COUNSELLING HUMAN BEINGS OF THE FEMALE SEX

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Abstract

Two questions are considered: (1) whether women experience sex discrimination in counselling and (2) whether an adequate solution to experienced sex bias is counselling by the same sex counsellor.

Relevant literature is cited, and it is concluded (1) that although there is evidence of sexist bias in counselling and in definitions of "mental health," there is little evidence that male counsellors are more subject to bias than female counsellors; and (2) that it is essential for both male and female counsellors to be aware of how their social values and sexual biases may affect their attitudes and behaviour toward clients of either sex; and (3) that bias brought to counselling by clients must be considered a significant factor in the determination of counsellor credibility.

Résumé

L'étude examine les deux questions suivantes: (1) les femmes sont-elles victimes de discrimination sexuelle lors de la consultation, et (2) la consultation effectuée par un conseiller du même sexe que le client peut-elle agir à titre de solution adéquate au problème du préjugé sexiste?

L'auteur cite les études appropriées et il tire les conclusions suivantes: (1) bien que la consultation et que les définitions attribuées au terme 'santé mentale' fassent preuve, à certains moments, de préjugés sexistes, il y a très peu d'indications que les conseillers soient plus sujet à ce genre de préjugés que les conseillères; (2) il faut absolument que les conseillers et les conseillères soient conscients de l'effet de leurs valeurs sociales et de leurs préjugés sexuels sur le comportement et sur les attitudes manifestés à l'égard des clients des deux sexes; (3) le préjugé du client doit être considéré à titre de facteur signifiant lorsqu'il est question d'établir la crédibilité du conseiller.

> Man is willing to accept woman as an equal, as a man in skirts, as an angel, a devil, a baby-face, a machine, an instrument, a bosom, a womb, a pair of legs, a servant, an encyclopedia, an ideal or an obscenity; the thing he won't accept her as is a human being, a real human being of the female sex. (D.H. Lawrence)

The trend in society in recent years has been to assert women's equality or, put more accurately, women's personhood on an equal basis with men. Critics of counselling and therapy (these terms are judged to be equivalent within the context of this paper) have questioned whether the pervasive sexual bias in society is present in counselling for women. Assertions of sexual bias stemming both from psychological theory as well as traditional practices have, at times, been vehement. Phyllis Chesler (1972) at one extreme says men drive women mad; for a woman to trust any but a female feminist therapist is therefore a sign of pathology. It has also been claimed that only a therapist with feminist training can adequately handle therapy with today's women.

Historically this debate about what constitutes good therapy for women has not been specifically addressed until very recently. Texts on counselling and psychotherapy show little or no distinction between males and females as clients either in diagnosis, treatment procedures, or goals (Fabrikant, 1974). The argument currently is that this neglect of the male-famale difference as *a* difference, not *the* difference, is now becoming more apparent as social role stereotypes are being challenged (Keller, 1974). Whether this neglect is considered a significant problem by only a small group of ardent feminists or by a broader cross-section of women is as yet an unresolved issue.

Anne Steinman's (1974) extensive 20 year cross-cultural research suggests there is a broad base to the movement to extend women's activities beyond the traditional primary focus on wife-mother roles. Her studies of over 20,000 women and men drawn from 18 countries indicate that women at all social and educational levels want a combination of activity aimed at self-realization and activity centered around traditional wife-mother roles.

The issue of the adequacy of therapy then, particularly as it relates to role conflicts, may be an issue both for women who desire a slight shift

in roles that is perceived as conflicting with male expectations and for women desiring a major shift which may include rejection of traditonal roles.

THERAPY, BAD THERAPY AND SEXIST THERAPY

The issue in this largely speculative debate seem to revolve around whether one can distinguish sexist therapy as a notable instance of bad therapy and/or whether there is a sexist bias intrinsic to all or most therapeutic encounters.

Therapy as Intrinsically Sexist

The assertion that a sexist bias is intrinsic to most therapeutic encounters is based on the major influence of classical analytic formulations, on the predominance of male therapists, and on mental health concepts (Chesler, 1972; Fabrikant, 1974; Report of the task force, 1975; Rice & Rice, 1973; Steinmann, 1974).

Freud's Therapeutic Influence. Rightly or wrongly, a major portion of difficulties experienced by women in therapy are ascribed to the use of analytic concepts (Fabrikant, 1974; Report of the task force, 1975; Rice & Rice, 1973; Steinmann, 1974). The conception of deviation form a traditional role as a pathological phenomenon and Freud's negative descriptions of women as "less ethical, with less of a sense of justice, more envious, weaker in social interest, more vain, narcissistic, secretive, insincere, masochistic, passive, childlike and incomplete" (Rice & .Rice, 1973, p. 191) have led to the assessment of psychoanalysis as a major source of clear sexist and counter-therapeutic theoretical formulations underlying therapeutic practice. The fact that reformulation of analytic theory have taken very different tacks from what Freud admitted was a blind spot for him has sometimes been overlooked. That he was *describing* rather than *advocating* the male and female positions in a patriarchal society is usually not considered in this debate.

Predominance of male therapists. The greater availability of male therapists brings with in the question of whether a male-female therapy relationship carries within it the sex-role stereotypes of the culture and by so doing counter-therapeutic constraints to the therapists judgment and to the client's options (Rice & Rice, 1973).

The lack of process studies of sex bias and sex-role stereotyping during therapy (Stricker, 1977) leaves the necessity of relying on clinical judgments (sometimes better characterized as rampant unsupported speculation) for suggestive rather than definitive statements in assessing potential concerns during the ongoing process of therapy.

The presence of sex stereotypes which express a bi-polar conception of male-female attributes with a predominance of negative traits belonging to females and a predominance of positive traits presumed to be more characteristic of males is well documented (Maccoby & Jacklin, 1974; Sargent, 1977; Stricker, 1977). That sex-role stereotypes exist is unquestioned; that they influence the course of therapy is the issue in evaluating the adequacy of therapy available to women.

The Broverman, Broverman, Clarkson, Rosenkrantz and Vogel (1970) studies and the replication of these studies by Fabrikant (1974) are frequently cited as demonstrating that sex-role stereotypes are reflected in clinical judgments and that devaluation of feminine traits is clearly apparent in assessment of clients. There is contradictory evidence about whether this pro-male bias exists equally in male and female therapists (Report of the task force, 1975). The Broverman et al. (1970) studies have been criticized, however, both for the methodological approach used as well as for the conclusion drawn from them that therapist behaviour necessarily follows from expressed attitudes (Stricker, 1977).

A number of recent studies seem to demonstrate a shift in male therapist attitudes in the direction of more positive assessment of feminine attributes and a more accepting view of deviations from traditional sex roles. The determination of whether this is a genuine attitude shift which is reflected in subsequent behaviour or whether it is an intellectual commitment to a new liberal stance that is not backed by an emotional and behavioural shift is a crucial but as yet uncertain issue. The Rosenthal studies (Tavris, 1977) have demonstrated that we unconsciously transmit to others our expectations and that these cues are transmitted largely through nonverbal communication. The process studies so far done in education suggest that equality of treatment for male and female students may be a strongly held value by teachers but one that is belied by their classroom behaviour (Guttentag & Bray, 1977). One might reasonably expect the same phenomena to occur in the counselling process.

The APA Task Force Report on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice (1975) notes that female members of APA believe that fostering of traditional sex roles, bias in expectations, and devaluation of women are common therapeutic occurrences. The research of Steinmann (1974) is again intriguing and apropos. Her research covering a broad cross-section of society suggests that men and women express very similar views of their ideal woman as having a combination of independent self-achieving goals and family oriented goals. However, the large

majority of women do not believe men are sincere in stating their ideal. They believe, instead, that men in fact want women to be more passive and dependent and to put nurturance of husband and children *before* self-nurturance. Steinmann (1974) also found that a group of highly achieving academic and professional members of a feminist organization saw the discrepancy between a woman's self-ideal and her view of a man's ideal woman as three times greater than the analogous discrepancy for a cross-sectional sample of women. This brings into sharp focus the extreme conflict of at least some achievement-oriented women in how they see themselves and how they think men want them to be.

An important point in this research that bears on the adequacy of available therapy is that the large majority of women do not believe that men are sincere in expressing acceptance of non-traditional goals for women. The more highly achieving women believe there is a very great discrepancy between goals for themselves and the goals a man is likely to have for them. Because of the predominance of male therapists, then, comes the expection that the therapist will have implicit values and goals which are at odds with those a woman might have for herself. Whether these expectations could be changed by the therapist is doubtful if there is ambivalence or conflict expressed in his behaviour. High sensitivity, if not downright suspicion, is likely to be the approach of at least some women to a male-female therapeutic relationship. Sex-role stereotypes then may well be entering the therapeutic situation in a constraining fashion from *both* the client and the therapist.

Mental Health Concepts. Some of the literature suggests that women have been caught in double-binding assessments of their mental health. To deviate from traditional roles has been judged to be a neurotic escape from health (Task force report, 1975) while to have traditionally negative feminine characteristics, that is to be more submissive, less independent, less competent, less objective, less adventurous, and more easily influenced is, strangely enough, judged to be healthy if you are a woman but not if you are a man (Broverman, et al., 1970). While the Broverman studies may have tended to exaggerate the clinical judgments made, the possibility of a double standard of mental health must be considered as part of our cultural bias in viewing women. However, the fact that the symptomology of depression — passivity, dependence, self-depreciation, self-sacrifice, fearfulness, failure — bears a close resemblance to the traits socialized in women and the fact that estimates of depression in women run as high as 8% as compared to 4% for men bears some thought. Perhaps an equally suggestive case could be made in juxtaposing the greater socialized aggressiveness in males and the greater incidence of character disorders in men. This would, however, serve to strengthen the argument that our socialization practices may differentially serve to encourage distinct types of mental illnes for males and females. This would seem to be a stronger argument for evaluating the effects of our socialization practices than it is an argument demonstrating a necessary bias in the therapeutic process *per se.*

The concept of deviance from the norm as psychopathological is clearly a narrow concept but, if used, is likely to create problems for women wanting to break new trails and deviate from traditional roles. "If mental illness is, by definition, a departure from expected social roles, then women, offered a narrower range of roles than men, will more often suffer mental illness" (Beck & Greenberg, 1974, p. 117). That deviance from social norms is in fact considered more pathological for women than men is suggested in the treatment they receive in mental hospitals and for alcoholism. Howard & Howard (1974) report that similar behaviours such as getting drunk, fighting, or leaving an institution for a few days without permission is more likely to be seen as an indication of pathology in a female patient than in a male patient. Similar differential assessments are given by physicians to women who are alcoholics. Women alcoholics are more likely to be diagnosed as "sicker" and given a poorer prognosis than comparable males even though virtually all work on alcoholism has been on male alcoholics (Gomberg, 1974).

To the extent, then, that therapy is viewed as maintaining the status quo and as helping an individual fit into the society, the assertion that women may be victimized may have some weight. A broader definition of mental health appears to be more frequently used. However, goals that include the individual's sense of well-being, his/her fit within the culture or subculture to which he/she belongs and some notion of the intra-psychic strengths needed to function appear to be operating in some integrated fashion in most attempts at conceptualizing mental health goals (Strupp & Hadley, 1977). This assertion of bias would consequently appear to be valid for a relatively small section of the therapeutic community. Its relevance may be more accurately related to the need for examination of socialization practices and the influence of those practices in encouraging or discouraging mental illness.

Sexist Therapy as Bad Therapy

Stricker (1977) makes a distinction between bad therapy and sexist therapy. In his view, any intrusive, insensitive, exploitative therapy is bad therapy for both sexes. Failure to consider

external social forces as well as internal forces in diagnosing a problem is also bad therapy. For Stricker, sexist therapy occurs when the quality of therapy offered to one sex is inferior to that offered to the other. Sexist therapy also occurs when a therapeutic approach appropriate for only one sex is provided to the other.

According to this veiw, sexist therapy exists where the therapist misuses his position and fails to provide appropriate treatment *because* of the sex of the client. Stricker makes the dogmatic claim that this exists in therapy (1) when a sexual relationship exists between therapist and client, (2) when the length of therapy suggests exploitation of the dependent relationship, and (3) when any barriers such as sex stereotypes are raised by the therapist which serve to impede the client's growth. While these may be labelled sexist issues, why they could not be as adequately characterized as ethical issues is difficult to see. Is misuse or abuse of power unethical when it affects only the same sex recipient and sexist when it affects the opposite sex? If it can be shown that the misuse occurs preponderantly with one sex then the label may apply, otherwise it muddies the waters.

The most frequent instance of sexist misuse of power and of exploitation of female dependency is said to be the relative length of time males and females spend in therapy. Fabrikant (1974) reports finding that males were in therapy an average of 2.3 years while females averaged 5.7 years. It may also be possible to characterize this greater length of therapy time in a more positive way as related to a women's greater attention to feelings and greater willingness to work on relationship concerns. Length of time as a variable in therapy in isolation from other variables such as type of problem and therapeutic approach is a very limited basis on which to make a sexist judgment.

Stricker's (1977) third instance of sexism in therapy, that of the barriers that sex-role stereotypes bring to therapy, is essentially the same issue as that discussed as a potential reality problem for a predominantly female client population and a predominantly male therapist population. The Task Force Report (1975) mentions a related issue — that of reportedly widespread ignorance of important aspects of a woman's life such as emotional changes associated with the menstrual cycle, pregnancy, childbirth, and menopause. Again, intrusion of values and ignorance of the issues involved strikes me as bad or incompetent therapy. It is just as bad therapy when it happens to a male client as a female client, and I suspect it would be as likey to occur to a male who rejects the traditional masculine role and aims at a nurturant, dependent, domestic life stype as a female that does the opposite. The potential on the part of a female therapist to understand or to be perceived as understanding, the nuances of a competitive job market, the anxiety over impotence, or the changes occurring with male hormonal cycles would, I suggest, be no different than the male therapists pointed to by the Task Force Report.

The instances of sexist practices enumerated by Stricker (1977) and the Task Force (1975) need further demonstration of their existence as specific to a preponderance of one sex but not the other in similar circumstances. That these practices may be unethical or incompetent seems to be both a more apt and a more constructive criticism to level. If one is truly concerned with improving bad therapy, one does not raise defensive postures with unnecessary labels of "sexism."

CONCLUSIONS

My overall impressions of this debate are that the significant issues involved have more to do with improving therapeutic practices and making them more attuned to social issues and values than they have to do with sexist practices specifically with women.

The major issue, it seems to me, is whether sex-role stereotypes and related values are influencing therapeutic practices. The lack of process studies on this issue is unfortunate. However, both significant portions of major theoretical conceptions of the therapeutic process as well as recent research such as the Rosethal studies and the process studies in education point to the probable instrusion of values and attitudes into the therapeutic relationship regardless of the intent of the therapist. There is no reason to assume that this is any less a concern to male or to female therapists. This likely intrusion emphasizes the well recognized and continued need for self-awareness on the part of therapists particularly as this relates to the possibility of counter-transference responses.

This issue may bring into sharper focus the need for self-awareness in therapists to include not only intra-psychic factors that may be introjected into the therapeutic relationship but also selfawareness of the values and conflicts involved in the social milieu from which both therapist and patient come. The assumption that therapists can maintain neutrality in social values is particularly difficult to accept when the specific problem area is that of changing values as related to changing sex roles. Every man and every woman is inextricably involved in the issue by the fact of being a man or a woman. The raising of consciousness by whatever means is a continuing need not only to be truly helpful to today's women but to today's men as well.

A critical issue in providing adequate therapeutic services particularly in a university setting is the repeated finding of Steinmann (1974) that, no matter what men say, women do not believe men are sincere in accepting a more independent, self-nurturing or self-achieving life style for them. Whether this is a projection on women's part of a recognition of a discrepancy between what men say and what they do is not at all certain at this point. What is clear is that women generally doubt a man's willingness to accept a shift away from traditional roles. This belief seems to be implicit in the arguments for the necessity of female feminist therapists or for therapists of either sex *only* if training and supervision are provided by a feminist.

To follow the argument that one must have personal experience (or intensive training by someone with such experience) to understand another's experience through to its logical conclusion is to argue that only Christians can counsel Christians, only blacks can understand blacks, only the dying can speak meaningfully to the dying. The eventual conclusion one must reach is that only the cloning of oneself will yield a truly empathic therapist! As ridiculous and unrealistic as the extreme but logical conclusion is, I think there is a point to the argument that stems from a solid base of everyday experience. There is a common assumption made that the probability of obtaining understanding and the ease of making one's feelings clear will be considerably greater with someone who has shared similar experiences. The strong feelings of minority groups on this point is vividly expressed by a black in white-ruled Africa: "But I no think say you yourself understand plenty things. And I no think say you go fit understand them if you live here for one hundred years! . . . You no go see broad daylight (Ulsai, 1970, p. 160). Both learning theory and information theory support the validity of this common feeling. The postulation that "What you know already will greatly shape and constrain what environmental information you can detect and process" (Flavell, 1977, p. 8) appears well established. This argument also relates to Comte's philosophical postulation that the operation of *Verstehen* as a kind of knowledge "is fatuous to overlook" (Abel, 1953, p 678). *Verstehen* is conceived of as a kind of comprehension, an ability to share a state of mind, that is a more profound level of understanding than statistical knowledge can ever be. While it may be argued that *Verstehen* on some feeling level is present in any productive therapeutic endeavour, it must be recognized that a same sex counsellor or therapist may have an initial advantage in establishing a relationship of trust.

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