SEX-ROLE IDENTIFICATION OF GROUP CO-THERAPISTS BY GROUP MEMBERS

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CHAPTER I

Introduction

As the use of co-therapists in group psychotherapy is becoming more popular, many questions are being raised concerning the effect of two therapists on the group setting. One important controversial question concerns the group members' perception of the therapists' sex-roles.

Our society has always had traditional expectations of male and female behavior. Today more people are breaking away from the traditional sex-roles and are coming to see that in each of us there are some "feminine" and "masculine" traits. While some people are satisfied with the traditional sex-role expectations, others are seeking new ways of relating.

The primary purpose of psychotherapy is to assist people in solving their problems and regaining or establishing their individual autonomy. The co-therapy group method is thought to offer many advantages in accomplishing these goals. However, little or no research has been done to assess its effectiveness as a treatment model and to determine if, in fact, therapists are teaching men and women to realize their full human potential or if they are reinforcing the roles traditionally expected by society.

Statement of Problem

The problem of this study was to investigate the sex-role perception of group members toward co-therapists in psychotherapy treatment groups.

Purposes

1. To determine whether or not group members in a psychotherapy group with a co-therapy team of male-female leaders perceived one therapist in a masculine role and one in a feminine role.
2. To determine whether or not group members in a psychotherapy group with a co-therapy team of male-male leaders perceived one therapist in a masculine role and one in a feminine role.
3. To determine whether or not group members in a psychotherapy group with a co-therapy team of female-female leaders perceived one therapist in a masculine role and one in a feminine role.
4. To determine whether or not group members in a psychotherapy group with a co-therapy team of male-female leaders perceived the male in a masculine role and the female in a feminine role.
5. To determine whether or not group members in the same psychotherapy group perceived the same therapists in the

same sex-roles.

6. To determine whether or not group members within different psychotherapy groups led by the same co-therapy team perceived the therapists in the same sex-roles.
7. To determine whether or not group members within different psychotherapy groups led by different co-therapy teams, with the groups having one therapist in common, perceived that therapist in the same sex-role.
8. To determine whether or not group members in psychotherapy groups whose leaders were from different professional disciplines, perceived the therapist from the profession with the higher status in the masculine role and the therapist from the profession with the lower status in the feminine role.
9. To determine whether or not female group members in the same psychotherapy group perceived the therapists in the same sex-roles.
10. To determine whether or not male group members in the same psychotherapy group perceived therapists in the same sex-roles.

Background Significance

The definitions of male and female roles are part of our socialization as children and are constantly reinforced throughout our lives. As men and women we are socialized to develop certain parts of our personalities while suppressing the development of other parts. "The aggressive, strong, active, competitive, impervious male and the dependent, supportive, receptive, emotional female conform to the cultural stereotypes" (Wyckoff 1974).

Men and women have more similarities as human beings than differences as men and women. Men and women tend to differ in their feelings, desires, and personalities because they have been taught these differences (Johnson 1975).

The personal qualifications attributed in the literature to the hypothetical "good therapist" include characteristics stereotypically attributed to both sexes. A good therapist must be in touch with, unthreatened by, and therefore free to use those aspects of himself which are associated traditionally with the opposite sex as well as those attributed to his own sex (Schonbar 1973).

Schonbar (1973) indicates that most neurotic problems related to sex-role identity arise from deficiencies in self-esteem. She sees society's role in the development of such problems being primarily that of limiting the child's freedom

to select identification models congruent with his basic potentials. The process of identification is the means whereby a child rehearses roles for the future, and, if free to do so, selects behaviors, interests, and values which are congenial to him and his constitutional predisposition and rejects those which are not (Bradwick 1971; Erickson 1959; Freud 1950).

One of the ways in which therapists are able to help people increase their self-esteem through psychotherapy is to serve as corrective models to earlier faulty identification processes. An advantage to the co-therapy method of treatment is the doubling of possible identification models. The co-therapy group setting is considered an ideal technique for correcting early deficits in identity problems as it provides an opportunity for members to see that there are many ways of being a man or a woman just as there are many ways of being a person (Mintz 1965; Schonbar 1972).

Another outstanding factor operating in the co-therapist group method is the simulated family setting which is created by the presence of two authority figures. Due to the phenomenon of transference, patients are stimulated to act out conflicts in the group that originated in their original family setting (Lundin and Aronov 1952).

Mintz (1965) maintains that the value of co-therapy goes beyond its obvious recreation of a two-parent family

situation. The two therapists, male and female, represent masculine and feminine authority as well as mother and father figures. She attributes much of the confusion about sexual roles in our culture to the shifting definitions of masculinity and femininity. For this reason, she feels it is essential that the therapists be male and female to provide real people, against whom fantasy stereotypes of male and female can be tested, and to provide models for an enhanced understanding and acceptance of sexual roles.

Many writers do not feel that the two therapists need to be male and female in order to simulate the family structure and masculine and feminine roles. Regardless of the therapists' sex, the patient will consciously or unconsciously react to one of two male therapists as a woman or choose one of two female therapists as a male (Mullan and Sanguilliano 1960).

> As might be expected, the physical characteristics of the therapists become less important than the subtle psychological differences which schizophrenic patients can easily detect and respond to. One therapist will be seen as more aggressive and masculine, the other as more protective and feminine... (Lundin and Aronov 1952, p.79)

Mintz (1965) and her followers feel that this point of view disregards reality altogether and can be very destructive to patients.

> It seems likely that the expectation that patients will distort a reality so basic as gender, and the implicit readiness to accept such a distortion, must necessarily create a continuing fantasy in the group....The neurotic wish or the psychotic uncertainty can hardly fail to be rein-

> forced if, for example, two male therapists join in the pretense that one of them shall for a continuing period of time be regarded as a female (p.294).

Rosenbaum (1971) agrees that a man-woman pairing is often effective. However, he warns that one must not be fooled by surface appearance as sometimes the man is quite feminine and the woman is quite masculine, which can result in confusion for the patient.

Another factor in the male-female pairing is that often the physician is a man and the social worker a woman. What can ensue are patterns of dominance-passivity or displacement of unresolved earlier issues of sexual identity. These countertransference responses may impede the formation of a working alliance inasmuch as the co-therapists may use the group to act out personal issues (Bailis and Adler 1973).

Sometimes a nurse is chosen as the female co-therapist with the male therapist being a physician. Since the nurse generally ranks low in the hospital setting, as well as traditionally being seen in a dependent relationship with the physician, she may be supportive only and may pass on feelings of inadequacy to the women patients in the group (DeYoung and Tower 1971; Rosenbaum 1971).

There is currently, within the nursing profession, much conflict between giving up the "expressive role" and assuming more responsibility by taking on a more "instrumental role". Some nurses are very content with playing the "ideal" female

expressive role while others are dissatisfied and frustrated with the role and are seeking ways to gain their independence and respect as a professional (Babich 1969).

Group therapy must supply corrective models since patients have been traumatized by identifying with incorrect models or images earlier in their lives. Subtle intrafamily influences in the past have often made children the scapegoat for the unresolved conflicts of their parents. If now, in group therapy, the patient senses the same disharmony and competition which marked his earlier years, he will have no recourse but to further strengthen sick defenses which were erected in his childhood. In some respects the co-therapist method is more fraught with hazards than groups which are individually led, for here the patient is truly confronted with a situation closer to the reality of his own conflicts (Slavson 1972).

For this reason, people who work as co-therapists must be reasonably conscious of their feelings for one another and be able to relate to each other with respect. The hazards of co-therapy may apply to any professional discipline using this technique; however, the pairing of individuals from different disciplines to serve as a co-therapy team can further compound the hazards involved (Lundin and Aronov 1952; Mintz 1963).

Although much has been said about the possible hazards

of the co-therapy group method as well as its many advantages, little or no research has been done to assess the effectiveness of this method or to determine if in fact patients do perceive therapists in sex-roles and if therapists are unknowingly contributing to the confusion of their clients regarding sex-role behavior.

Hypotheses

The hypotheses formulated for this study were as follows:

1. There is no difference in the perception of group members regarding sex-role characteristics of the group leaders and the actual sex of the leaders in groups which are led by male-female co-therapists.
2. There is no difference in the perception of group members regarding sex-role characteristics of the group leaders and the actual sex of the leaders in groups which are led by male-male co-therapists.
3. There is no difference in the perception of group members regarding sex-role characteristics of the group leaders and the actual sex of the leaders in groups which are led by female-female co-therapists.
4. Members of the same group do not differ in their perceptions of the sex-role characteristics of the same co-therapists.

5. Members of different groups do not differ in their perceptions of the sex-role characteristics of the same co-therapists working as a team.
6. Members of different groups do not differ in their perceptions of the sex-role characteristics of the same therapist when working with a different co-therapist.
7. The professional status of the therapist makes no difference in the sex-role perceptions of them by group members.
8. The sex of the group member makes no difference in the group member's perception of the sex-role characteristics of the leaders.

Definition of Terms

Group therapy - a psychotherapy method in which two or more clients participate in therapy simultaneously in the presence of a therapist or therapists.

Co-therapy - a form of group psychotherapy in which two therapists treat the members of the group at the same time.

Professional status - the ranking in a social structure of the members of a specific vocation in relationship to other vocations in the structure.

Feminine role - a cultural more describing female behavior.

Masculine role - a cultural more describing male behavior.

Limitations

The limitations of this study were as follows:

1. The cultural background of each individual group member was unknown; therefore, their perception of masculine and feminine roles may have differed from the cultural stereotypes selected.
2. The generalizations that can be made from this study are limited as there was no guarantee that the representation of the groups studied was an average sample of the population.
3. The degree of pathology of the group members and the length of time each group member had been a participant in the group were uncontrolled variables in this study.

Delimitations

The delimitations of this study were as follows:

1. The study was limited to group members presently attending a psychotherapy treatment group led by co-therapists.
2. The group member was a minimum of eighteen years of age.
3. Only group members attending a psychotherapy group where the therapists had agreed to participate in the study were given the questionnaire.

Assumptions

The assumptions considered basic to this study were as follows:

1. Identification is a major mechanism in the process of group treatment.
2. There are cultural stereotypes for sex-role expectations and sex-role related behavior.
3. Transference occurs in varying degrees of intensity in every psychotherapy situation and nearly all other relationships of an individual as well.

Summary

In chapter I, the investigator has established the need for research in regard to the sex-role perception of group members toward their co-therapists in psychotherapy treatment groups. The purposes, hypotheses, limitations, delimitations, and the assumptions of the problem under study have been established.

Chapter II of this study is concerned with reviewing the literature pertinent to: the cultural attitudes toward traditional sex-roles and related behavior expectations; the relationship between the different professional disciplines and the cultural stereotypes attributed to them, with a major focus on the nursing profession; the effect of sex-role

identity on the personality development of an individual and the treatment approaches for correcting early faulty identification processes with specific focus on the co-therapy group approach. Chapter III, the procedure for collection and treatment of data, contains the development and validation of the tool used in determining how the group members perceived the therapists' sex-roles, and describes the method of data collection. Chapter IV is concerned with the analysis of this data. Chapter V of this paper deals with the summary, recommendations, implications, and conclusions of this study.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The study of the sex-role perception of group members toward co-therapists in psychotherapy treatment groups involved the investigation of several areas in the literature. These areas included: the development of sex-role identity, the cultural attitudes toward sex-roles, and the advantages and disadvantages of co-therapy group treatment in correcting early faulty identification processes.

Development of Sex-Role Identity

In our society existence, each of us has to play a variety of roles. Each of us early in life has to begin to learn our sex-role - how to act like a girl or a boy (Sanford and Wrightsman 1970).

Regardless of the personality theory one supports, it is agreed that there are a series of developmental tasks or stages through which a child grows and which influence the course of his further growth. The importance of the early parent-child relationship is also recognized by most theorists as being crucial to the development of the personality of an individual (Mintz 1965; Payne 1970).

With the studies of the "environmentalists" in the 1920's and 1930's, the influence of cultural factors in the structuring of the personality were discovered. Mead's publication in 1935 regarding the sex and temperament in three primitive societies in which "masculine" and "feminine" traits and occupations differed strikingly from those of our own culture demonstrated the profound influence of cultural values on the resultant behavioral patterns and personalities of individuals (Johnson 1973).

The learning of roles is carried on both through intentional instruction and through incidental learning. With respect to intentional learning, the elders in a society deliberately instruct the young in ways to behave in a position. In the area of incidental learning, the individual child will "pick up" or imitate whole patterns of behavior from his peers or from his elders; he will retain those patterns which have led to positive reinforcement, while nonreinforced or punished patterns will be dropped from his repertoire (Sarbin and Allen 1968).

Along with the learning of patterns of overt behavior, the individual learns patterns of expectancies. The little girl not only learns the patterns of behavior that her culture regards as girl-like; she learns also to expect the same behavior pattern from other girls. And when the other girls depart from the expected pattern, they are brought back into

line through one form or another of social reinforcement. And, of course, boys are similarily involved in role learning and teaching (Sanford and Wrightsman 1970).

Childhood play is an important process in the learning of social roles. In their play, children gain experience of social expectations, and they learn to shift roles, to take on the roles of assorted others. The shifting of roles is a significant part of the process of socialization (Erickson 1963; Mead 1935).

Bandura, Ross, and Ross (1963) demonstrated that children's role behaviors (specifically their reactions to frustration) may be modified drastically by observation of adult-models. One example showed how children after watching an aggressive model, spontaneously reproduced the behavior exhibited by the model.

A child is born with a finite but wide set of genetic and constitutional potentialities into a world consisting of a particular subculture of the larger culture and with the parents' own idiosyncratic expectations and reactions. Through the process of identification a child can rehearse roles for the future, and if free to do so, selects behaviors, interests, values, and the like, which are congenial to him and his constitutional predisposition and rejects those which are not (Erickson 1963; Schonbar 1972).

Identification under certain conditions can be used

defensively and in these conditions loses its primary growth-enhancing potential. The following are such recognized conditions:

> 1) when it occurs for primary defensive purposes;
> 2) when there is demand or pressure, backed with reward and punishment, direct or indirect, conscious or unconscious, for acceptance of certain identification possibilities and rejection of others;
> 3) when the potential for a reasonably wide range of identification opportunities is limited;
> 4) when the only or primary available models for identification are themselves pathologic and/or antithetical to the basic direction of the child's potential;
> 5) when double messages are given concerning the permissibility of certain identification models;
> 6) when the values of a subculture differentially support sources of identification and are used in the service of any of the above.
>
> The situation is even worse when there is a combination of any of these factors (Schonbar 1973, p.340).

Patients are individuals whose natural development toward psychological well-being has been thwarted, interfered with, or disturbed in some way. Brody (1966) states that most identity conflicts have their roots in disturbed patterns of parental identification. His findings show that such developmental problems are exhibited in a variety of manners from prejudice vulnerability and authoritarian personality, to more severe symptoms such as exhibited in paranoid schizophrenia and homosexuality.

Cultural Attitudes Toward Sex-Roles

In our culture today, there is a reorientation of the

sexual roles of men and women taking place. A great deal of confusion and controversy exists over these changes, especially in regard to the changing status of women. As women all over the world have become more educated and exposed to opportunities, they have begun to alter their traditional expectations and demand equal rights in society with men. Conflicts have arisen between men and women over the changes in women's goals and values (particularly as they threaten the power and privileges of men) and the ways in which these changes affect the individual woman and society at large.

The evolution of the traditional sex-roles began with early man, when the first business of life was survival. Men and women took on equal but very different responsibilities to insure both the survival of the individual and the species. Masculinity and femininity came to be identified with the division of labor that originally had been very practically determined on the basis of biological considerations; for example, physical strength and childbearing functions. Marriage, in one form or another, originally evolved to assure that the divisions of labor and responsibility remained equal (Steinmann 1974).

The intellectual and scientific advances of the last two centuries have reduced the problem of survival. The role activities for each sex that were developed in the first

stages of mankind's evolution are now open to question and revision.

The traditional concept of the feminine role is one in which the woman conceives of herself as the "mother", the counterpart of the man and the children in her life. She realizes herself indirectly by fostering their fulfillment. She performs a nurturing role. Her achievement is to help others achieve. Her distinguishing feature is that she fulfills herself by proxy (Fast 1971; Steinmann 1974; Wyckoff 1974). On the other hand, the liberal concept of the female role is that concept held by the woman who embraces a self-achieving orientation. She strives to fulfill herself by realizing her own potentialities. She performs an achieving role. Her distinguishing feature is that she seeks fulfillment through her own accomplishments (Steinmann 1974; Wyckoff 1974).

Many brilliant women are caught up in the problem of making an unconscious identification between intelligence and masculinity. To probe, to search, to be curious, to affirm, to discover - all of these she may feel as defeminizing, especially if her husband, in his uncertain masculinity, is threatened thereby. Many cultures and many religions have kept women from knowing and studying, in a sado-masochistic sense, to keep them feminine. The timid man also may tend to identify probing curiosity as somehow challenging to others,

as if somehow, by being intelligent and searching out the truth, he is being assertive and bold and manly in a way that he can't back up, and that such a pose will bring down upon him the wrath of other stronger men (Maslow 1968).

Men have also been programmed to fit a sex-role. The "strong, all-knowing, silent, he-man" describes the stereotyped image of the masculine man. Men have been brainwashed into repressing any impulses that have been characterized as being "feminine", such as softness, passivity, tenderness, and emotion (Fast 1971; Gould 1973; Wychoff 1974).

Steinmann (1974) insists that the problem of sex-role stereotyping in men and women is paramount in importance. "If for one reason on another, a person is forced to suppress his need for self-expression, he will experience a loss of self-esteem, he will become less effectual in all spheres of life" (p.55).

There is a trend in our time to draw the previously exclusive and excluding two sexual polarized organizations of life into one - opening the resources of each to one another, presumably allowing individuals to make their own choices according to their own inclinations. The word unisex has been popularly adopted to describe the recent phenomenon of sexual togetherness - a drawing together of male and female so that the two sexes seem more alike, with many of their most traditional, superficial distinctions deliber-

ately blurred or even erased. Gould (1973) feels the term unisex is misleading and a better word for the movement is androgyny. The word androgyny comes from the Greek: a combination of andro ("male") and gyn ("female"), conveying the message that human traits are not rigidly assigned to either the male or the female, and that to be truly human, both men and women must have the qualities traditionally thought of and described as "masculine" and "feminine".

There are a great many indications that the usual distinguishing features that once so clearly marked men as men and women as women have indeed begun to disappear. The evidence is most obvious in the changing clothing and hair styles. These changes are not merely superficial. The way we dress is always symbolic; a badge defining and reflecting many psychological truths about ourselves as individuals (Badaracco 1973; Gould 1973; Landsman 1973).

The motivating forces influencing this trend come from both women and men, but primarily from women in the feminist movement. These women are actively rebelling against the traditional female position in society. The way a woman adorned her body has traditionally dramatized her position in society. The sense of identity of many women has relied largely on how they looked to others rather than on any intrinsic sense of self-worth. Thus, women's dramatic shift from dresses into pants, loose clothes, and jeans emphasizes

their rejection of object status (Gould 1973; Wyckoff 1971).

Men's style of dress has been traditionally conservative and uninteresting. The recent move toward long hair, high heels, and tight flamboyant clothing for men shows a bridging in the existing gap between the sexes. If, in the past, clothing emphasized and exaggerated sexual differences, the recent moves in men's and women's clothing serve to minimize and possibly also eliminate some of the artificial distinctions (Gould 1973).

Badaracco (1973) insists that these dissatisfactions and movements are not just behavioral fads, but come from stirrings in the depths of human beings. She believes that as a movement, unisex indicates that the previously existing state was pathological, and that the directional life-force in individuals has mobilized them to search for what is healthier and more appropriate.

Schonbar (1973) disagrees with the theory of imbalance. She believes the social movements are a result of individuals suffering from severe deficits in self-esteem, and that such deficits lead to expressed concern or self-hate in relation to sex-role behavior. The social movements encourage these symptoms by declaring them to be the natural results of social conditions and therefore actually reinforcing defenses and contributing to a false sense of self-worth.

Also on the negative side of the present trend of

blurring sexual differences is the resulting confusion of identity for the young. One explanation for the persistence of a concept of maleness and femaleness lies in man's innate need for structure. Structure and form are the essence of all existence. Structure is essential to the ordering of many and varied experiences into meaningful units which can be comprehended and grasped by anxiety-prone man as he tries to understand and accept the realities of his life. The male and female are provided by nature with two different structures. How they are different in functioning and responsibility is, doubtless, inherent in biological coding (Landsman 1973).

Gould (1973) does not share the concern that the blurring of sexual roles will give rise to identity problems and sexual confusion.

> I believe that the cultural pressures to conform to a masculine or feminine ideal, and the anxieties engendered if one's temperament tends to cross the prescribed gender line, conspire to produce a more fertile soil for the growth of homosexuality (p.37).

Steinmann and Fox (1974), recognizing the lack of research in regard to the attitudes of men and women toward the changing sex-roles, conducted studies oriented toward the self-perception of men and women toward their sex-roles. Their main intention was to analyze conflicts and problems men and women had due to their respective sexes.

The instrument they used for their studies was the

MAFERR Inventory of Feminine Values. The inventory consisted of 34 statements, each of which expressed a particular value or value judgment related to women's activities and satisfactions. Three forms of the inventory were used in the research with females. First, subjects were asked to respond to the items in terms of how they themselves felt, as they thought their ideal woman would and as they thought men's ideal woman would.

They reported consistent results from the studies. The majority of women tested perceived themselves as more or less balanced between self and family orientations. While most saw their ideal woman as slightly more family-oriented than themselves, some described their ideal woman as slightly more active and outgoing than they believed themselves to be. A dramatic shift occurred when women were asked what man's ideal was like. Consistently women believed that men wanted a woman who was passive and submissive in social and personal situations, and who clearly saw her role as wife and mother taking precedence over any possible activity as an individual outside the family.

When men were given the inventory, they consistently portrayed as their ideal a woman who was balanced between family-orientation and self-orientation; nothing like the passive, family-oriented, home-centered ideal the female samples had attributed to men. These results strongly indicate

that men and women, cross-culturally and over a period of 20 years, profess agreement as to the proper role for women, but have failed utterly to communicate this agreement to each other.

Fast (1971) conducted similar studies to determine how women saw men. He administered a questionnaire asking women what, in their opinions, made a man manly.

Twenty-nine percent saw manliness as the ability to function as a strong human being, to bear life's burdens without whimpering - strong, not in terms of physical characteristics, but in his personality. He was the man who stood up to the system and didn't let it grind him down. He was also the man who could be leaned on by the rest of the family in times of trouble. Twenty-four percent thought a man was manly when he was involved with women, and nineteen percent saw a zest for life or virility as part of the manliness.

Only nine percent of these women listed physical characteristics as any indication of manliness. Ten percent saw a man's relationship with his children indicative of his manliness, and nine percent saw manliness in terms of egocentric qualities. "When a man is tied up with himself, concerned about his own health, his own looks, his own feelings, then I think of him as manly. A manly man is a self-centered man" (Fast 1971, p.80).

These were the only negative views of manliness in this group. However, when women were asked to list male characteristics, over half of them listed some sort of physical strength. Some tied it to athletics, and some tied it to hard work, such as digging ditches or hauling wood, "hard, dirty, sweaty work" (Fast 1971, p.81). Creativity, sensitivity, generosity, and idealism were held to be male characteristics by 3 percent. Twice that number saw men as self-deceiving, arrogant, rigid, and aggressive. The rest varied in their views from naive to realistic, from competitive to selfish. There is a strong agreement between the results of this study and a recent Harris poll of 3,000 women in America which said that 67 percent of the women polled viewed men as "kind, gentle, and thoughtful" (Fast 1971).

Broverman and associates (1972) reported that "contrary to the phenomenon of 'unisex' currently touted in the media, our research demonstrates the contemporary existence of clearly defined sex-role stereotypes for men and women" (p.59). Their studies showed that women are perceived as less competent, less independent, less objective, and less logical than men. Men are perceived as lacking interpersonal skills, sensitivity, warmth, and expressiveness in comparison to women. Moreover, stereotypically masculine traits are more often perceived to be desired

than the stereotypically feminine characteristics.

Jackson's series of studies (1974) also showed that traits ascribed to women are in general more negative than those ascribed to men. Masculine traits are perceived as socially desirable and reflecting better adjustment and competency.

Fabrikant (1974) did studies regarding patients' and therapists' perception of male-female sex-roles. He conducted the study by giving both patients and therapists an adjective check list and having them describe the sex-roles by using these characteristics. This was done to see if there was a more liberal response with therapists than with patients. Both therapists and patients described the sex-roles relatively the same.

Both male and female therapists described the male: aggressive, assertive, bold, breadwinner, chivalrous, crude, independent, and virile. Male therapists added: achiever, animalistic, attacker, competent, intellectual, omnipotent, powerful, and rational. Female therapists did not agree with the above, but added: exploiter, ruthless, strong, unemotional, and victor.

Both male and female therapists described the female as: chatterer, decorative, dependent, dizzy, domestic, fearful, flighty, fragile, generous, irrational, nurturing, overemotional, passive, subordinate, temperamental, and virtuous.

Male therapists added: manipulative and perplexing. Female therapists disagreed with above, but added: devoted, empathic, gentle, kind, sentimental, slave, and yielding.

As a further comparison with other studies, the words were grouped with respect to positive and negative values. Male therapists rated 70 percent of the female words as negative as contrasted to 71 percent of the male words as positive. Female therapists were very close, rating 68 percent of the female words as negative and 67 percent of the male words as positive.

Stevens (1971) did a similar study. He gave the therapists a questionnaire asking questions regarding their values and perceptions of sex-roles. He then gave the same questionnaire to the patients instructing them to mark the questionnaire in the manner they perceived their therapists believed. The results of the study showed that the patients readily picked up the therapists' actual values and perceptions during the process of therapy.

Another study, conducted by Broverman and associates (1972), proving there are therapists who are biased, was completed recently at Worcester State Hospital, Massachusetts. They developed a sex-role questionnaire with over a hundred polar items, one pole being stereotypic male traits and the other being stereotypic female traits. A group of clinical professionals were divided into three groups. One group

was asked to describe a mentally healthy adult. A second group was asked to describe a mentally healthy male adult, and a third group was asked to describe a mentally healthy female adult. An important point in this study is that the therapists were responding to the questionnaire as professionals.

The mental health therapists reinforced the standard sexual stereotypes of the society. They assigned the same characteristics to a mentally healthy adult and a mentally healthy male adult, but a mentally healthy female, unlike the male, was seen as passive, emotional, dependent, uncompetitive, non-objective, submissive, and easily influenced.

Chesler (1971) from her research and clinical work presents the following conclusions: 1) For a number of reasons, women "go crazy" more often than men, and this craziness is more likely to be self-destructive rather than other destructive; 2) Most female "neuroses" are a result of societal demands and discrimination rather than the supposed mental illness of the individual; and 3) The therapist-patient relationship reinforces a system of beliefs and attitudes that is psychologically damaging to the patient and psychologically rewarding to the doctor. Chesler goes on to say:

> It is difficult for me to make practical suggestions for improving treatment for women as long as it keeps its present form and structure. How can a woman learn to value being female from a therapist who devalues and misunderstands that sex? She cannot. It therefore seems to me that

> some far-reaching changes will have to take place both in the attitudes of clinicians and in the nature of the therapy they dispense (p.287).

In her more recent book, Chesler (1972a) presents the case even more strongly. "Only a woman therapist who herself is a feminist can understand and help a woman patient. Therapists, far from letting women out, have been adding more locks. We can no longer expect them to set women free" (p.52).

Rice and Rice's recent (1973) and thorough review of the implications of the women's liberation movement for psychotherapy focuses on the predominance of the male therapist in both the psychological and psychiatric professions. They also reiterate the fact that the older female therapists were trained in the male dominated training programs and so are molded in the male model. Rice also points out that the older group of both male and female therapists does follow a more traditional approach in their perception of female patients' sex-role expectations. They feel that the male therapist in his traditionally perceived role as the authority expert and father figure is threatened by the use of female therapists, and any challenge to this is met with strong resistance.

They propose training the newer therapists in the areas of sex differences and the newer knowledge of the psychology of women. They also feel that the therapists should be more aware of alternative life-styles and sex-roles, and take the initiative as direct agents of social change. They do not

accept the passive analytic or client-centered approach, which they feel simply reinforces the older patterns of male-female behavior. For them a possible approach to therapy for women would be a group with male-female co-therapists as leaders.

Co-Therapy Group Approach

The emergence of group psychotherapy as a major treatment modality within the past two decades constitutes one of the most significant and extraordinary developments in the field of psychiatry. Group therapy has not only been seen as a viable solution to the shortage of trained personnel qualified to care for a growing patient population, the lack of adequate community resources for psychiatric patients, and the high cost of individual treatment, but has also come to be regarded as the treatment of choice for a widening range of patients with highly diversified problems (Kaplan and Sadock 1971).

It is felt by some that the group setting offers the therapists far more opportunities for behavioral analysis than does individual therapy. When dealing with the patient in an individual session, the therapist is able to observe his behavior in relation to only one person - the therapist - which gives little knowledge of the patient's responses to other persons. In the group setting the therapist can observe the behavior patterns of an individual, and the feelings,

attitudes, and behavior of others in response to it (Goldstein 1971).

The group therapist also has powerful interventions available to him that are not available to the therapist performing individual therapy. Within the group setting five operations are present that facilitate the relearning of behavioral responses that in turn result in the personality changes sought. The five operations specified are: feedback, modeling, behavioral rehearsal, desensitization, and motivational stimulation and social reinforcement (Goldstein 1971).

Group psychotherapy, because of its very structure, has encouraged the use of co-therapists. Since the relationship is no longer one-to-one, but is one-to-a-group, the group members are more responsive to the idea of another therapist. The use of co-therapists is thought to aid therapy in several ways: first, the patient has another person to whom he may transfer; second, more movement is promoted in the therapy group; third, the group members appear to move toward greater depths; fourth, co-therapy offers an effective method to break through blockages; and fifth, one therapist is able to support the patient's defenses while the other therapist is able to confront the patient with his behavior (Rosenbaum 1971).

Although co-therapy is growing in popularity in its use, it is still considered a very controversial practice. Authors

who question its value argue that it compounds countertransference phenomena, that it tends to contaminate the transference reactions of patients, and that their treatment is also interfered with because competitive strivings and even serious differences between the team members develop more or less inevitably (Rosenbaum 1971).

The use of co-therapy dates back as far as 1921 when Freud used a kind of multiple therapy in the case of Little Hans. Adler and his co-workers at the Vienna Child Guidance Clinic consistently used forms of co-therapy. Originally co-therapy was used to help resolve specific problems in therapy or to teach certain goals, such as interns and residents observing for the purpose of training. Apparently, little attention was paid to the impact of the therapist on the group. Rosenbaum (1971) points out that many of the people who used co-therapy stumbled on the technique without any planning or with no awareness of the work that others were doing with the technique.

Lundin and Aronov (1952) reported the co-therapy work they were doing with psychotic patients using co-therapy psychotherapy groups and their observations regarding some of the advantages and disadvantages they saw with the technique. They stressed the fact that it was important to survey further the dynamic implications and consequences of two therapists on the group setting as at this time it was an unexplored

field. Lundin and Aronov (1952) reported that of all the factors operating in the co-therapist methed, the most outstanding observed was the simulated family setting created by the presence of the two authority figures.

> A child must learn early in life to adjust to a reality determined by the presence of two adult figures. Since the average family includes two parents and siblings there is a greater chance that any one patient will be more highly stimulated to act out his conflicts in a group that approaches the social norm. Especially for the schizophrenic who cannot always verbalize his feelings, the symbolic value he attaches to the therapists (parents) and to the group members (siblings) becomes an important transference phenomen which can yield insights which would be difficult to obtain were only one therapist present (p.77).

Few therapists will deny that the primary family of each group member haunts the group therapy room like an omnipresent specter. The patient's experiences in his primary family obviously will, to a greater degree, determine the nature of his transference distortions. However, the desirability of the transference phenomenon and the handling of transference material when it does arise is a very controversial issue.

Many theorists see an advantage of the group process being that the transference to the therapist is diluted, as the other group members also serve as transference objects. The use of the co-therapist modifies the transference even further (Rosenbaum 1971; Yalom 1970).

Slavson (1972) does not see this as an advantage.

He feels the "working through" of a psychoneurosis requires the establishment of the transference neurosis. The core of transference neurosis is the patients' investment in the therapist of libidinal strivings as a parent substitute. With the presence of two therapists in the group, the patient may split his transference between the co-therapists which prevents the patient from resolving his ambivalent feelings toward his parents.

Mintz (1965) disagrees with this viewpoint on the grounds that the "normal" personality is developed, and ambivalence worked out in a two-parent family. Lundin and Aronov (1952) do not agree that the transference is diluted in a co-therapy group setting, but rather that transference is promoted due to the situation being closer to the reality of the patients' true conflicts.

Yalom (1970) feels that the past material from early life does inevitably play a part in the group therapeutic process; however, he sees it as taking a form and a function considerably different from that in traditional analytic therapy.

> The past may be explored, not to explain the present, not to elucidate and work through major past traumata, but instead to aid in the development of group cohesiveness by increasing intermember understanding and acceptance.
>
> Although a successful group experience may, in a sense, recapitulate the early experience in the family in a more gratifying and growth-inducing manner, the recapitulation remains on

> an unconscious level. To focus unduly on the sibling rivalries and incestuous, incorporative, or patricidal desires is to deny the reality of the group and the other members the living experience of the here-and-now (p.121).

Several other theorists agree with Yalom in regard to transference. They feel it is unsuitable and ineffective for interpretive work. They see the past as being greatly influenced by the present and as only being important in so far as it influences the here-and-now of the therapist-patient relationship (Frank 1963; Goffman 1959; Rycroft 1966).

Demarest and Teicher (1954) report from their experience that transference is the enabling instrument, the working tool, which enables therapy to accomplish the goal of effecting changes in the lives of people. They felt that the transference phenomenon in their groups was a product of the use of co-therapists of opposite sexes. "The presence of male and female therapists made it possible for each patient to structure a family group, which allowed him to act out family conflicts, as well as helping him with problems in relating to the opposite sex" (p.187).

> It seems to be an axiom that every patient must work through problems originating in a two-parent family and therefore a joint treatment by a male and female therapist seems natural and almost inevitable development in psychotherapeutic technique (Mintz 1965, p.294).

Dynamically, the value of co-therapy goes beyond its obvious recreation of a two-parent family situation. In a

broader sense, the therapists become models for masculine and feminine authority. Due to the shifting definitions of masculinity and femininity in our culture, confusion about sexual roles seems a more widespread source of trouble than difficulty in handling sexual desires. Two therapists are real people against whom fantasy stereotypes of male and female can be tested; and models for an enhanced understanding and acceptance of sexual roles.

> Since it can, hopefully, be assumed that the male group therapist is mature enough to experience feelings of tenderness and solicitude without anxiety, and the woman therapist is able to accept her own competence without fearing loss of womanhood, patients of both sexes can find in a co-therapy group evidence that it is possible to be either masculine or feminine without giving up basically worthwhile human qualities (Mintz 1965, p.294).

"Regardless of whether the therapists are of different sex or not, the patient will conceive of them unconsciously as being of different sex" (Mullan and Sanguilliano 1960,p.550). One therapist may seem less threatening than the other (Loeffler and Weinstein 1954); one may seem "good" and one "bad" (Cameron and Stewart 1955); indeed some writers state that patients may react to one male therapist as to a father and to another male therapist as a mother.

> The physical characteristics of the therapist become less important than subtle psychological differences...one therapist will be seen as more aggressive and masculine, the other as more protective and feminine...The patients will have a primary reaction of depend-

> ence, anger, seduction, ambivalence, etc., to either one of the two therapists. This primary reaction will represent the major method of adjusting to the more important of the two therapists. Once the primary reaction is fixed, the other therapist readily assumes, in the patient's mind, the secondary qualities associated with the less dominant parent. The dominant parent may in reality be either the mother or the father (Lundin and Aronov 1952, p.79).

This finding is in line with the general belief that, in individual psychoanalysis, the analyst's sex is seldom crucial. "Both men and women patients can and do develop father and mother transferences toward their analysts, whether male or female" (Fenichel 1945, p.10).

Group therapy does not really duplicate the classical psychoanalytical situation in which the impact of the analyst's real personality is minimized, so that an important part of his function is to serve as a screen for the patient's fantasies and projections. The real personality is relatively more important in group treatment. Consequently, many values usually considered characteristic of group therapy are enhanced by the presence of a man and a woman as co-therapists, but would presumably be lessened if both therapists are of the same sex (Mintz 1963).

The group therapist has more powerful therapeutic interventions available to him in correcting faulty identification processes than does the individual therapist. Partly due to his more revealed stance, partly because of the family-

like structure of the group. The main way the group therapist helps a patient regain his self-esteem is by serving as a corrective model. The patient imitates the attitudes and behavior patterns of the therapist until he comes to accept the standards and norms of the therapist as his own. In respect to sex-role related behavior, the opportunity for corrective identification almost demands that the therapists be of opposite sex (Kramer 1968; Schonbar 1967).

Rosenbaum's and Hartley's survey (1965) on the differences in personalities of individuals and group therapists revealed that therapists in general believe that group therapists are more flexible, less authoritative, more open, more exhibitionistic, and more dramatic. The therapist is seen as more of a real person in the group, and he reacts more spontaneously to the greater stress he experiences. Because of this, it is important that the group therapist be in touch with and deal with his own feelings as they emerge (Sugar 1970).

More and more psychotherapists are becoming aware of themselves and the necessity to study and define themselves as "objects" of scientific investigation. As students and specialists in understanding human intrapsychic and interpersonal systems, psychotherapists have developed increasing interest in aspects of self and personality which go beyond transference in effecting the therapeutic process and outcome.

There are many factors making up the personality structure of the therapist.

> What is reflected in the personality of the group therapist are cultural mores and traits, drives, needs, values, anxiety, controls, inherited familial biology and transmitted myths, conditioning, social conformity and rebellion, super-ego, conscience, idealized image, adaptive functions, awareness of context or situation, capacity for reality testing, and of course residual elements of unconscious multi-transferences (Berger 1970, p.213).

All these are in operation simultaneously, and are some of the factors determining what elements of a therapist's personality will be in the foreground at a particular time in the life of the group.

Along with stressing the importance of the therapist's personality on the group, the importance of the therapist's willingness to be involved with his patients as a person is also being recognized. In the dynamic psychoanalytically oriented psychotherapy, especially in the earlier stages of its evolution, the therapists mask their personalities in a misguided attempt to be perfectly objective with their patients. The patients experience the detachment and silence of the therapist as abandonment, cruelty, and not caring. These feelings were not engendered by transference alone, but due to the trend at that time, therapists did not appreciate the need for an atmosphere of trust and humaness in order for the patient to risk what needed to be risked in his search to find his real self (Astrachan 1967).

Every human being has the need for intimacy or to be in contact with other human beings. Fulfillment of this need is essential for normal growth and development; therefore, the greater the potential for and quality of intimacy in the therapist-patient relationship, the greater the potential for healing or change in the individual. The establishment of this kind of experience requires the whole-hearted participation and authentic involvement of the therapist (Ferreira 1964).

From their research on personality factors in trained therapists, Whitehorn and Betz (1960) found that the most successful therapists manifested initiative in sympathetic inquiry, expressed honest disagreement at times, challenged the patients' self-deprecatory attitude, indicated their respect for the patients' potential and participated in an active personal way. On the basis of their long-term research findings (over ten years), Whitehorn and Betz emphasized that the technique of passive permissiveness or efforts to develop insight primarily by interpretation appeared to have much less therapeutic value.

Recent studies concerning the impact on the group of the group leaders' behavior found that the direction of the group process is most influenced by the basic orientation of each therapist. It will become directive, nondirective, persuasive, suggestive, inspirational, analytical, didactic, experiential, or a changing mixture of these depending on the

leader's philosophy, beliefs, and personality (Atrachan 1967).

Careful attention should be paid to the personality characteristics of therapists who plan to join one another as co-therapists. Most important is compatibility of temperament. Both therapists must be comfortable with intimacy and able to accept their differences. In working together, co-therapists usually establish a style, and it is important that the co-therapists respect each other's style. Ideally, their styles blend together, so that a smoothly working team of co-therapists has its own style (Rosenbaum 1971).

One of the major aspects of co-therapy is the potential it offers the two therapists to advance their own personal growth.

> It offers a chance to fight out differences, to struggle with being separate from the other, as well as together. The struggles we go through, being together and deferring to each other, being leader and follower - all these things are part of our struggle to grow, and they serve as models for the patients (Ferber, Mendelson, and Napier 1973, p.491).

Another beneficial aspect of the co-therapy method is that the two therapists form a bilateral participant/observer situation. One holds back and observes while the other participates on an emotional level (gets involved) and then they reverse. This allows for one therapist to observe the working therapist within the group setting and enables him to perceive problems the other therapist may be encountering with his own unresolved feelings or counter-

transference problems.

> A common mistake is that one or both partners can't ask for help from their co-therapist; a facade of pseudo-adequacy keeps the partners from sharing confusions, fears, discouragement about the therapy process. Ideally, each therapist should be willing to be patient or therapist to the other co-therapist (Ferber, Mendelson, and Napier 1973, p.501).

In institutional settings, co-therapists are frequently selected in random to meet the needs of the institution, and very little attention is paid to the specific anxieties and problems of the therapists. It requires fairly secure therapists to disagree with one another (Bailis and Adler 1973).

Many co-therapy relationships falter because one or both of the therapists are afraid to fight in front of the group. The most important element in therapy is the model the therapists present. An intense fight between the therapists can be very beneficial for the group, as it can teach patients how to fight. The alternative to fighting out differences is a pseudo-mutuality between the therapists which is easy for the group members to pick up, and the temptation is for the patients to act out the therapists' aggression (Ferber, Mendelson, and Napier 1973, p.501).

The issue of competition between the co-therapists is a complicated one. One of the major aspects involved in this problem is the insecurities of therapists concerning their professional identity. It is not uncommon for a beginning psychiatric resident to be assigned a position working with a

social worker who has more experience. The medical model training of physicians is that the doctor is responsible for the patient and makes all the decisions. The social worker training does not emphasize the assuming of responsibility for patients. This kind of situation can cause a lot of conflict between the therapists, especially if the therapists do not hold mutual respect for each other (Bailis and Adler 1973). The expectation of the co-therapy model is that of joint responsibility and that power and decision-making are equal between co-therapists. Role fixation in the co-therapy situation hinders the spontaneity and growth of the leaders; as well as modeling another separation for the group (Ferber, Mendelson, and Napier 1973).

Changing of Professional Roles

Today there is a shift in the premises of psychiatric problems. The traditionally psychiatric problem was thought of as medical. Therefore it was correct that a medically trained psychiatrist be the primary authority and have the greatest status and salary. Social workers and psychologists were thought of as auxiliary personnel.

Nurses were seen as being in a dependent relationship with the physician. A study of the perception of the nursing role by persons of various classes showed that all of these persons, regardless of social class or sex, perceived the

nurse to be a mother-type figure, who performed expressive functions such as being affectionate, understanding, appreciative, and helpful (Babich 1969; DeYoung and Tower 1971).

When the social or interpersonal theories of psychopathology were introduced and popularized, revolutionary changes occurred. A number of therapeutic programs, ranging from Glasser's "reality therapy" (closely related to the behavior therapies) to group therapy and family therapy, were introduced.

The changes occurred in the roles of the professions along with the change in the definition of the problem. For example:

> In a child psychiatric facility, when the unit with the problem was the child, the treatment was in a medical framework and all the professionals had a function that was related to their training. Typically, the child psychiatrist treated the child, who was the sick unit, the social worker saw the parents, and the psychologist tested the child. If the child was put in custody, a psychiatric nurse took care of him under the medical supervision. In a child treatment facility today, the psychiatrist can treat the whole family, and the psychologist can treat the whole family. The sociologist can treat the whole family and some places are training the psychiatric nurse to treat the whole family (Haley 1971, p.284).

In group therapy, the focus of intervention is on the patient's interpersonal problems here-and-now, on a conscious, ego-involving level concerning the patient's relations to society. According to Goffman (1970), "the domain of face-to-face social contact is one in which every participant is

equally licensed to carry and use the scalpel" (p.357).

The breakdown of the role barriers separating the professions, and the emerging power of psychiatric nurses as qualified therapists in their own right, has been a source of notable controversy (Churchill 1967; Hays 1962; Osborne 1970; Turner 1973). But as Calnen (1972) states:

> It seems fair to conclude that, because of their improved education, their ongoing contact with the patient, and their capacity to intervene in his interpersonal conduct and manipulate his environment psychiatric nurses have joined other professionals as therapists (p.211).

Haley (1971) stresses the fact that the traditional professions must change to adapt to the changing of thinking in regard to new psychiatric treatment and the resulting status changes of the professional groups.

> Since no particular profession has shown superior skill or better training than the other, why should one have more status or salary than another? (p.285).

A therapist is now often judged on his merit - the success of his therapy - not upon his professional background. Perhaps that is the most radical change introduced through the introduction of the behavioral sciences and the emphasis on the patient's interpersonal problems (Goffman 1970; Haley 1971).

McGee (1974) reports on the triadic approach to supervision being extremely helpful in training co-therapists and

in assisting co-therapists in adjusting to their "new role" or changing professional identity.

Summary

In chapter II, the investigator has reviewed the literature pertaining to: the development of sex-role identity of a child, and the problems that can develop due to the lack of or faulty identification models; the changing trends of our society in regards to the stereotypes of "masculine" and "feminine" sex-role characteristics and the resulting behavior changes; the majority of the chapter deals with the controversial use of co-therapy psychotherapy treatment groups in correcting early faulty identification processes, the controversial issue of liked-sex therapists working as team members and the possible complications as well as advantages of the co-therapy group approach. The shifting premises of psychiatric problems and the resulting changes in treatment approaches were discussed in regard to their effect on the professional roles and identities of the various professional disciplines.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

Introduction

In investigating the problem of sex-role perception of group members toward co-therapists in psychotherapy groups, data was collected from thirty groups. Before collecting the data, a research design was chosen for the study, and an instrument was developed and validated as the tool to be used in collecting the data. These areas along with the procedure for collection and treatment of data are discussed in this chapter.

Design

A non-parametric, qualitative descriptive design was chosen for this study. There are several advantages in using non-parametric techniques of hypothesis testing: one, they do not assume that the scores under analysis were drawn from a normally distributed population; two, they may be used with scores which are not exact in any numerical sense, but which in effect are simply ranks; and three, they are very useful in computing small samples (Siegel 1956). The descriptive studies are primarily concerned with obtaining meaningful descriptions of the phenomenon under study (Abdellah 1965).

Population and Setting

The population of this study was a convenience sample of thirty psychotherapy groups led by co-therapists: ten led by male/female co-therapy teams, ten led by male/male co-therapy teams and ten led by female/female co-therapy teams. The criteria set for participation in the study was as follows: that the group met for the purpose of psychotherapy, at an appointed time and place for a definite time period (each member had to have been to the group at least one time prior to taking the questionnaire); that the same two therapists led the group consistently; and the group members were a minimum of eighteen years of age. The psychotherapy groups studied were recruited from private hospitals, county mental health mental retardation services, and private institutions of counseling and guidance. All groups with the exception of three were located in a large metropolitan city; the other three groups were from a mental health mental retardation center located in a small city near the large metropolitan city.

Description of the Sample

The sample consisted of one hundred and eighty-seven group members. A total of thirty psychotherapy groups were studied ranging in size from three to nine members; the average group size was six members. The only demographic data

collected on the group members was in regard to their sex; sixty-seven percent of the members were female, and thirty-three percent of the group members were male.

A total of thirty-eight therapists were studied, the breakdown of the professional disciplines was as follows: eight nurses (one male-seven females), twelve social workers (seven females-five females), one male psychologist, five psychiatrists (one female-four males), five male ministers, four therapist aides (two female and two male), and two female technicians. Appendixes I, II, and III list the combinations of co-therapists by group number, sex, and professional status.

Development and Validation of the Instrument

The instrument used in this study was a questionnaire developed by the investigator. The questionnaire consisted of twenty-one descriptive words and phrases describing some culturally expected behaviors of males and females. The words and phrases were compiled from the review of literature regarding cultural stereotypes for masculine and feminine sex-roles. Care was taken to use only words carrying a positive description for the sex-roles.

The questionnaire was subjected to a panel of experts to achieve face validity. The panel consisted of five individuals: three having a Ph.D. in psychology, two males and a female; one female having a Ph.D. in sociology and one male

having a master's degree in psychology. Each member of the panel was given a questionnaire containing the twenty-one descriptive words and phrases compiled by the investigator, and instructed to determine for each word or phrase if in our culture it would be considered a masculine or a feminine characteristic, or if it applied equally to both sexes or if it applied equally to neither sex (see appendix IV). The panel agreed on ten characteristics, five masculine traits and five feminine traits. The five traits agreed on for the masculine sex-role were: aggressive, powerful, tells-it-like-it-is, problem-solver, and has strong opinions. The five traits agreed on for the feminine sex-role were: accepting, supportive, caring, gentle, and kind. These were the only items scored on the questionnaire in determining the sex-role of the therapists. The other items served as buffers to detract from the distinction of the sex-role traits.

In scoring the questionnaires, two definitions for masculine and feminine sex-roles were established. One definition was very stringent in that it allowed no overlapping of the sex-role traits. In order to be perceived in a masculine or feminine sex-role, the therapist had to be given a minimum of three out of five traits for one sex-role and zero traits of the other. The total possibilities of scores for this definition were (5-0,4-0, 3-0). Throughout the study this definition of masculine and feminine sex-roles will be

referred to as the tighter definition. The other definition established for masculine and feminine sex-roles was considered looser because it did allow the overlapping of sex-role traits. A therapist could be given up to two traits of one sex-role and still be considered to belong in the opposite sex-role if he had been assigned all five of the traits belonging to that sex-role. The total possibilities included in this definition were (5-2, 5-1, 5-0, 4-1, 4-0, 3-0) involving a minimum difference of three traits. Throughout the study this set of scores is referred to as the looser definition of masculine/feminine sex-roles.

Hypotheses I, II, III, and IV were tested using both definitions of masculine/feminine sex-roles. The looser definition was considered more conservative in rejecting the null hypotheses, that each therapist is perceived in the sex-role corresponding to his true sexual identity.

Professional Status of Therapists

In establishing the professional status of the different professional disciplines involved in this study three general categories were established. The psychiatrist was the only discipline placed in the first class. Class two contained the "so-called" middle level professional such as the social worker, psychologist, and nurse (Pattison 1974). The third class formed was the paraprofessional (see appendixes I, II, and III for the professional status of each therapist).

The paraprofessional may be considered to be partly in and partly out of the professional mental health care system (Pattison 1974). The paraprofessional category in this study consisted of therapists' aides, technicians, students, and ministers. The investigator made no distinction between the therapist aide and the technician, but merely used the title the therapist went by. The status of paraprofessional does not necessarily pertain to the educational level of the individual, but rather as to whether the individual has the sanction of a professional organization behind him. For the purpose of this study, the minister was classified in a paraprofessional category. There is a lot of controversy regarding the ministers' place in the psychiatric health team. Many ministers are associated with professional organizations, meeting the ethical and professional standards for that particular organization; however, at this particular time there is no specific professional framework tied with the title "minister" (Strollberg 1974).

Again in the second category the emphasis in this study is not necessarily on the level of education of the therapist but rather the professional title, for instance, in the case of the nurse there is no distinction made between the B.S. and the M.S. level nurse. The psychologist was also placed in this category, despite the fact that he has a Ph.D. level of education, due to the relatively undefined position he holds

in the mental health care team (Greiff 1973; Volmat 1973). The psychiatrist is still rated as the head of the mental health care team and therefore, was placed in a category alone (Greiff 1973; Kramer 1973).

Procedure for Collection of Data

The investigator contacted the therapists initially by telephone. Out of the forty-five therapists contacted, who met the requirements for the study, only four refused to participate (one psychologist and three psychiatrists). All four refused on the basis that they felt the study might disrupt the transference in the group. Of the other forty-one agreeing to participate in the study, thirty-eight completed the study. It was difficult to contact psychiatrists for the study, due to their busy schedules. Nurses were also difficult to study as many worked in hospital settings and due to the rotating of shifts, there was no consistency in the assigning of co-therapists to the groups. It was especially difficult to get doctor-nurse teams. Out of the three teams contacted, two of the doctors did not consider the nurse as a co-therapist but rather as a recorder or in the case of the in-patient hospital group as a liaison between the group and the carrying out of treatment orders and communication to the rest of the staff. This problem in the study was of significance in light of the findings of Calnen (1972) and Halperin (1974), who hold that the psychiatrists are resistant to

changing their traditional perceived role as the authority expert and power figure in the treatment setting.

The following information was given to the therapists regarding the study: 1) the study was being conducted by a graduate student at Texas Woman's University, 2) the purpose of the study was to determine how group members saw their therapists' behavior, and 3) the anonymity of the therapist was insured. The offer was made to inform the therapist of the results of the study after completion. Twelve groups requested interest in knowing the results of the study. The anonymity of the therapist was guaranteed by assigning each therapist and psychotherapy group studied a code number. All the results were reported in code and only the investigator had access to the original list of names, numbers, and questionnaires.

Those therapists meeting the criteria and expressing an interest were provided an opportunity to review the questionnaire that would be used in the study. The therapists upon agreement of participation were delivered the questionnaires, either personally by the therapist or through mailing, and asked to administer the questionnaires to the group members.

The following instructions were given the therapists in administering the questionnaire: 1) to allow the group members approximately five minutes at the beginning of a

group session to mark the questionnaire, 2) to not give the group members any more information about the study than that which was provided the group members on the cover letter to the quesionnaire, 3) to not answer questions regarding definition of terms but to instruct the group members to leave the item blank, and 4) to have the group members seal the envelopes before collecting the questionnaires. To the investigator's knowledge, all therapists followed the instructions with the exception of two teams; one team asked the group members' permission to see the questionnaires and requested them not to seal the envelope if they were in agreement with the therapists' viewing the questionnaire, in the other team one therapist did define terms for the group members.

The group leaders collected the questionnaires immediately after the group members completed marking them. The questionnaires were then collected from the group leaders personally by the investigator or in a few cases, the leaders preferred to mail the questionnaire, in which case a stamped envelope was provided the therapists for convenience in returning the data.

The group members were informed by means of a cover letter (see appendix V) of the voluntary nature of the study, of the anonymity, confidentiality, and purposes of the study, as well as the procedure for returning the questionnaire to

the group leaders. The subjects were asked to describe each therapist by determining for each of twenty-one descriptive words and phrases on the questionnaire (appendix VI) if the word or phrase applied to one therapist more than the other, if it applied equally to both therapists or if it applied to neither therapist.

All the questionnaires were returned completed except in two cases, where the group members stated they did not wish to participate in the study. One questionnaire was returned with numerous comments regarding the group members' feelings toward the therapists. The female group member had perceived one female therapist in a dominant role and the other female therapist in a feminine role. The group member made comments regarding the therapist seen in the dominant role like: "doesn't care", "wants too much", while making the following comments, "would like to be friends with", "like to get to know better", and "love her" in regards to the therapist seen in the feminine role. The therapists reported this particular patient as being psychotic. A few other members made isolated comments such as "____ needs to be more like this" or would make clarifying comments, such as, for the word problem-solver would add "helps us" or "assists us".

Procedure for Analysis of Data

The general problem involved in testing the hypotheses of this study was one of determining if the samples came from

specific populations. The scale of measurement underlying the data is ordinal. Sex-roles are ordered in terms of masculinity; that is, the feminine sex-role is less masculine than the "neither" sex-role (that is neither masculine nor feminine) and the neither sex-role is less masculine than the masculine sex-role. Kolmogorov-Smirnoff tests are "goodness of fit" type tests which are applicable for testing hypotheses involving ordinal data. Both one-sample and two-sample Kolmogorov-Smirnoff tests were used to test the hypotheses of the study. A one-sample test is employed to test the significance of the difference between the distribution of a set of sample values (observed scores) and a specified (theoretical) distribution. The theoretical distribution represents what would be expected under the null hypothesis. The two-sample test is concerned with the difference between two sample distributions. In either case, a two-tailed test is employed to test the likelihood that the two samples come from the same population. A one-tailed test is used to determine the likelihood that one sample came from a population which is stochastically larger than the population from which the other sample was drawn.

The Kolmogorov-Smirnoff test uses the maximum difference between the two cumulative distributions to determine the likelihood that the corresponding samples were drawn from the same population. If F_1 (X) denotes the cumulative frequency

distribution functions under the null hypothesis of the random variable X (where the only values that X can have are: feminine, neither, or masculine), then for each value of X, the value of F_1 (X) is the proportion of cases expected to have scores equal to or less than X. Similarly, let F_2 (X) denote the observed cumulative distribution function of a sample of N_2 observations. Where X is any possible score, $F_2(X) = k/N_2$ where k denotes the number of observations equal to or less than X. Under the null hypothesis that the sample has been drawn from the same population that underlies the cumulative distribution $F_1(X)$, the difference between $F_1(X)$ could be expected to be small. The Kolmogorov-Smirnoff test focuses on the largest deviation between the two cumulative distributions. The two-tailed tests, the magnitude of the largest difference is called D: D= maximum $\left|F_1(X) - F_2(X)\right|$. The sampling distribution of D is known, and critical values for the distribution have been tabulated (Siegel 1956) for both one-sample and two-sample Kolmogorov-Smirnoff tests.

For one-tailed, two-sample Kolmogorov-Smirnoff tests, the direction of the difference between the cumulative distributions is accounted for by defining the largest signed difference as D: D= maximum $\left[F_1(X) - F_2(X)\right]$ the sampling distribution of D is known, and the probabilities associated with the occurrence of values as large as observed value for D under the null hypothesis have been tabled (Siegel 1956).

When the two samples of size N_1 and N_2 were not of the same size, the following statistic formula: $X^2 = 4D^2N_1N_2 / (N_1+N_2)$ was used to determine the significance of an observed value of D under the null hypothesis. It has been shown that X^2 is distributed approximately as a chi-square variable with two degrees of freedom. The approximation is conservative for small values of N_1 and N_2.

The Kolmogorov-Smirnoff one sample test was used for testing the levels of significance for Hypotheses I, II, III, and IV. The Kolmogorov-Smirnoff two sample test was used for testing the levels of significance for Hypotheses V, VI, and VIII. The Kolmogorov-Smirnoff one tailed two-sample test was used for testing the levels of significance for Hypothesis VII. A .05 level of significance was set for rejection of the hypotheses.

Summary

In investigating the problem of sex-role perception of group members toward therapists in psychotherapy groups led by co-therapists, thirty psychotherapy groups were studied: ten led by male/female co-therapy teams, ten led by male/male co-therapy teams, and ten led by female/female co-therapy teams. A questionnaire developed by the investigator and validated by a panel of experts was used to collect the data. A non-parametric, qualitative descriptive research design was chosen for this study. A ranking of the professional status of the

different professional disciplines was established for the study. The Kolmogorov-Smirnoff tests were used in the statistical analysis of the data.

CHAPTER IV

ANALYSIS OF DATA

Introduction

This study concerned an investigation of thirty psychotherapy groups to determine how group members perceived their therapists' sex-roles. A questionnaire developed by the investigator was used to collect the data. The Kolmogorov-Smirnoff tests were used to test the hypotheses, the results of these tests are discussed in this chapter.

Results

Hypotheses I, II, III, and IV

The first four hypotheses deal with group perceptions of the sex-role characteristics of the co-therapists when the therapy teams are male/female, male/male, or female/female. In each of the first three cases, the null hypothesis was that each therapist will be perceived in the sex-role corresponding to his true sexual identity. Each null hypothesis was tested, using a one-sample Kolmogorov-Smirnoff test, by comparing the sample cumulative distribution against the theoretical cumulative distribution corresponding to the sex of the therapist. For male therapists, the theoretical distribution is (0,0,1.0) and for female therapists, the corresponding distribution is (1.0,1.0,1.0).

The fourth hypothesis is that the group as a whole perceives each co-therapist in a particular sex-role (not necessarily the role corresponding to the sex of the therapist). In this case, the consensus of the group is determined by comparing the sample distribution with each of the three theoretical cumulative distributions; i.e., the "feminine" distribution (1.0,1.0,1.0), the "neither" distribution (0,1.0,1.0), and the "masculine" distribution (0,0,1.0).

Hypothesis IV is tested with respect to the theoretical distribution for which the maximum difference between it and the sample distribution is smallest. "No consensus" is indicated by rejection of the hypothesis that the sample comes from the population corresponding to the theoretical distribution to which the sample distribution is closest.

Hypothesis I

The sample for testing hypothesis I consisted of ten psychotherapy groups led by male/female co-therapists. The groups ranged in size from four to nine members. The average group size was seven members. Four groups were led by a male and female social worker. One group was led by a female nurse and a male minister. Two groups were led by a female psychiatrist and a male psychologist. Two groups were led by a female nurse and a male psychiatrist and one group by a male and a female therapist aide. (See appendix I.)

The first hypothesis is stated in the null as follows:

H_1: There is no difference in the perception of group members regarding sex-role characteristics of the group leaders and the actual sex of the leaders in groups which are led by male/female co-therapists.

Using the tighter definition of femininity and masculinity, the results listed in table 1 were obtained. The hypothesis that the female co-therapist would be perceived in a feminine sex-role can be rejected at the .01 level of significance in seven out of ten cases (i.e., groups). For the male co-therapist the hypothesis that they would be perceived in masculine sex-roles can be rejected in all ten cases at the .01 level of significance. The last two columns in table 1 are tabulations of the group consensus of the co-therapists' sex-roles, as determined by tests of the fourth hypothesis:

H_4: Members of the same group do not differ in their perceptions of the sex-role characteristics of the same co-therapists.

As indicated, two of the female co-therapists were perceived in a feminine sex-role, and seven were cast in a "neither" role; a consensus was not reached only once, in group 6. Similarly, one of the male co-therapists was perceived in a feminine sex-role, eight were cast in the "neither" role, and a consensus was not obtained by group 5.

When the criteria defining masculine and feminine sex-roles were loosened by allowing a limited number of traits corresponding to the opposite sex (as discussed in chapter III), the results listed in table 2 were obtained. As indicated by

TABLE 1

PERCEPTION OF SEX-ROLE DIFFERENCES BY GROUP MEMBERS
WHEN ONE CO-THERAPIST IS MALE AND THE OTHER IS FEMALE

Tighter Definitions of Masculine/Feminine Sex-Roles

GROUP NUMBER	NUMBER OF MEMBERS	RESPONSES TO THERAPIST						LEVELS OF SIGNIFICANCE		TOTAL GROUP PERCEPTIONS	
		FEMALE A			MALE B						
		Fem	"N"	Masc	Fem	"N"	Masc	Fem A	Male B	Fem A	Male B
1	8	3	5	0	0	6	2	.01	.01	N	N
2	5	0	5	0	0	5	0	.01	.01	N	N
3	5	1	3	1	1	4	0	.01	.01	N	N
4	8	0	8	0	5	3	0	.01	.01	N	F
5	9	0	8	1	5	4	0	.01	.01	N	*
6	4	2	2	0	0	4	0	.20	.01	*	N
7	6	1	5	0	0	6	0	.01	.01	N	N
8	5	0	5	0	0	5	0	.01	.01	N	N
9	8	6	2	0	0	6	2	.20	.01	F	N
10	8	6	2	0	0	8	0	.20	.01	F	N

* = No Consensus

TABLE 2

PERCEPTIONS OF SEX-ROLES BY GROUP MEMBERS
WHEN ONE CO-THERAPIST IS MALE AND THE OTHER IS FEMALE

Looser Definitions of Masculine/Feminine Sex-Roles

GROUP NUMBER	NUMBER OF MEMBERS	RESPONSES TO THERAPIST						LEVELS OF SIGNIFICANCE		TOTAL GROUP PERCEPTIONS	
		FEMALE A			MALE B						
		Fem	"N"	Masc	Fem	"N"	Masc	Fem A	Male B	Fem A	Male B
1	8	4	4	0	0	5	3	.05	.01	*	N
2	5	0	5	0	0	5	0	.01	.01	N	N
3	5	2	2	1	2	3	0	.05	.01	N	N
4	8	1	7	0	6	2	0	.01	.01	N	F
5	9	2	6	1	7	2	0	.01	.01	N	F
6	4	3	1	0	0	4	0	.20	.01	F	N
7	6	2	4	0	0	6	0	.01	.01	N	N
8	5	1	4	0	2	3	0	.01	.01	N	N
9	8	8	0	0	0	5	3	.20	.01	F	N
10	8	7	1	0	0	6	2	.20	.01	F	N

* = No Consensus

a comparison of tables 1 and 2, the results were similar. Seven out of the ten groups did not perceive the female co-therapist in a feminine sex-role, although a consensus was reached in nine of the ten groups. Similarly, none of the male co-therapists were seen in a masculine sex-role (two were seen in a feminine sex-role), and a consensus was achieved by all ten groups.

Hypothesis II

The sample for testing Hypothesis II consisted of ten psychotherapy groups led by male/male co-therapists. The groups ranged in size from four to nine members; the average group size was seven members. Three groups were led by co-therapy teams with both therapists being ministers. One group was led by a team composed of a male nurse and a minister. One group was led by a minister and a social worker. Three teams consisted of a social worker and a therapist aide. One group was led by a co-therapy team consisting of a social worker and a minister. One group was led by two psychiatrists, and the last group was led by a psychiatrist and a doctoral student (see appendix II).

The second hypothesis is stated in the null as follows:

H_2: There is no difference in the perception of group members regarding sex-role characteristics of the group leaders and the actual sex of the leaders in groups which are led by male/male co-therapists.

Using the tighter definitions of feminity and masculinity, the

results listed in table 3 were obtained. As illustrated in table 3, the hypothesis that the male therapists would be perceived in masculine sex-roles can be rejected in all twenty cases at the .01 level of significance. The last two columns in table 3 are tabulations of the group consensus of the co-therapists' sex-roles, as determined by tests of the fourth hypothesis. As indicated, two of the male co-therapists were perceived in a feminine sex-role and seventeen were perceived in a "neither" sex-role; a consensus was not reached in only one group, (8).

When the criteria defining masculine and feminine sex-roles were loosened, the results listed in table 4 were obtained. Again, as indicated by comparing tables 3 and 4, the results were similar. None of the males were seen in a masculine sex-role (four were seen in a feminine sex-role). A consensus was not reached by two groups in regard to the therapists' sex-roles.

Hypothesis III

In testing Hypothesis III, ten groups led by female/female co-therapists were studied. The groups ranged in size from three to nine members, with the average size being five members. Two groups were led by co-therapy teams consisting of two nurses. Group 22 was led by a social worker and a nurse and group 29 was led by a therapist aide and the same nurse as in group 22. Two groups were led by the same co-

TABLE 3

PERCEPTION OF SEX-ROLE BY GROUP MEMBERS
WHEN BOTH CO-THERAPISTS ARE MALE

Tighter Definitions of Masculine/Feminine Sex-Roles

GROUP NUMBER	NUMBER OF MEMBERS	RESPONSES TO THERAPIST						LEVELS OF SIGNIFICANCE		TOTAL GROUP PERCEPTIONS	
		MALE A			MALE B						
		Fem	"N"	Masc	Fem	"N"	Masc	Male A	Male B	Male A	Male B
11	5	0	5	0	2	3	0	.01	.01	N	N
12	4	0	4	0	3	1	0	.01	.01	N	F
13	4	0	3	1	3	1	0	.01	.01	N	F
14	7	1	6	0	0	6	1	.01	.01	N	N
15	8	1	7	0	0	5	3	.01	.01	N	N
16	5	0	4	1	1	4	0	.01	.01	N	N
17	9	0	9	0	1	8	0	.01	.01	N	N
18	9	3	6	0	4	5	0	.01	.01	N	*
19	8	2	6	0	1	7	0	.01	.01	N	N
20	6	0	6	0	0	6	0	.01	.01	N	N

* = No Consensus

TABLE 4

PERCEPTION OF SEX-ROLE BY GROUP MEMBERS
WHEN BOTH CO-THERAPISTS ARE MALE

Looser Definitions of Masculine/Feminine Sex-Roles

GROUP NUMBER	NUMBER OF MEMBERS	RESPONSES TO THERAPIST						LEVELS OF SIGNIFICANCE		TOTAL GROUP PERCEPTION	
		MALE A			MALE B						
		Fem	"N"	Masc	Fem	"N"	Masc	Male A	Male B	Male A	Male B
11	5	0	5	0	4	1	0	.01	.01	N	F
12	4	0	4	0	4	0	0	.01	.01	N	F
13	4	1	2	1	3	1	0	.01	.01	N	F
14	7	4	3	0	1	4	2	.01	.01	F	N
15	8	3	5	0	0	4	4	.01	.05	N	*
16	5	1	3	1	2	2	1	.01	.01	N	N
17	9	2	7	0	1	6	2	.01	.01	N	N
18	9	3	6	0	5	4	0	.01	.01	N	*
19	8	3	5	0	2	5	1	.01	.01	N	N
20	6	4	2	0	2	4	0	.01	.01	F	N

* = No Consensus

therapy team composed of two female technicians. Two groups were led by co-therapists who were both social workers, and the last group was led by a nurse and a social worker (see appendix III).

The third hypothesis is stated in the null as follows:

H_3: There will be no difference in the perception of group members regarding sex-role characteristics of the group leaders and the actual sex of the leaders in groups which are led by female/female co-therapists.

Using the tighter definitions of masculinity and femininity, the results listed in table 5 were obtained. As illustrated in table 5, the hypothesis that the female therapists would be perceived in the feminine sex-roles could be rejected in eighteen out of twenty cases at the .01 level of significance. As indicated by the last two columns on table 5, two therapists were perceived in feminine sex-roles and seventeen were cast in "neither" sex-roles; a consensus was not reached in only one group, (25).

When the criteria defining masculinity and femininity were loosened, the results in table 6 were obtained. As indicated by comparing tables 5 and 6, the results varied more than in the previous cases. The hypothesis that the female therapists would be perceived in a feminine sex-role could only be rejected in eight cases; although, as indicated in the last two columns of table 6 only five cases were perceived by the groups in feminine sex-roles. Eight were cast in

TABLE 5

PERCEPTION OF SEX-ROLE DIFFERENCES BY GROUP MEMBERS
WHEN BOTH CO-THERAPISTS ARE FEMALE

Tighter Definitions of Masculine/Feminine Sex-Roles

GROUP NUMBER	NUMBER OF MEMBERS	RESPONSES TO THERAPIST						LEVELS OF SIGNIFICANCE		TOTAL GROUP PERCEPTIONS	
		FEMALE A			FEMALE B						
		Fem	"N"	Masc	Fem	"N"	Masc	Fem A	Fem B	Fem A	Fem B
21	4	1	3	0	1	3	0	.01	.01	N	N
22	4	1	3	0	3	1	0	.01	.20	N	F
23	5	0	5	0	0	5	0	.01	.01	N	N
24	8	6	2	0	0	8	0	.20	.01	F	N
25	9	3	6	0	4	5	0	.01	.01	N	*
26	4	0	4	0	1	2	1	.01	.01	N	N
27	7	0	7	0	1	6	0	.01	.01	N	N
28	3	0	3	0	0	3	0	.01	.01	N	N
29	6	0	6	0	0	6	0	.01	.01	N	N
30	6	0	6	0	0	6	0	.01	.01	N	N

* = No Consensus

TABLE 6

PERCEPTION OF SEX-ROLE DIFFERENCES BY GROUP MEMBERS
WHEN BOTH CO-THERAPISTS ARE FEMALE

Looser Definitions of Masculine/Feminine Sex-Roles

GROUP NUMBER	NUMBER OF MEMBERS	RESPONSES TO THERAPIST						LEVELS OF SIGNIFICANCE		TOTAL GROUP PERCEPTIONS	
		FEMALE A			FEMALE B						
		Fem	"N"	Masc	Fem	"N"	Masc	Fem A	Fem B	Fem A	Fem B
21	4	2	2	0	1	3	0	.20	.01	*	N
22	4	2	2	0	3	1	0	.20	.20	*	F
23	5	0	5	0	0	4	1	.01	.01	N	N
24	8	8	0	0	0	6	2	.20	.01	F	N
25	9	4	5	0	5	4	0	.01	.05	*	*
26	4	0	4	0	3	0	1	.01	.20	N	F
27	7	0	7	0	5	2	0	.01	.20	N	F
28	3	2	1	0	1	2	0	.20	.10	F	N
29	6	0	6	0	4	2	0	.01	.20	N	F
30	6	3	3	0	3	3	0	.10	.10	*	*

* = No Consensus

"neither" sex-roles. Only six groups reached a consensus regarding both therapists' sex-roles.

Discussion of Findings Hypotheses I, II, III, and IV

In testing Hypotheses I, II, and III, one-hundred percent of the male therapists tested were not seen in the masculine role frequently enough to be significant. Usually if a therapist was assigned the masculine traits, he was also assigned most of the feminine traits. These results tended to agree with Lundin and Aronov's theory (1952) that regardless of the sex of the therapist one will be perceived as more dominant and the other as less dominant, rather than the therapist being perceived in masculine and feminine roles. Another possibility is that the masculine role is overall seen as more positive and is assigned more characteristics which would agree with the findings of Broverman (1972) and Fabrikant (1974).

The assigning of roles did not seem to be influenced as greatly by the sex of the therapist, as there were almost as many men assigned to feminine sex-roles as women. The total percentages of therapists placed in feminine roles in each series of co-therapy teams was nearly the same, regardless of the sexes of the therapists making up the teams. In the groups led by male/female co-therapy teams using the tighter definitions of masculine and feminine sex-roles, ten percent of the therapists were seen in the feminine sex-role

(two females and one male). In the groups led by male/male therapists, six percent of the males were seen in a feminine sex-role, and in the groups led by female/female co-therapists the group member assigned six percent of the females to the feminine sex-roles.

When using the looser definitions for masculinity and femininity, sixteen percent of the therapists were perceived in feminine sex-roles (3 females and 2 males) in the groups led by male/female co-therapists. In the groups led by male/male co-therapists, sixteen percent of the therapists were seen in a feminine role and in the female/female co-therapy teams the group members perceived twenty percent of the therapists in the feminine sex-roles. When using the looser definition of masculinity/femininity the shift was always toward an increase in the therapists seen in feminine roles.

Hypotheses V, VI, and VIII

These three hypotheses deal with one sample's perception of the sex-role characteristics of the therapist in comparison with another sample's perception. In Hypotheses V and VI, the samples are different groups. In Hypothesis VIII, one sample is the male group members and the other sample is the female group members. The null hypothesis in each of these cases is that there is no difference in the two samples' perceptions of the therapists' sex-roles. Each null hypothesis was tested using the two-sample Kolmogorov-Smirnoff test.

By comparing the two samples cumulative distributions and finding the agreement between them, the likelihood of the two samples coming from the same population was established.

Hypothesis V

The sample for testing Hypothesis V consisted of ten groups led by five co-therapy teams. Groups 4 and 5 were led by five co-therapy teams. Groups 9 and 10 were led by a male psychiatrist and a female nurse. Groups 14 and 15 were led by a male social worker and a male therapist aide. Groups 18 and 19 were led by two male ministers and groups 26 and 27 were led by two female technicians.

The fifth hypothesis is stated in the null as follows:

H_5: Members of different groups do not differ in their perceptions of the sex-role characteristics of the same co-therapists.

As illustrated in table 7, there was a high agreement between the members in both groups led by the same co-therapists, regarding the sex-role characteristics of the leaders. In no case could the null hypothesis be rejected.

Hypothesis VI

In testing hypothesis VI all therapists working with more than one co-therapist were studied. The individual group responses a co-therapist received when working with one therapist were compared with the responses received when working with a different therapist. Therapist 2 (male) worked with three different co-therapists and was a co-therapist in

TABLE 7

PERCEPTION OF SEX-ROLES BY DIFFERENT GROUPS
OF THE SAME CO-THERAPY TEAM

GROUP NUMBER	THERAPIST	FEM	"N"	MASC	LEVELS OF SIGNIFICANCE	THERAPIST	FEM	"N"	MASC	LEVELS OF SIGNIFICANCE
4	21-Female	0	8	0	.90	4-Male	5	3	0	.95
5		0	8	1			5	4	0	
9	5-Female	6	2	0	.99	8-Male	0	6	2	.50
10		6	2	0			0	8	0	
14	2-Male	1	6	0	.99	14-Male	0	6	1	.50
15		1	7	0			0	5	3	
18	17-Male	3	6	0	.90	19-Male	4	5	0	.50
19		2	6	0			1	7	0	
26	11-Female	0	4	0	.99	12-Female	1	2	1	.70
27		0	7	0			1	6	0	

four of the groups studied. Therapist 13 (female) also worked with three different co-therapists and was a leader in three of the groups studied. The other eight therapists studied worked with two other co-therapists. Six of the therapists were leaders in two groups in the study and two were leaders for three groups.

The sixth hypothesis is stated in the null as follows:

H_6: Members of different groups do not differ in their perceptions of the sex-role characteristics of the same therapist when working with a different co-therapist.

As indicated in table 8 in no case could the null hypothesis be rejected.

Hypothesis VIII

The sample for testing hypothesis VIII consisted of the twenty-five groups having members of both sexes (five groups had no male members). In sixteen groups there were more female members than male members. Only two groups had more males than females, and seven groups had an equal distribution of males and females.

The eighth hypothesis is stated in the null as follows:

H_8: The sex of the group members makes no difference in the group members' perception of the sex-role characteristics of the leaders.

As illustrated in table 9, in no case could the null hypothesis be rejected.

Discussion of Findings Hypotheses V, VI, and VIII

The very high levels of significance obtained in testing

TABLE 8

SEX-ROLE PERCEPTIONS BY DIFFERENT GROUPS OF THE SAME THERAPIST WHEN WORKING WITH DIFFERENT CO-THERAPISTS

THERAPIST	CO-THERAPIST	GROUP NUMBER	FEM	"N"	MASC	LEVEL OF SIGNIFICANCE
1 (Male)	19(Female)	1	0	6	2	.70
	11(Male)	12	0	4	0	
20 (Female)	2(Male)	2	0	5	0	.99
	7(Female)	23	0	5	0	
17 (Male)	18(Male)	17	0	9	0	.50
	19(Male)	18	3	6	0	
	18(Male)	17	0	9	0	.50
	19(Male)	19	2	6	0	
	19(Male)	18	3	6	0	.90
	19(Male)	19	2	6	0	
5 (Female)	8 (Male)	10	6	2	0	.99
	8 (Female)	24	6	2	0	
	8 (Male)	9	6	2	0	.99
	8 (Female)	24	6	2	0	
	8 (Male)	10	6	2	0	.99
	8 (Male)	9	6	2	0	
5 (Male)	7 (Female)	6	0	4	0	.99
	2 (Male)	20	0	6	0	
14 (Female)	3 (Female)	3	1	3	1	.80
	13 (Female)	28	0	3	0	
7 (Female)	5 (Male)	6	2	2	0	.50
	6 (Female)	23	0	5	0	
16 (Female)	3 (Female)	22	3	1	0	.10
	15 (Female)	29	0	6	0	
2 (Male)	20 (Female)	2	0	5	0	.80
	14 (Male)	14	1	6	0	
	20 (Female)	2	0	5	0	.99
	5 (Male)	20	0	6	0	
	14 (Male)	14	1	6	0	.80
	5 (Male)	20	0	6	0	
	20 (Female)	2	0	5	0	.80
	14 (Male)	15	1	7	0	
	14 (Male)	15	1	7	0	.80
	5 (Male)	20	0	6	0	
	14 (Male)	14	1	6	0	.99
	14 (Male)	15	1	7	0	
13 (Female)	6 (Male)	7	1	5	0	.80
	7 (Male)	8	0	5	0	
	6 (Male)	7	1	5	0	.80
	14 (Female)	28	0	3	0	
	7 (Male)	8	0	5	0	.99
	14 (Female)	28	0	3	0	

TABLE 9

SEX-ROLE PERCEPTION BY MALE AND FEMALE GROUP MEMBERS TO CO-THERAPISTS

GROUP NUMBER	SEX OF GROUP MEMBER	NUMBER OF GROUP MEMBERS	THERAPIST	FEM "N"		MASC	LEVEL OF SIGNI-FICANCE	THERAPIST	FEM "N"		MASC	LEVEL OF SIGNI-FICANCE
1	M	3	19	1	2	0	.99	1	0	2	1	.95
	F	5	(Female)	2	3	0		(Male)	0	4	1	
2	M	1	6	0	1	0	.99	2	0	1	0	.99
	F	4	(Female)	0	4	0		(Male)	0	4	0	
3	M	3	14	1	1	1	.80	3	0	3	0	.70
	F	2	(Female)	0	2	0		(Male)	1	1	0	
4	M	4	21	0	4	0	.99	4	2	2	0	.80
	F	4	(Female)	0	4	0		(Male)	3	1	0	
5	M	4	21	0	3	1	.80	4	3	1	0	.70
	F	5	(Female)	0	5	0		(Male)	2	3	0	
7	M	3	13	0	3	0	.80	7	0	3	0	.99
	F	3	(Female)	1	2	0		(Male)	0	3	0	
8	M	2	13	0	2	0	.99	7	0	2	0	.99
	F	3	(Female)	0	3	0		(Male)	0	3	0	
9	M	4	5	3	1	0	.99	8	0	3	1	.99
	F	4	(Female)	3	1	0		(Male)	0	3	1	
10	M	3	5	3	0	0	.70	8	0	3	0	.99
	F	5	(Female)	3	2	0		(Male)	0	5	0	
11	M	3	9	0	3	0	.99	10	1	2	0	.95
	F	2	(Male)	0	2	0		(Male)	1	1	0	
12	M	1	1	0	1	0	.99	11	1	0	0	.90
	F	3	(Male)	0	3	0		(Male)	2	1	0	
14	M	2	2	0	2	0	.90	14	0	2	0	.90
	F	5	(Male)	1	4	0		(Male)	0	4	1	
15	M	2	2	0	2	0	.95	14	0	2	0	.50
	F	6	(Male)	1	5	0		(Male	0	3	3	

TABLE 9 (continued)

GROUP NUMBER	SEX OF GROUP MEMBER	NUMBER OF GROUP MEMBERS	THERAPIST	FEM "N"		MASC	LEVEL OF SIGNI-FICANCE	THERAPIST	FEM "N"		MASC	LEVEL OF SIGNI-FICANCE
16	M	2	15	0	2	0	.80	16	0	2	0	.80
	F	3	(Male)	0	2	1		(Male)	1	2	0	
17	M	4	17	0	4	0	.99	18	1	3	0	.80
	F	5	(Male)	0	5	0		(Male)	0	5	0	
18	M	4	17	1	3	0	.95	19	1	3	0	.70
	F	5	(Male)	2	3	0		(Male)	3	2	0	
19	M	4	17	0	4	0	.50	19	0	4	0	.80
	F	4	(Male)	2	2	0		(Male)	1	3	0	
20	M	3	2	0	3	0	.99	5	0	3	0	.99
	F	3	(Male)	0	3	0		(Male)	0	3	0	
21	M	2	1	0	2	0	.70	2	0	2	0	.70
	F	2	(Female)	1	1	0		(Female)	1	1	0	
24	M	4	5	4	0	0	.50	8	0	4	0	.99
	F	4	(Female)	2	2	0		(Female)	0	4	0	
25	M	4	9	1	3	0	.95	10	2	2	0	.95
	F	5	(Female)	2	3	0		(Female)	2	3	0	
26	M	1	11	0	1	0	.99	12	0	0	1	.70
	F	3	(Female)	0	3	0		(Female)	1	2	0	
27	M	2	11	0	2	0	.99	12	0	2	0	.90
	F	5	(Female)	0	5	0		(Female)	1	4	0	
29	M	2	15	0	2	0	.99	16	0	2	0	.99
	F	4	(Female)	0	4	0		(Female)	0	4	0	
30	M	1	17	0	1	0	.99	18	0	1	0	.99
	F	5	(Female)	0	5	0		(Female)	0	5	0	

these hypotheses indicated that the responses of the group members are not due to the phenomenon of transference, but rather that the therapist is being perceived as the real person he is. These findings agree with Stevens' (1971) study showing that patients readily picked up the therapists' actual values and perceptions during the process of therapy.

Hypothesis VII

In testing this hypothesis, the Kolmogorov-Smirnoff one-tailed, two sample test was used. The cumulative distributions of the two samples were compared to determine the amount of agreement between the two samples. The one-tailed test was used to determine if the therapist with the higher professional status was seen in the masculine role and the therapist with the lower professional status in the feminine role.

The sample in testing this hypothesis consisted of thirteen psychotherapy groups in which the co-therapists had different professional status. A total of ten co-therapy teams were tested. Group 1 was led by a co-therapy team consisting of a male minister and a female nurse. The same minister also led group 12 with a male social worker. A female psychiatrist and a male psychologist were the co-therapists for groups 4 and 5. Groups 9 and 10 were led by a male psychiatrist and a female nurse. Groups 14 and 15 were led by a male social worker and a male therapist aide. The same social worker was also co-therapist with a different therapist aide in

group 20. Group 23 was led by one female social worker and a female therapist aide. In group 29 a female nurse and a female aide were co-therapists and in group 16 the co-therapists were a male psychiatrist and a male doctoral student.

The seventh hypothesis was stated in the null as follows:

> H_7: The professional status of the therapist will make no difference in the sex-role perception of them by group members.

As indicated in Table 10, the null hypotheses could only be rejected in three of the groups. In groups 4, 9, and 10 the therapist with the higher status was seen toward the masculine sex-role and the therapist with the lesser status toward the feminine sex-role. However, four of the groups (1, 12, 14, and 15) showed the opposite direction, that is the higher status toward the feminine sex-role and the lower status toward the masculine sex-role. Three of the groups (20, 23, and 29) showed the same distribution between the therapists.

Discussion of Findings Hypothesis VII

The one doctor-nurse team studied (groups 9 and 10) showed the female nurse in a feminine sex-role with the male psychiatrist toward the masculine sex-role. This would agree with the comments of Rosenbaum (1971) and DeYoung and Tower (1971) that the nurse might be seen in a more dependent role (feminine role) when working with a psychiatrist since nursing is traditionally dependent to the medical profession. However,

TABLE 10

SEX-ROLE PERCEPTION BY GROUP MEMBERS OF THERAPISTS HAVING DIFFERENT PROFESSIONAL STATUS

GROUP NUMBER	CO-THERAPISTS	STATUS OF CO-THERAPISTS	FEM	"N"	MASC	LEVEL OF SIGNIFICANCE
1	19 (Female)	2	3	5	0	*
	1 (Male)	3	0	6	2	
4	21 (Female)	1	0	8	0	.05
	4 (Male)	2	5	3	0	
5	21 (Female)	1	0	8	1	> .05
	4 (Male)	2	5	4	0	
9	8 (Male)	1	0	6	2	.01
	5 (Female)	2	6	2	0	
10	8 (Male)	1	0	8	0	.01
	5 (Female)	2	6	2	0	
11	9 (Male)	2	0	5	0	> .05
	10 (Male)	3	2	3	0	
12	11 (Male)	2	3	1	0	*
	1 (Male)	3	0	4	0	
14	2 (Male)	2	1	4	0	*
	14 (Male)	3	0	6	1	
15	2 (Male)	2	1	7	0	*
	14 (Male)	3	0	5	3	
16	15 (Male)	1	0	4	1	> .05
	16 (Male)	3	1	4	0	
20	2 (Male)	2	0	6	0	*
	5 (Male)	3	0	6	0	
23	6 (Female)	2	0	5	0	*
	7 (Female)	3	0	5	0	
29	16 (Female)	2	0	6	0	*
	15 (Female)	3	0	6	0	

* = No Consensus

the same nurse was also perceived in the feminine sex-role when working with another female nurse (group 24). From these results it might be concluded that this particular nurse demonstrates only the behaviors descriptive of the feminine sex-role.

The female nurse working with a male minister (group 1) was also seen toward the feminine sex-role with the minister being perceived toward a masculine sex-role. It is interesting to note that a male social worker when working with the same minister (group 12) was seen in the feminine sex-role.

The investigator from personal knowledge of the theoretical backgrounds of the therapists and the findings discussed here agrees with Atrachan (1967) and Berger (1970) that the personality and the training of the therapist has more effect on the group setting than the professional status or the sex of the therapist.

Summary

In testing Hypotheses I, II, and III using the tighter definitions of masculine and feminine sex-roles, thirty out of thirty of the male therapists were not seen in masculine sex-roles. Twenty-five out of the thirty female therapists were not seen in feminine sex-roles. With the looser definitions of masculine and feminine sex-roles, the perception of the group members toward the male therapist remained the same;

however, only sixteen out of the thirty female therapists were not seen in a feminine sex-role.

In testing Hypothesis IV in conjunction with Hypotheses I, II, and III, when using the tighter definitions of masculine and feminine sex-roles, the thirty groups came to a consensus of about fifty-seven of the sixty therapists studied. When using the looser definitions of masculine and feminine sex-roles, the thirty groups came to a consensus on the sex-roles of forty-one of the sixty therapists.

The high levels of significance found in the testing of Hypotheses V, VI, and VIII indicated that the group members perceived the therapists in the same sex-roles, regardless of the sex of the group member or the co-therapist the therapist was working with. Only three out of the thirteen cases could be rejected when testing Hypothesis VII regarding the therapist with the higher professional status being perceived in the masculine role and the therapist with the lower status in the feminine role.

CHAPTER V

SUMMARY

The present study was designed to investigate the sex-role perception of group members toward their therapists in psychotherapy groups led by co-therapists. Additional purposes for the study were: to determine whether or not the group members perceived the therapists' in the same sex-roles, to determine whether or not different groups led by the same co-therapy teams perceived therapists in the same sex-roles, to determine whether or not different groups led by different co-therapy teams having one therapist in common perceived that therapist in the same way, to determine if the sex of the group member made a difference in the sex-role perception of the therapist and to determine if therapists from different professional disciplines working as co-therapists were perceived differently, with the therapist from the higher professional status seen in the masculine role and the therapist from the lower status seen in the feminine role.

A non-parametric qualitative descriptive design was chosen for this study. The instrument used in the collection of the data was a questionnaire developed by the investigator and validated by a panel of experts. The subjects were selected for the study by convenience sample. Thirty psychotherapy groups were studied: ten led by male/female co-therapy teams,

ten led by male/male co-therapy teams, and ten led by female/female co-therapy teams. The Kolmogorov-Smirnoff tests were used in the statistical analysis of the data.

Two definitions for masculinity and femininity were used in the study: the tighter definition for masculinity/femininity allowed no overlapping of the sex-role traits; the looser definition was considered more conservative in rejecting the null hypotheses.

The results of the study showed that the therapists were not necessarily seen in the sex-role stereotypes belonging to their true sexual identity. In fact, one hundred percent of the male therapists were not seen in a masculine sex-role using both the tighter and looser definitions of masculinity and femininity. When using the tighter definition of masculinity/femininity, eighty-three percent of the female therapists were not seen in feminine sex-roles. When testing the total group perception of the therapists' sex-roles, seventeen percent of the females were seen in feminine sex-roles and ten percent of the males were seen in feminine sex-roles. When using the looser definitions of masculinity/femininity, seventy-three percent of the females were not seen in feminine sex-roles. When testing the total group perception of the therapists' sex-roles, twenty-seven percent of the male therapists were seen in feminine sex-roles and thirty percent of the female therapists were seen in feminine sex-roles.

There was a high level of agreement between the group members' perception of the therapists' sex-roles, regardless of the sex of the group member or the co-therapist the therapist was working with. Of the thirteen groups having co-therapy leaders from different professional disciplines, the null hypotheses could be rejected in only three cases. In twenty-three percent of the groups, the group members perceived the therapist from the higher status toward the masculine sex-role and the therapist from the lower status toward the feminine sex-role. Thirty-seven percent of the groups perceived the therapists in the opposite direction, that is, the lesser status toward the masculine sex-role and the greater status toward the feminine sex-role. Twenty-three perceived the therapists in the same way.

Recommendations

Based upon the findings of this study, the researcher makes the following recommendations:

1. Future studies to determine how the therapists perceive their own behavior as well as that of their co-therapist.
2. Future studies to determine how the therapists' perception of their own behavior correlates with the group members' perception.
3. Future studies to determine if one therapist is seen in a dominant role and the other in a less dominant role.
4. Future studies to determine reasons behind a therapist's

selection of another therapist for a co-therapy team leader.

5. Further studies to determine the effect of different professional disciplines working as team members, on the group members' perceptions of the therapists' sex-roles; especially doctor-nurse teams working in the hospital setting.
6. Further development of a reliable instrument to determine the sex-role identification of the therapists by group members.
7. Develop further methods for effective evaluation of the co-therapy team approach.
8. Further studies to determine if the theoretical framework of the therapist makes a difference in the group members' perception of the therapists' sex-roles.
9. Further studies to determine if therapists view their clients according to sex-role stereotypes.
10. Further studies to determine if the therapists' perception of the client's sex-role affects the therapists' perception of the client's mental health status.

Implications

Based upon the findings of this study, the following implications seem justified:

1. Need to educate therapists in the recent trends toward androgynous sex-roles.

2. Opportunities should be provided for therapists to identify and evaluate their feelings and reactions to sex-role related behaviors exhibited by co-therapists and clients in the group setting.
3. Training for therapists should include increased emphasis upon the continual exploration by the therapist of his own systems of beliefs and values and their effect upon the therapeutic process.
4. Continued exploration of identity conflicts of therapists resulting from the changing premises of psychiatric problems and the fusion of the different professional disciplines, especially doctor-nurse teams working in the hospital setting.
5. Provide interdisciplinary groups for co-therapists to discuss and resolve common problems and conflicts arising in the co-therapy treatment approach.

Conclusions

Based upon the findings of this study, the following conclusions were made:

1. The therapists were not seen in traditional masculine/feminine sex-roles.
2. The group members' perceptions of their therapists' sex-roles goes beyond the phenomenon of transference as the group members perceived the therapists consistently in the same roles.

3. The personality of the therapist has a greater effect on the group members perceptions of the therapists' sex-roles than the sex or the professional status of the therapist.

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APPENDIX I

MALE/FEMALE CO-THERAPY TEAMS

GROUP NUMBER	NUMBER OF MEMBERS	THERAPIST FEMALE A	PROFESSIONAL STATUS	THERAPIST MALE B	PROFESSIONAL STATUS
1	8	19	Nurse (2)	1	Minister (3)
2	5	6	Social Worker (2)	2	Social Worker (2)
3	5	14	Social Worker (2)	3	Social Worker (2)
4	8	21	Psychiatrist (1)	4	Psychologist (2)
5	9	21	Psychiatrist (1)	4	Psychologist (2)
6	4	7	Therapist Aide (3)	5	Therapist Aide (3)
7	6	13	Social Worker (2)	6	Social Worker (2)
8	5	13	Social Worker (2)	7	Social Worker (2)
9	8	5	Nurse (2)	8	Psychiatrist (1)
10	8	5	Nurse (2)	8	Psychiatrist (1)

APPENDIX II

MALE/MALE CO-THERAPY TEAMS

GROUP NUMBER	NUMBER OF MEMBERS	THERAPIST MALE A	PROFESSIONAL STATUS	THERAPIST MALE B	PROFESSIONAL STATUS
11	5	9	Nurse (2)	10	Minister (3)
12	4	1	Minister (3)	11	Social Worker (2)
13	4	12	Psychiatrist (1)	13	Psychiatrist (1)
14	7	2	Social Worker (2)	14	Therapist Aide (3)
15	8	2	Social Worker (2)	14	Therapist Aide (3)
16	5	15	Psychiatrist (1)	16	Doctoral Student (3)
17	9	17	Minister (3)	18	Minister (3)
18	9	17	Minister (3)	19	Minister (3)
19	8	17	Minister (3)	19	Minister (3)
20	6	2	Social Worker (2)	5	Therapist Aide (3)

APPENDIX III

FEMALE/FEMALE CO-THERAPY TEAMS

GROUP NUMBER	NUMBER OF MEMBERS	THERAPIST FEMALE A	PROFESSIONAL STATUS	THERAPIST FEMALE B	PROFESSIONAL STATUS
21	4	1	Nurse (2)	2	Nurse (2)
22	4	3	Social Worker (2)	4	Nurse (2)
23	5	7	Therapist Aide (3)	6	Social Worker (2)
24	8	5	Nurse (2)	8	Nurse (2)
25	9	9	Social Worker (2)	10	Nurse (2)
26	4	11	Technician (2)	12	Technician (2)
27	7	11	Technician (2)	12	Technician (2)
28	3	13	Social Worker (2)	14	Social Worker (2)
29	6	15	Therapist Aide (2)	4	Nurse (2)
30	6	17	Social Worker (2)	18	Social Worker (2)

APPENDIX IV

Below is a list of descriptive words and phrases. For each word or phrase, determine if in our culture it would be considered a masculine or a feminine characteristic. If it applies equally to both sexes, check both. If it applies equally to neither sex, check neither.

Masculine	Feminine	Neither	Both	
____	____	____	____	aggressive
____	____	____	____	directive
____	____	____	____	accepting
____	____	____	____	supportive
____	____	____	____	understanding
____	____	____	____	protective
____	____	____	____	powerful
____	____	____	____	caring
____	____	____	____	gentle
____	____	____	____	kind
____	____	____	____	decision-maker
____	____	____	____	enthusiastic
____	____	____	____	spontaneous
____	____	____	____	intellectual
____	____	____	____	tells-it-like-it-is
____	____	____	____	realistic
____	____	____	____	straight-forward
____	____	____	____	logical
____	____	____	____	problem-solver
____	____	____	____	has strong opinions
____	____	____	____	helpful

APPENDIX V

This study is being conducted by a graduate student at Texas Woman's University. The purpose of the study is to collect data about co-therapy treatment groups. Involvement is the choice of each individual group member. All answers will be confidential, and only the investigator will have access to the questionnaires. After completing the questionnaire, please place the questionnaire in the envelope provided and seal the envelope before returning it to your group leaders.

APPENDIX VI

Your sex_____

Below is a list of descriptive words and phrases. For each word or phrase check the therapists for whom it best applies. If it applies equally to both therapists check both. If it applies equally to neither therapist check neither.

1 =

2 =

_____	_____	_____	_____	aggressive
_____	_____	_____	_____	accepting
_____	_____	_____	_____	supportive
_____	_____	_____	_____	directive
_____	_____	_____	_____	understanding
_____	_____	_____	_____	protective
_____	_____	_____	_____	powerful
_____	_____	_____	_____	caring
_____	_____	_____	_____	gentle
_____	_____	_____	_____	kind
_____	_____	_____	_____	decision-maker
_____	_____	_____	_____	enthusiastic
_____	_____	_____	_____	spontaneous
_____	_____	_____	_____	intellectual
_____	_____	_____	_____	tells-it-like-it-is
_____	_____	_____	_____	straight-forward
_____	_____	_____	_____	logical
_____	_____	_____	_____	problem-solver
_____	_____	_____	_____	has strong opinions
_____	_____	_____	_____	helpful