predicted less relationship satisfaction, greater depression, and anxiety (Rochlen & Mahalik, 2004). Additionally, women's report of partners' lower RABBM predicted women's greater depression and anxiety. One interpretation of this finding is that when men indicate no conflict with showing affection towards other men, it may raise women's concerns about the man's sexual orientation and manifest as greater anxiety and depression.

Two studies have assessed how GRC actually affects couple's interactions and dynamics. Husbands' GRC has been significantly related to increased levels of reported spousal criticism (Breiding, 2003). Furthermore, in this same study, husbands' criticism mediated the relationship between husbands' GRC and wives' marital adjustment and depressive symptoms. In another study, husbands with high GRC engaged in hostile behaviors during marital interactions and more

importantly, husbands' hostility mediated the relationship between husbands' GRC and wives' marital adjustment (Breiding, 2004). These studies indicate that men's GRC affects couple dynamics negatively, adversely affects women's psychological functioning, and relates to men's hostility during marital interactions. Future research with couples could explore how GRC relates to other marital problems like emotional abuse and the epidemic rates of violence against women (Harway & O'Neil, 1999; O'Neil & Nadeau, 1999).

Conclusions

Based on the past theory and research, I support the use of GRCS-F with current research. The GRCS-F has been found to have adequate reliability and validity based on two studies that have assessed the psychometrics of the revised scale. The factor structure has been shown to be the same for men and women and the internal consistency reliabilities are adequate. Like with male version of the GRCS, women's patterns of GRC have been found to be significantly correlated with negative psychological consequences including stress, anxiety, and depression. Sex differences with GRC also provide further evidence of construct validity. The studies assessing couple's dynamics indicate that men's GRC affects women's psychological health in negative ways suggesting there is complexity in how GRC is experienced between the sexes. The biggest limitation to using the GRCS-F is a lack of research on the face/content validity of the items for women and whether the male GRC patterns mean exactly the same for women as with men. Future research should pursue these validity issues to better understand whether GRC patterns of men and women are the same or different constructs. Specifically, qualitative research and focus groups with women of all ages could help determine the content/face validity of the GRCS-F. Furthermore, there is a need for the development of a new GRCS for women.

References (Available Upon Request – Jimoneil1@aol.com)