8-1983

Gender Difference as a Factor in Psychological Crisis

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GENDER DIFFERENCE AS A FACTOR IN PSYCHOLOGICAL CRISIS

by

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A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counseling and Personnel

Western Michigan University
Kalamazoo, Michigan
August 1983

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Western Michigan University, 1983

The study's purpose was to examine possible gender differences in problem perception and desired treatment outcome of 311 persons (135 males and 176 females) selected from a pool of 1500 clients seeking treatment at an outpatient mental health clinic in a medium-sized midwestern city. One hundred males and one hundred females were randomly selected for inclusion.

Literature related to crisis theory, research in linguistics, and gender role indicated evidence supporting gender role differences in a variety of interpersonal situations. Clients' verbatim written statements and their reactions to a standard problem checklist at the time of intake provided the data base for analysis. Coding of verbatim statements following neurolinguistic categories permitted comparisons between male/female response to psychological crisis. Chi-square and t-tests were used to compare linguistic categories and problem perception; the $p. < .05$ level of significance was used.

Statistically significant findings were: (1) Women expressed a desire for intrapersonal change in their treatment outcome statements; (2) Women identified more symptom items on the problem checklists; (3) Women used more first person pronouns in their treatment statements; (4) Women used more kinesthetic or feeling words in their problem statements; and (5) Both sexes' use of unspecified

representational predicates increased from the problem statements to the desired outcome statements.

The research results provided support for the theoretical propositions of Miller (1976) and Gilligan (1982), who hypothesized that women are different from men in their intrapersonal and interpersonal processes. Females, as clients, possessed attributes such as the desire to change intrapersonally, an acceptance of responsibility to change themselves, and a willingness to discuss and express their problems in the affective domain. For counselors and psychotherapists such client characteristics are highly desirable for participation in counseling and psychotherapy.

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ACKNOWLEDGEMENTS

I am sincerely grateful to Dr. Robert Betz, Dr. Robert Brashear, and Dr. George Sidney for their guidance and encouragement throughout my academic pursuits at Western Michigan University. As my mentors, their instructive criticism, faith, and emotional caregiving provided me with the energy to carry on with my task.

I would also like to take this opportunity to thank my parents, Mr. and Mrs. Lief, for their financial and emotional support. Their ongoing encouragement added greatly to my success.

A special acknowledgement to my dearest friends and colleagues: Georgette Rogers, whose assistance in scoring the data was invaluable to me, and Maureen O'Toole and Les Kertay, whose thoughtful editorial commentary helped me through the arduous rewriting process.

Paula Laufer

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CHAPTER I

INTRODUCTION

The Problem and Its Background

During the last ten years there has been a virtual explosion of theoretical literature examining questions related to various differences between men and women. Many differences have been postulated, and some have been substantiated by research. The nature, extent, and origins of sex-linked differences, as well as the effects of societal and clinical attitudes toward these differences, have formed important areas of investigation. Since this has been a relatively new field of endeavor for researchers, both the formulation of the questions and the language of the answers have been somewhat conditioned by old habits and prejudices. Historically, in the fields of psychiatry, psychology, and counseling, women have been viewed in the role of caretaker or nurturer. An individual woman was judged in terms of pathology according to how well or how poorly she seemed to fit the prevailing notions as to the requirements of that role. However, even a woman who performed well in that role was often still seen as inferior in comparison to the (masculine) standard. More recently, women have begun to examine the position this assumption has put them in and ask that many professionals, including those in counseling and psychology, view them and meet their needs in a different way. This has created a need for research which bypasses

old assumptions and searches for and delineates actual differences between men and women in this society. It is only when these differences have been properly identified that their implications for clinical practice can be assessed.

Statement of the Problem

The purpose of this study was to examine differences between men and women seeking treatment in a crisis situation. The language which men and women used on a clinic intake form to describe their problem(s) and their desired outcome(s) of treatment was first examined to determine whether or not men and women would conceptualize the basis of their problems differently. Additional significant questions included: whether or not the number of somatic symptoms reported would vary by sex; whether or not the number of problems reported or the length of description of the problems would vary by sex; and whether or not certain linguistic structures would predominate in the language of one sex or the other. The study also examined desired outcomes of treatment as expressed by both sexes in order to determine whether or not men and women were, in fact, seeking the same results when they entered into a therapeutic relationship.

Research Objectives

The aim of this study was to identify significant differences between men and women entering treatment. If it could be shown that a client's understanding of his or her problem and his or her expectations of treatment were related to sex or gender, this would

imply that the treatment would need to be modified to address this variable. It was thought that the more exactly these differences could be defined, the more information could be provided to clinicians in terms of developing more gender-specific treatment modalities, resulting in more effective treatment.

The study was begun by searching the literature in three areas: crisis intervention, sex-role differences, and linguistics. First, crisis intervention literature was studied to develop a working model of the functioning of persons in crisis and to answer questions about their common needs, expectations, beliefs, and stages. Second, the literature was examined for definitions and explanations of male-female differences. Examination of this literature indicated that there are differences, although there is contradictory information about exactly what those differences are, and also about what the differences mean, particularly in their applications to clinical practice. Third, literature was examined in the field of linguistics to explore the connections between language and meaning. Based on that examination, three questions were formulated: (1) what are the differences in men's and women's language about a crisis situation?; (2) do men and women identify the crux of their problem(s) differently when seeking treatment?; and (3) do men and women desire different outcomes from treatment? It was decided to examine narratives written by men and women seeking treatment.

Definition of Terms

For purposes of this examination, the following definitions were used.

Crisis was defined as an upset in a steady state characterized by the following phenomena: (1) a specific and identifiable stressful event; (2) the perception of that event as meaningful and threatening; (3) the response to the event; and (4) the coping task involved in successful adaptation.

Deletion was considered to be one of the three universals of human modeling--the process by which selected portions of the world are excluded from the representation created by the person modeling. Within language systems, deletion is a transformational process in which portions of the deep structure are unspoken and, therefore, do not appear in the surface structure (spoken) representation. For example, in the surface structure statement, "I'm scared," the question may be of whom or what. The answer to the question embraces a deep structure representation. It is necessary to determine whether the statement presented can occur in a sentence which is fuller, which provides a statement with more arguments or noun phrases than the original (e.g., "I am scared of feeling alone when my husband goes out of town"). (surface structure / deep structure)

Generalization was defined as another one of the three universals of human modeling. It was the process by which a specific experience comes to represent the entire category of which it was

a member. (For example, "Lois doesn't like me," may be generalized from "Women don't like me.")

Length of Sentence was simply the number of words which were used in the verbatim descriptions of the problem and desired treatment outcome statements (Appendix A).

Nominalization was the linguistic representation of a process by an event. (For example, "I'm in a deep depression" to "I'm deeply depressed," thereby changing the process of feeling depressed to a state of depression.)

Presupposition was defined as a basic underlying assumption which was necessary for a representation to make sense linguistically. Within language systems, a presupposition took the form of a sentence which had to be true for some other sentence to make sense. (For example, when a woman says, "I'm afraid that my son is turning out to be as lazy as my husband," it had to be accepted, though unstated, that she considered her husband to be lazy.)

Pronoun reference was a word belonging to one of the major form classes that is used as a substitute for a noun. The pronoun took noun construction and referred to persons or things named, asked for, or understood in the context. ("I" and "me" are the two pronoun usages to be tabulated.)

Representational Predicates referred to the part of a sentence or clause that expressed what was said of the subject; they usually consisted of a verb with or without objects, complements, or adverbial modifiers. Predicates were representational in that they provided categories of verb use which corresponded to the sensory

functions of human physiology. These systems were kinesthetic, visual, auditory, olfactory, and gustatory. (See Appendix B for examples of usage.)

It was expected that males and females would conceptualize their crises differently, and the following hypotheses were formulated about differences that would be found between males' and females' written responses to items on a clinical intake form.

Hypotheses

H I.A: Women would perceive their problems as intrapersonal (i.e., as a function of their own inadequacies) more than would men.

H I.B: Women would seek intrapersonal change in describing the desired treatment outcome more often than would men.

H II.A: Men, when compared with women, would perceive their problems as interpersonal and as a function of being misunderstood by others.

H II.B: Men, when compared with women, would seek to change their relationships or their situations, interpersonal change, when describing the desired treatment outcome.

H III.A: When stating their problems, men would express more somatic symptoms, such as nervousness and palpitation, than would women.

H III.B: Men, more than women, would seek to change their somatic symptoms in stating their desired treatment outcomes. (For example, "I need to control my nervousness for my job.")

H IV: Women would check more items on the problem check list than would men.

H V.A: Women would write longer statements (use more words) to describe their problems than would men.

H V.B: Women would write longer statements (use more words) to describe their desired treatment outcomes than would men.

H VI.A: In describing their problems, women would use more "I" and "me" statements than would men.

H VI.B: Women would use more "I" and "me" statements in describing their desired treatment outcomes than would men.

H VII.A: Men would use more nominalization than would women by changing a process to an event in their descriptions of the problems.

H VII.B: Men would use more nominalization than would women in describing their desired treatment outcomes.

H VIII.A: The occurrence of presuppositions would not differ between males and females in their descriptions of the problems.

H VIII.B: The occurrence of presuppositions would not differ between males and females in describing desired treatment outcomes.

H IX.A: The occurrence of generalizations would not differ between males and females in describing their problems.

H IX.B: The occurrence of generalizations would not differ between males and females in describing their desired treatment outcomes.

H X.A: Women would use more deletions than would men in the description of their problems.

H X.B: Women would use more deletions than would men in describing their desired treatment outcomes.

H XI.A: Women would use more kinesthetic predicate representations than would men in stating their problems.

H XI.B: Women would use more kinesthetic predicate representations than would men in stating their desired treatment outcomes.

H XII.A: The occurrence of the use of visual representation would not differ between women and men in describing their problems.

H XII.B: The occurrence of the use of visual representation would not differ between women and men in describing their desired treatment outcomes.

H XIII.A: The occurrence of the use of auditory representation would not differ between women and men in describing their problems.

H XIII.B: The occurrence of the use of auditory representation would not differ between women and men in describing their desired treatment outcomes.

H XIV.A: The occurrence of the use of gustatory representation would not differ between women and men in describing their problems.

H XIV.B: The occurrence of the use of gustatory representation would not differ between women and men in describing their desired treatment outcomes.

H XV.A: The occurrence of the use of olfactory representation would not differ between women and men in describing their problems.

H XV.B: The occurrence of the use of olfactory representation would not differ between women and men in describing their desired treatment outcomes.

H XVI.A: Men would use more unspecified predicate representations than would women when describing their problems.

H XVI.B: Men would use more unspecified predicate representations than would women when describing their desired treatment outcomes.

Significance of the Study

Evidence was found (Gilligan, 1982; Miller, 1973; Schaef, 1981) that women were different from men in some key areas which impacted on their presentation to therapists and on their expectations of therapy. There was further evidence that these differences were sometimes used by therapists in an analysis which did not flatter or serve women (Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Davidson, 1980; Green, 1980). If actual sex-linked differences were evident, and if an objective theoretical basis for understanding and using them to empower clients could be developed, clinicians would be more effective in helping the majority of their clients. If differences were evident and significant, it would be possible to work toward answers about whether these differences were innate, or socially learned and perpetuated, and, if the latter, whether or not they contributed to healthy development. Thus, this study formed a beginning point for the reevaluation of the clinical treatment of women.

Limitations

The design of the study was problematic in some areas which

could have impacted on the overall applicability of its findings. It was a retrospective study, in which the researcher had no input into the milieu or instructions given at the time the intake forms were completed by the prospective clients. The intake forms constituted the clients' perceptions of their problems, raising questions about their validity because they contained only self-reported factors. A third problem concerned how representative the sample was of the general population. This sample population was drawn from people seeking outpatient services at a clinic in a medium-sized (population 100,000) midwestern city. Its applicability to other groups would need to be verified.

The groups themselves (male and female) were equivalent in terms of age. However, other factors such as educational level and socio-economic status were not measured, and differences here may have skewed the results. Finally, much of the framework of Neurolinguistic Programming was developed to categorize verbal responses. The results of this study may have been influenced by using a verbal format to analyze written narratives.

Summary

This study was intended to contribute to the literature on sex-role differences and, by so doing, to sharpen clinical skills, particularly in the treatment of women. It was developed by exploring the literature of crisis intervention, sex-role differences, and linguistics, and formulating specific areas of inquiry into clinically significant differences between men and women at the

point of entering treatment. Written narratives on a clinic intake form were compared by sex for certain variations in expression of the clients' problems and their desired outcomes.

The following section describes in detail the background literature and contains the null hypotheses which were tested. Chapter III details the population and the manner in which the study was carried out. This is followed by a presentation and discussion of the present state of clinically applicable knowledge about women, areas of prejudice detrimental to women in clinical treatment, and suggestions for further study.

CHAPTER II

REVIEW OF THE LITERATURE

Crisis Intervention

During the last few decades, crisis intervention theory and practice have moved from an offshoot interest of a few psychologists to a respected field of study. In the review of crisis literature, the contributions of Erich Lindemann, Gerald Caplan, Lydia Rapoport, Howard Parad, and Robert Cole are presented in order to provide the reader with the necessary foundation and understanding of the theory and practice of crisis intervention.

Howard Parad (1971) defined crisis intervention as "a process for actively influencing the psychosocial functioning of individuals during a period of disequilibrium" (p. 196). The roots of this definition go back to the work of Erich Lindemann. This classic study of the bereaved disaster victims of the Coconut Grove nightclub fire of 1943, in which more than 400 persons lost their lives, opened a new area of inquiry in psychology. During the aftermath of this catastrophic event, Lindemann studied the grief reactions of its survivors. The results of this research became the cornerstone and impetus of further investigation for the development of crisis theory and practice.

Lindemann's contributions to crisis theory were best characterized as statements of symptomology. In 1944, he published his

findings on the characteristics of "grief reaction." He was impressed by the recurring similarities in his clients' presentations, noting: (1) a marked tendency toward sighing respiration which was most conspicuous when the patient was asked to discuss his grief; (2) a recurring complaint about loss of strength and overall exhaustion; (3) a repeated reference to digestive symptoms such as nausea, loss of appetite, or tastelessness of food; and (4) a struggle with feelings of increased emotional distance from other people.

Lindemann concluded that individuals experiencing acute grief usually had five related reactions: (1) distress, (2) preoccupation with the image of the deceased, (3) hostile reactions, (4) guilt, and (5) loss of patterns of conduct.

In addition, he found that the stages and duration of grief reaction seemed dependent upon the success with which persons conducted their "grief work." This work included achieving emancipation from the deceased, readjusting to the environment in which the deceased was missing, and forming new relationships. Lindemann also found that in cases of delayed grief reaction, particularly when the affected person had been confronted with essential tasks (continuing work or homemaking chores) and had assisted in maintaining the "morale of others" (caretaker role), the individual found him/herself experiencing grief after the tasks were completed.

This caretaker role was an important concept, as both men and women functioning in rigidly defined role systems could deny or suppress their feelings because they believed the care of others to be more important. When significant others were finally confronted

with the grief reaction of the caretaker, they did not understand and saw the reaction as inappropriate, because the time of crisis had passed.

In 1948, Lindemann and Gerald Caplan established an innovative community mental health program in Boston called the Wellesley Human Relations Service. Wellesley provided a field laboratory where together they continued to explore, refine, and explicate the use of what was later to be known as short-term treatment and crisis intervention.

In 1964 Caplan associated the concept of homeostasis with crisis intervention. He theorized that the human organism endeavored to maintain a homeostatic balance with the outside environment. When this delicate balance was threatened by either physiological or psychological forces, the human organism engaged in problem-solving activities designed to restore balance. He stated:

> The problem is one where the individual is faced by stimuli which signal danger to the fundamental need satisfaction or evoke major need appetite, and the circumstances are such that habitual problem-solving methods are unsuccessful within the time span of past expectations of success. (p. 39)

Caplan defined a crisis as an upset of a steady state in which the individual was faced with an obstacle, usually important to his/her life goals, that could not be overcome through ordinary methods of problem-solving.

In introducing the concept of homeostasis, Caplan described and differentiated the various stages of crisis; he viewed crisis as having four stages within a time-limited period of disequilibrium or

homeostatic imbalance. The first stage was a building of tension, manifested physically and/or emotionally, that resulted from the crisis-provoking event. As tension mounted, the individual tried to resolve the crisis by using familiar patterns of problem-solving behavior such as denial, projection, procrastination, etc. The second stage was characterized by increased tensions caused by the individual's inability to resolve the crisis; he/she could also attempt to use emergency problem-solving skills to reduce tensions. As emergency activities failed to alleviate tension, the individual entered the third stage of crisis. In this stage, the level of tension experienced was so great that the individual could experience acute depression because he/she felt helpless and lost. As he/she entered the final stage, one of two results was noted: If tension continued to increase, he/she could experience a major psychological breakdown, or he/she could resolve this crisis by using maladaptive patterns of behavior that decrease the tension but impair his/her future social functioning.

To broaden his definitions and descriptions of crisis, Caplan looked to the work of Erickson (1968), incorporating Erickson's model of developmental and accidental crises into crisis theory. Caplan defined developmental crises as transitional periods in personality development characterized by cognitive and affective upset, i.e., birth, infancy, childhood, adolescence, adulthood, and old age. Accidental crises were periods of psychological and behavioral upsets that are precipitated by life hazards involving significant losses, such as illness and death. Caplan emphasized that developmental and

accidental crises were transitional periods that presented the individual with an opportunity for personal growth, or were experiences of emotional and mental deterioration.

In further refinement of Lindemann and Caplan's basis crisis concepts, Lydia Rapoport (1962) emphasized that a crisis situation results in the creation of a problem that can be perceived as a threat, a loss, or a challenge. She adds that three interrelated factors usually produce a state of crisis:

(1) a hazardous event,

(2) a threat to life goals, and

(3) an inability to respond with adequate coping mechanisms.

Though both Lindemann and Caplan referred to a hazardous event, it was Rapoport who amplified their ideas and more clearly described the nature of this crisis-producing event. Her notion of a precipitating event which created a feeling of threat, loss, or challenge to life goals became a rallying point on which theorists and practitioners could agree as to when a situation was labeled a crisis.

Rapoport identified a three-phase model of crisis reaction:

(1) In the initial or beginning stage, there was a rise in tension due to the stressful precipitating event; this tension forced the individual to apply habitual problem-solving mechanisms to the crisis situation.

(2) If these traditional problem-solving mechanisms failed, tensions increased and the person moved into the middle phase or crisis. The person then would draw on emergency problem-solving mechanisms such as denial or flight into health and apply them to the crisis.

(3) These emergency mechanisms resulted in one of three

> conclusions: (a) problem solved, (b) problem redefined, or (c) problem denied.

Rapoport viewed all crisis reactions as having an end phase in which some type of equilibrium was restored. The quality of equilibrium achieved, however, could be the same, lower, or higher than the one present before the crisis. Like Lindemann and Caplan, she believed that a crisis is time-limited and could be growth producing. In addition, Rapoport said that a person in crisis was most amenable to help. This notion reinforced the importance of providing him or her with immediate access to a helper. The role of helper was to provide support and guidance during the process of crisis resolution. The intervention of the helper enabled the client to gain or enhance the skills necessary to resolve the crisis in a positive way.

Howard J. Parad, a colleague of both Lindemann and Caplan at the Wellesley Human Relations Service during the 1950s and 1960s, further refined the concepts of crisis theory and presented a conceptual framework for its practice. Parad stated (1966),

> A crisis is an upset in a steady state characterized by the following phenomena: (1) a specific and identifiable stressful event, (2) the perception of that event as meaningful and threatening, (3) the response to the event, and (4) the coping tasks involved in successful adaptation. (p. 275)

Parad identified an important concept which earlier authors did not discuss as clearly: that the event precipitating the crisis must be perceived by the person as a stressful situation before it became a crisis. Parad (1971) believed that when a stressful event became a crisis there was a period of disequilibrium in which the person was both vulnerable to further breakdown and amenable to

therapeutic influence. This crisis signified a "turning point" requiring the use of new coping mechanisms. If these new coping mechanisms were not found, however, during the six to eight week period that marked a crisis reaction, the person could suffer irreparable emotional and mental damage (p. 198).

Crisis theory, as it has developed, was based on individual or situational crisis. Robert Cole (1964) looked at the great societal upheaval caused by the civil rights movement in the South during the 1960s. Underlying the headlines of the media, he found individual stories of struggle, fear, and courage; he saw the crises that each person had undergone and observed that each crisis had, more often than not, provided an opportunity for growth. Confrontation with stress, he posited, could lead to growth when it presented an opportunity to confront obstacles to further development. Reflecting on the experiences of both black and white families, he wrote about the children, who grew through their experiences

> by summoning every bit of their humanity in the face of every effort made to deny any of it to them. In so doing they have become more than they were, more than they themselves thought they were, and perhaps more than anyone watching them can quite put into words: bearers and makers of tradition; children who in a moment--call it existential, call it historical, call it psychological--took what they had from the past, in their minds, out of their homes, and made of all those possessions something else; a change in the world, and in themselves. (p. 365)

It was hoped that the investigation of gender as a psycho-social factor influencing the course of psychological crisis would add to the further refinement of crisis intervention theory and counseling practice.

Gender Roles

In the mid 1960s, a new cultural phenomenon emerged as women began meeting in small groups to discuss their discontent with the restrictive nature of the roles they felt had been assigned to them on the basis of gender. At first, the issues they raised caused massive consternation and denial on the part of the culture at large. It has since led, in painful stages of recognition, to a culture-wide re-evaluation of restrictions imposed on both sexes by means of gender role expectations.

It was critical to distinguish between the terms "sex" and "gender role." For most individuals, their sex was determined at birth. They were male or female as indicated by their physical attributes, including distinctions of gonadal, chromosomal, and hormonal characteristics. Chafetz (1978) described gender role as a different order of phenomenon from sex. The relevant terms were "masculine" and "feminine." Chafetz described gender role as "a cluster of socially and culturally defined expectations that individuals in a given situation are expected to fulfill" (p. 3). It was the hope that with continuing research into male and female performance behaviors and expectations, we could someday provide a clearer picture of masculine and feminine traits and their respective gender roles. In searching the literature, it was found that researchers used sex (male and female) and gender (masculine and feminine) interchangeably, presumably because researchers had been unable to clearly delineate what was innate and what was learned through social process.

The individual born into a culture was confronted by a set of socially and culturally prescribed roles and was pressured, rewarded, and punished to accept or reject certain role behaviors and expectations and internalize them during the process of socialization. The concept of role centered on two fundamental phenomena: (1) role as defined more or less precisely by society and presumed to apply to all individuals in a given category and (2) role as a more or less well-learned set of responses by individuals.

The main implication of these two aspects of the definition of "role" was that specific role definitions were subject to change over time and space. With gender roles we implied not one role, but a number of specific roles which tended to cluster together, depending on the sex of the individual.

The works of Maccoby (1974), Rohrbaugh (1974), Unger (1975), and Bernard (1981) reviewed and commented on the presently available research literature on the biological, intellectual, sociological, and psychological functioning and patterns of males and females. The authors felt that the abilities and aptitudes of men and women appeared to be highly adaptive. Their research indicated that there were some differences in verbal development, spatial skills, motor coordination and strength, but they contended that there was as much variation between males and females as there was within each respective sex. They suggested that humans must eat, drink, breathe, and reproduce, but that the various ways they go about these functions appeared to be culturally developed and transmitted, varying from one culture to another.

According to the authors, the review of gender research suggested that genuine differences between the sexes could exist, but that they were probably obscured by the imposed restrictive adherence to and social enforcement of gender role, thereby perpetuating the inequities experienced by both males and females. There was growing evidence (Gove & Tudor, 1973; Hyde & Rosenberg, 1976; Spence, 1975; Pleck & Pleck, 1980; Meinecke, 1981) that forcing both males and females into stereotypical roles resulted in dysfunctional adaptation (psychological or physiological illness) to an ever-changing environment. The authors contended that the growth of human potential and the ability to adapt were thwarted by limiting choices and resources for personal expression.

Hyde and Rosenberg (1976) suggested that the course of female role development was filled with the potential for the creation of psychological disturbance. They suggested that the essence of the female personality was ambivalence. Women were taught that achievement was rewarding but unfeminine; sexiness was important for popularity but also dangerous; and motherhood was expected yet not valued.

Studies by Gove and Tudor (1973) posed some striking statistics about the need for psychological treatment for both men and women. Their studies showed that more women than men were treated psychotherapeutically in general hospitals, mental hospitals, psychiatric outpatient clinics, and in private medical practices.

Women were treated for more transient disorders of an emotional nature and more psychobiological reactions than were men. Gove and

Tudor hypothesized that in the United States, the frequency of mental illness in women was due to the restrictive nature of the feminine role. Role restrictions were greater for women because the instrumental activity of raising children was filled with frustration, was considered to be of low status, and was often found to be intellectually beneath their level of competence. The idealized feminine role was unstructured, and the expectations for women were unclear and diffuse.

Dohrenwend (1973) suggested that women are exposed to more life changes than are men. The contrast between the sexes became more significant when all events were compared to events over which the person had no control. Women had a larger life change score for both. These results meant that women found themselves in more crisis situations and, due to increased stress, were less able to predict future life events than were men. In addition, Pearlin (1977), in a study of 2300 people, aged eighteen to sixty-five, found that women at home with children under six years old were especially vulnerable to depression.

The adverse effects of sex role stereotyping are not experienced by women alone. Pleck and Pleck (1980) and Pleck (1981) have examined and reviewed literature which has historically insisted that it is essential for men to acquire "a sex-role identity" expressed by masculine traits, attitudes, and interests. Pleck felt this theory was unsubstantiated and had damaging consequences for men, women, and society. The conventional expectations of being "a man" were difficult to fulfill and could lead to unnecessary self-deprecation

for men who had not measured up. Other researchers such as Goldberg (1976) and Stearns (1979) spoke to the impossibility of meeting the all-knowing, all-providing, all successful image of the American male. Pleck supported a new approach to understanding masculinity and femininity, which he labeled the theory of role strain.

O'Neil (1981) urged that men's gender conflicts needed more attention and empirical investigation. Most research had dealt with the male attributes of achievement, ambition, and aptitudes. Little had been done to explore the socialization process which had resulted in extreme prices of aloneness, inability to deal with feelings, premature death, alcoholism, and personality disorders. He presented several hypotheses that men's gender role socialization and values of the masculine mystique produced a devaluation of feminine values and a learned fear of femininity in men's lives. He suggested that the way men were socialized could produce sexist attitudes and behaviors and that this socialization could explain many aspects of personal and institutional sexism in our society.

Since the late sixties, we have seen much social change. For women, the widespread use of contraception, the legalization of abortion, and new state and federal legislation, such as equal opportunity employment practices, have recognized the autonomy and rights of women over their bodies and their abilities. The raising of women's consciousness had brought with it a new curiosity and inquiry into women's abilities. Women began to seek active participation in what was traditionally considered to be "a man's world." After having achieved status and success in the performance

of traditional male roles, many women began to reflect on the differences in feminine and masculine role expectations which had long been held sacrosanct. The 1970s saw an increase in the enrollment of women into graduate schools in the arts and sciences and business. The success of these women, both academically and professionally, moved their concerns beyond the notion of who was to blame for the oppression of women. It was their hope that an examination of gender role differences would discern the abilities and attributes of women which made them valuable contributors to society, rather than its helpless victims.

In analyzing male and female fantasies of power, McClelland (1975) found that women focused on the world of relationships, equating power with care and giving. He indicated that what had been previously interpreted as dependence should more accurately be labelled interdependence. He reported that "women are more concerned than men with both sides of an interdependent relationship" (p. 85) and that "women are quicker to recognize their own interdependence" (p. 86). He suggested that mature men and women could relate to the world in different styles when confronted with the issue of power. Men reported powerful activities as assertion and aggression, while women saw the act of caring as powerful.

Also addressing the issue of power, Miller (1976) attempted to show that traditional "feminine" values and behaviors were truly valuable and necessary attributes for the healthy functioning of all human beings, without regard to sex. She suggested that "women

stay with, build on, and develop in a context of attachment and affiliation with others" (p. 83). She believed that

> a woman's sense of self becomes very much organized around being able to make, and then to maintain, affiliations and relationships . . . eventually, for many women, the threat of disruption of an affiliation is perceived not just as a loss of a relationship but as something closer to a total loss of self. (p. 83)

While this psychic structuring had often been interpreted as part of women's psychopathology, Baker suggested that "this psychic starting point contains the possibilities for an entirely different (and more advanced) approach to living and functioning . . . [in which] affiliation is valued as highly as, or more highly, than self-enhancement" (p. 83).

Gilligan (1981) presented an eloquent discussion of male and female differences in addressing the issues of power, maturity, and morality.

> To understand how the tension between responsibilities (women's care giving) and rights (men's desire for self-enhancement) is to see the integrity of two disparate modes of experience that are in the end connected. (p. 174)

> In women's development, the absolute of care, defined initially as not hurting others, becomes complicated through a recognition of the need for personal integrity. This recognition gives rise to the claim for equality embodied in the concepts of rights. . . . For men, the absolutes of truth and fairness, defined by the concepts of equality and reciprocity, are called into question by experiences that demonstrate the existence of differences between other and self. Then the awareness of multiple truths leads to a relativizing of equality in the direction of equity and gives rise to an ethic of generosity and care. (p. 166)

Schaef (1981) discussed the mythological beliefs of masculinity

and femininity held by our society and presented an understanding of the female socialization and maturation process to aid those professionals interested in helping women break through the barriers of their socialization and conflict of prescribed roles. They could achieve this by expanding their own unique attributes, not by adopting the male role system as their own. Schaef, Gilligan, and others suggested that the socialized devaluation of feminine attributes in our society and the rigid adherence and enforcement of gender role expectations contributed to inadequate functioning of women. Miller (1973) suggested that without these feminine values and attributes of interdependence, equity, and nurtrance, the fate of all human beings would be dismal.

In recent years there has been much criticism of the professional psychological community, suggesting that some clinicians appear to hold an implicit belief system that continues to impose expectations of stereotypical role behavior on the basis on one's sex (Broverman et al., 1972) or class (Frank, Eisenthal, & Lazare, 1978). In a landmark study by Broverman et al. (1970), research was presented showing that clinicians actually held different ideals for a healthy, fully functioning adult male and for a healthy, fully functioning adult female. The clinicians' ideal for the healthy male was similar to that of the healthy mature adult, but their ideal for a healthy female was far different, describing her as follows:

> more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more easily excitable in minor crises,

> more easily hurt, more emotional, more conceited about [her] appearance, less objective, and less interested in math and science. (pp. 59-78)

Such ideals for the healthy adult female implied a limited potential and an inferior function, if it was agreed that our changing environment requires a highly adaptive nature.

Another critical study by Frank, Eisenthal, and Lazare (1978) examined the notion that class differences in treatment, disposition, and outcome were attributable to the fact that lower-class individuals did not possess the characteristics that would render them amenable to dynamic psychotherapy. It was widely assumed that the "unsuitability" of the lower-class patient stemmed from his treatment needs, wants, or expectations. The authors found that social class differences in treatment disposition or outcome could not be attributed to social class differences in patients' treatment conceptions. In support of other researchers' findings, the suggestion was made by Frank et al. (1978) "that social class differences in treatment disposition and outcome may reflect the operation of a self-fulfilling prophecy by middle-class therapists" (p. 68).

Although this research was not directly related to gender differences, it did suggest that the imposition of stereotypical roles of behavior on individuals could result in treatment biases and minimize treatment effectiveness.

Linguistics

Since this investigator sought to examine gender difference in

psychological crisis by analyzing the language that males and females used in a written narrative describing their crisis situations and their desired outcomes for treatment, some of the more recent theoretical propositions and research in the field of linguistics are presented.

Both Freud and Jung were interested in the words of a client, for they both believed that within the client's language were hidden the deeper meaning of the unconscious. This idea was echoed by Paul Kugler (1978): "The morning process of writing down a dream involves the translation of a psychic image into a verbal structure, a phonetic script. Through words our fantasies move image to sound" (p. 140).

The language of therapist and client, the telling of the client's story, the written account of a dream, the homework assignments given to a client--all are carried out and understood through the sharing of a commonly held language system. Words are the soul of the work we do together. It is through words that we share our realities, make ourselves understood, and influence others.

During the last decade, the inquiry into sex as a linguistic variable in American English emerged. The assumption that there was a difference between the speech of women and men was implicit in the language and attitudes of many Americans. Still, the question of "genderlect" as myth or reality remained largely undefined and unanswerable.

Studies by Lakoff (1978, 1979) and Hiatt (1977) suggested that there were differences in language and style (both written and

verbal) between men and women as well as value-laden attitudes toward these languages differences. The authors believed that the language differences could be a product of social conditioning. With this in mind, they questioned the reasons for these differences and echoed concern that these differences could be interpreted to mean that one sex was inferior, deviant, or that both sexes were simply unequal.

Another attempt to understand how people used language to communicate their internal world is through the study of neurolinguistics. Bandler and Grinder (1975) suggested that the individual experienced numerous periods of change and transition which he/she had to negotiate. When those moments occurred, a seemingly infinite number of choices existed. Yet, clinicians were also aware that there would be limitations. They believed that these choices and limitations came from a dynamic model or perception of the world, which individuals created through their experiences and learning. Bandler and Grinder stated:

> The most pervasive paradox of the human condition which we see is that the processes which allow us to survive, grow, change, and experience joy are the same processes which allow us to maintain an impoverished model of the world--our ability to manipulate symbols, that is, to create models. (p. 14)

The error made was to mistake the model for the reality. The authors believed that "human behavior, no matter how bizarre it may first appear to be, makes sense when it is seen in the context of the choices generated by their model" (p. 14).

Bandler and Grinder (1975) stated that human language was a way of "representationing" the world around us. It was an explicit

model of the process of representing and at the same moment communicating that representation of the world. The individual who possessed a rich representation or model of his/her situation perceived him/herself as having a wide range of options in choosing his/her actions when change and transition occurred in the life cycle. Those who did not have a wide range of options from which to choose would experience pain and defeat, enduring simply to survive.

The review of linguistics literature suggested that sex or gender was a linguistic variable, and Bandler and Grinder suggested that language served as a representational system for human experience. It was the intent of this investigator to explore the possible language differences of males and females in psychological crisis to determine what similarities or differences existed in their representational systems.

Null Hypotheses

The review of literature led to the formulation of the hypotheses proposed in Chapter I, which stated that there would be differences based on gender in the written reactions of clients' statements which describe (A) the problems and (B) the desired outcomes of treatment. It was expected that males and females would conceptualize their crises differently. Presented below are the null hypotheses subjected to statistical analysis.

H_0 I.A: There would be no difference in the frequency of responses by men and women describing their problems as intrapersonal (i.e., as a function of their own inadequacies).

H_0 I.B: There would be no difference in the frequency of responses by women seeking intrapersonal change in describing their desired treatment outcomes.

H_0 II.A: There would be no difference in the frequency of responses by men and women in describing their problems as interpersonal (i.e., as a function of being misunderstood by others).

H_0 II.B: There would be no difference in the frequency of responses by men and women seeking interpersonal change in describing their desired treatment outcomes.

H_0 III.A: There would be no difference in the frequency of somatic responses by men and women in describing their problems.

H_0 III.B: There would be no difference in the frequency of somatic responses by men and women in describing their desired treatment outcomes.

H_0 IV: There would be no difference in the number of items checked by men and women on the Problem Checklist.

H_0 V.A: There would be no difference in the length of statements written by men and women describing their problems.

H_0 V.B: There would be no difference in the length of statements written by men and women describing their desired treatment outcomes.

H_0 VI.A: There would be no difference in the frequency of "I" and "me" statements used by men and women in describing their problems.

H_0 VI.B: There would be no difference in the frequency of "I"

and "me" statements used by men and women in describing their desired treatment outcomes.

H_0 VII.A: There would be no difference in the frequency of nominalization used by men and women in describing their problems.

H_0 VII.B: There would be no difference in the frequency of nominalization used by men and women in describing their desired treatment outcomes.

H_0 VIII.A: The occurrence of presuppositions used by men and women in describing their problems would not differ.

H_0 VIII.B: The occurrence of presuppositions used by men and women in describing their desired treatment outcomes would not differ.

H_0 IX.A: The occurrence of generalizations used by men and women in describing their problems would not differ.

H_0 IX.B: The occurrence of generalizations used by men and women in describing their desired treatment outcomes would not differ.

H_0 X.A: The occurrence of deletions used by men and women in describing their problems would not differ.

H_0 X.B: The occurrence of deletions used by men and women in describing their desired treatment outcomes would not differ.

H_0 XI.A: The occurrence of kinesthetic predicate representations used by men and women in describing their problems would not differ.

H_0 XI.B: The occurrence of kinesthetic predicate

representations used by men and women in describing their desired treatment outcomes would not differ.

H_0 XII.A: The occurrence of the use of visual representation would not differ between men and women in describing their problems.

H_0 XII.B: The occurrence of the use of visual representation would not differ between men and women in describing their desired treatment outcomes.

H_0 XIII.A: The occurrence of the use of auditory representation would not differ between men and women in describing their problems.

H_0 XIII.B: The occurrence of the use of audotory representation would not differ between men and women in describing their desired treatment outcomes.

H_0 XIV.A: The occurrence of the use of gustatory representation would not differ between men and women in describing their problems.

H_0 XIV.B: The occurrence of the use of gustatory representation would not differ between men and women in describing their desired treatment outcomes.

H_0 XV.A: The occurrence of the use of olfactory representation would not differ between men and women in describing their problems.

H_0 XV.B: The occurrence of the use of olfactory representation would not differ between men and women in describing their desired treatment outcomes.

H_0 XVI.A: The occurrence of the use of unspecified predicate representations would not differ between men and women when describing their problems.

H_0 XVI.B: The occurrence of the use of unspecified predicate representations would not differ between men and women when describing their desired treatment outcomes.

CHAPTER III

METHOD

Presented in this chapter are the rationale for and the procedure used in the selection of the sample population, a description of the data to be gathered, and a description of the methods used in analysis of the collected data.

Selection of the Sample

The sample for this study was drawn from the presently open client case records of approximately 1500 patients receiving treatment at the William Upjohn Delano Outpatient Clinic in Kalamazoo, Michigan. The following criteria were used to identify appropriateness of selection. The client: (1) had completed the personal history form, which was routinely required of all clients at intake and was completed prior to the assignment of a therapist; (2) had entered treatment within twelve months prior to the time of selection, the period being from September 1, 1981 to September 1, 1982; (3) had described the onset of the problem as having existed no longer than six months prior to seeking treatment; and (4) had no previous history of psychiatric intervention for the problem stated. Of the 1500 client cases reviewed, 311 clients (135 males, 176 females) were eligible by the stated criteria. Of those, 100 males and 100 females were randomly selected and their personal history forms analyzed.

Confidentiality

In order to gain access to the protocols of the selected population, the investigator obtained approval of the ethics committees of the following institutions: (1) The Department of Counseling and Personnel, Western Michigan University; (2) the Mental Health Board of Kalamazoo County; (3) the William Upjohn Delano Outpatient Clinic; and (4) the Borgess Medical Center. In accordance with ethical standards of maintaining client confidentiality, all original client records were assigned an identification number to protect client anonymity. In addition, all information necessary for the study was transcribed to another form, and all original files were kept within the offices of the William Upjohn Delano Outpatient Clinic.

The subject protocols represented a biased population sample, inasmuch as they were drawn from only one outpatient provider facility in a circumscribed geographical area, and were limited in number. It was understood that the responses which were analyzed could not be assumed to be applicable to universal populations of male and female persons in psychological crisis. Even with such limitations, it was believed that this study would contribute to the growing mass of literature already available in the area of gender difference and would encourage further study and replication among researchers in other geographical areas.

Treatment of the Data

The data were compiled from the Personal History Form of the Delano Outpatient Clinic, which the clinic required all clients to complete on intake prior to the assignment to a therapist. It was necessary that all original records be kept within the offices of the Delano Outpatient Clinic and all identifiable patient information be eliminated. A modified version of the Personal History Form was constructed (see Appendix A) and all data which were pertinent to the study were transcribed verbatim onto the new form.

Information included on this new form was:

(1) the client's identification number,

(2) the client's age,

(3) the client's sex, and

(4) the verbatim hand-copied transcription of the client's written responses to the questions:

    (1) "Describe your problem." (Section A), and

    (2) "What would you like the outcome of treatment to be?" (Section B).

Also included were the items checked by the client under the section designated "Check any of the following that applies to you." For purposes of identification, this section was retitled "Problem Checklist" and was included on the modified version of the Personal History Form. All of the items which were checked on the original Personal History Form were then transferred to the modified version of the form for tabulation.

Analysis of Data

After the data were collected and transferred to the modified Personal History Form, a scoring technician was trained to score all categories of responses in each section of the form. Tables were organized to summarize pertinent data for all hypotheses. Chi-square and associated probabilities were also calculated. Scoring for the written narrative sections, (A) Description of problem and (B) Desired outcome of treatment, was performed in the following manner:

Analysis of Section A, "Describe your problem," consisted of codifying by the designation "zero" for no response or "one" for all units of thought (phrases, clauses, or sentences). Analysis consisted of tabulation by sex the frequencies of occurrence of units of thought for exhibiting the following three categories:

(1) intrapersonal (i.e., "I feel inadequate");

(2) interpersonal (i.e., "My husband doesn't understand me.");

(3) somatic (i.e., "My doctor said there is nothing wrong, but I feel so nervous and faint.")

Hypotheses I.A, II.A, and III.A were submitted to Chi-square tests of significance, and the null hypothesis was rejected at the .05 level.

Analysis of Section B, "Desired outcome of treatment," consisted of codifying by the designation "zero" for no response or "one" for all units of thought (phrases, clauses, or sentences), and, as with Section A, analysis consisted of tabulation by sex the frequencies of occurrence of units of thought for exhibiting the

following three categories:

(1) intrapersonal (i.e., "I want to feel more confident.");

(2) interpersonal (i.e., "I want to understand my spouse.");

(3) somatic (i.e., "I want to be less nervous.")

Hypotheses I.B, II.B, and III.B were submitted to Chi-square test of significance, and the null hypothesis was rejected at the .05 level.

The Problem Checklist (CHTOT) was tabulated for the presence or absence of the symptoms listed and compared by sex for those symptoms most frequently checked. Analysis consisted of codifying by the designation "zero" for no response or "one" for all units of symptoms. Analysis of hypothesis IV was submitted to t-test of significance and the null hypothesis rejected at the .05 level, as were hypotheses I.A, I.B, II.A, II.B, III.A, and III.B.

The Number of Words in Each Statement (WDSA) consisted of counting each word in the statements written for (A) Description of the Problem and (B) Desired Outcome of Treatment. The total tabulation of words were compared by sex. Analysis of hypotheses V.A and V.B was submitted to t-test of significance, and the null hypotheses were again rejected at the .05 level.

Analysis of hypotheses VI through X, both sections A and B, constituted tabulation by sex, and the frequencies of occurrence for the following categories:

(6) First-person pronoun ("I" and "me")

(7) Nominalization

(8) Presupposition

(9) Generalization

(10) Deletion

Hypotheses VI through X, for both sections A and B, were also submitted to Chi-square test of significance, and the null hypotheses were rejected at the .05 level.

Analyses of hypotheses XI through XVI, both sections A and B, constituted tabulation by sex and the frequencies of occurrence for the following categories of predicates (see Appendix B):

(11) Kinesthetic

(12) Visual

(13) Auditory

(14) Gustatory

(15) Olfactory

(16) Unspecified

Hypotheses XI through XVI, both sections A and B, were submitted to Chi-square test of significance and the null hypotheses were rejected at the .05 level.

In an attempt to ascertain any male and female age group differences, a t-test was administered. Ages were tabulated and compared by sex. No significant difference on the basis of age was found.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF THE DATA

In recent years, the investigation of gender differences has begun to yield many new interpretations of the available data and has also caused the formulation of new theories to explain this phenomenon. Though a study of gender differences and similarities in psychological crisis had not yet appeared in the literature, studies by Gilligan (1981) of moral development in females who were deciding on abortion, by Miller (1976) of women's psychological development in therapy, by Sheehy (1974) of the differences between men and women in the developmental stages of early adulthood, and by McClelland (1975) of the relationship of power and maturity had opened up new dimensions in the gender question in relationship to male and female psychological functioning.

It was the expectation of this study that differences would occur in examining different categories of responses by men and women seeking counseling for a psychological crisis. Assessment was achieved by analyzing the response of 100 females and 100 males to the statements (A) describe your problem and (B) describe your desired outcome of treatment. Analysis of symptoms on the Problem Checklist were also calculated.

Since no other demographic data, except sex and age, were gathered or taken into consideration for the study, one could not contend that male and female group members constituted equivalent

groups. However, a preliminary t-test for differences in mean age for women (29.91) and men (30.79) showed no significant difference (t .7035, p .483). These findings indicated that initial random selection of women and men did result in equivalent age groups.

Variables

Gender (male/female) was the independent variable for analysis of the response data and was determined in five areas of inquiry. The dependent variables were:

(1) Intrapersonal, interpersonal, and somatic focus;

(2) Problem checklist (30 items);

(3) Length of statement;

(4) Analysis of linguistic classification; and

(5) Predicate representation systems.

Intrapersonal, Interpersonal, and Somatic References

Analysis of the written narrative responses to (A) describe your problem and (B) describe desired treatment outcome are presented in Table 1.

Chi-square analysis yielded a significant difference at the .05 level for women making more references to intrapersonal change as a desired outcome for treatment. For H.1.B, chi-square was significant, and therefore the null hypothesis rejected. However, for H.1.A, H.2.A, H.2.B, H.3.A, and H.3.B, the null hypothesis was accepted.

Table 1

Gender Comparison of Intrapersonal, Interpersonal, and Somatic References Used in Responding to Problem and Treatment Outcome Questions

Hypotheses	Intrapersonal, Interpersonal and Somatic	x^2	df	p
H.1.A	Intra-Prob	5.11	5	0.40
H.1.B	Intra-Trtmt	13.40	5	0.02*
H.2.A	Inter-Prob	1.57	4	0.81
H.2.B	Inter-Trtmt	2.68	3	0.44
H.3.A	Soma-Prob	0.22	2	0.90
H.3.B	Soma-Trtmt	0.072	1	0.99

*significant at .05 level

Examination of Table 1 reveals that there are no significant differences between males and females in any categories of responses except for intrapersonal change as a desired outcome of treatment. Therefore, it can be said that women do not see themselves as the cause of the problem, or "at fault" because of their own inadequacies significantly more often than do men. Nor do women describe themselves as having more somatic (physical) symptoms than do men. However, they do acknowledge a desire to change themselves more than do men.

Problem Checklist

In analyzing the Problem Checklist (see Table 2) by the tabulation of presence or absence of symptoms submitted to t-test of significance, we find that women responded to more items or symptomatic problems than did men. Therefore, the null hypothesis was rejected.

Table 2

Gender Comparison of Cross Number of Responses to Items on Problem Checklist

Hypothesis	Problem Checklist Responses	$\bar{x}$	SD	t	df	p
H.4	CHTOT					
	Females	11.07	4.61	3.904	198	<.001**
	Males	8.22	5.66			

**significant at the .001 level

Length of Statement

Examination of the research findings presented by Unger (1979), both in the United States and cross culturally, suggests that females are superior in the use of language. It was expected that women would write longer narratives (explaining more about their situations

and desires) and that this difference might present itself in lengthier statements. A t-test was performed for differences in means for number of words used in length of statement (Table 3). The test showed no significant difference between males and females, thereby accepting the null hypothesis.

Table 3

Gender Comparison of Number of Words Used in Responding to Problem and Treatment Outcome Questions

Hypotheses	Number of Words Used	$\bar{x}$	SD	t	p
H.5.A	WDSA-Prob				
	Females	21.47	23.55	1.24	.22
	Males	17.62	20.21		
H.5.B	WDSA-Trtmt				
	Females	23.58	27.69	1.51	.13
	Males	17.35	30.60		

Though superior verbal and language ability in women is upheld in the research literature, Hiatt's linguistical analysis (1977) of literary styles reported that contrary to the popular myth, women did not write longer books filled with content described by literary critics as superficial and flowery. It would appear that the same may be said for the written narratives of females and males in our

sample. There appears to be no significant difference in the length of statements they presented. However, it cannot be assumed because of these findings that the same would hold true of their use of verbal language.

Analysis of Linguistic Classifications

Chi-square analysis of linguistic classifications (Table 4) was an attempt to examine some neurolinguistic concepts presented by Bandler and Grinder (1975). They viewed the language processes of nominalization, presupposition, generalization, and deletion as universals of human modeling. Another classification of response analyzed was the frequency of first-person pronoun statements used in the narratives by men and women.

The classification of the use of first person pronouns in the narratives appeared to be the only category which was significant at the $p. < .05$ level and only in response to the desired outcome of treatment. Therefore, in the case of H.6.B, the null hypothesis is rejected. This appears to be consistent with the significant difference shown in H.1.B in which women responded to the desired treatment outcome by wanting intrapersonal change. It is reasonable to assume that the use of "I" statements connotes an acceptance of responsibility which is compatible with a desire for intrapersonal change and shows a personalized commitment to work toward such a goal.

Since H.7.A through H.10.A and B showed no significant

Table 4

Gender Comparison of the Frequency of Responses Using First Person Pronouns and Neurolinguistic Classifications to Problem and Treatment Outcome Questions

Hypotheses	Pronoun and Neurolinguistic Classifications	x^2	df	p
H.6.A	I-Prob	1.83	4	0.77
H.6.B	I-Trtmt	10.32	4	0.04*
H.7.A	Nom-Prob	1.77	4	0.78
H.7.B	Nom-Trtmt	7.42	3	0.06
H.8.A	Pres-Prob	2.08	2	0.35
H.8.B	Pres-Trtmt	2.93	3	0.04
H.9.A	Gen-Prob	4.12	4	0.39
H.9.B	Gen-Trtmt	3.32	3	0.35
H.10.A	Del-Prob	8.70	6	0.19
H.10.B	Del-Trtmt	8.49	6	0.21

*significant at .05 level

differences between women and men, the null hypotheses are accepted. A possible explanation for these results is that women do not see themselves as solely reponsible for the problems they encounter (H.7.A). Barring methodological error, Bandler and Grinder (1975) could be correct in assuming that these linguistic classifications are universals of human modeling and that these processes were experienced by both women and men through a commonly learned language.

Predicate Representational Systems

Chi-square analysis of the predicate representational systems used in the written narratives of men and women are presented in Table 5, showing some significant results at the $p. < .05$ level.

The analysis of this section of the data was an attempt to examine the descriptiveness of the use of representational systems and to see if any differences occurred between men and women in the use of these particular systems.

Results which were significant at the $p. < .05$ level were attained for H.11.A, H.13.A, and H.16.B. Unfortunately, interpretation of the significance of H.13.A (auditory) at the p. .02 level is impossible as non-zero responses were quite low, though men produced more auditory responses than did women. In addressing the significant findings for H.11.A, women used more kinesthetic representations (feeling statements) in the descriptions of their problems. It may also be notable that when discussing desired

Table 5

Gender Comparison of the Frequency of Occurrence of Various Predicate Representational Systems to Problem and Treatment Outcome Questions

Hypotheses	Predicate Representational System	x^2	df	p
H.11.A	Kin-Prob	10.26	4	0.04*
H.11.B	Kin-Trtmt	3.47	4	0.48
H.12.A	Vis-Prob	0.27	1	0.79
H.12.B	Vis-Trtmt	1.14	1	0.39
H.13.A	Aud-Prob	6.79	1	0.02*
H.13.B	Aud-Trtmt	0.89	1	0.48
H.14.A	Gus-Prob	3.70	1	0.12
H.14.B	Gus-Trtmt	1.85	1	0.37
H.15.A	Olf-Prob	0.00	1	1.00
H.15.B	Olf-Trtmt	0.00	1	1.00
H.16.A	Unsp-Prob	4.22	4	0.38
H.16.B	Unsp-Trtmt	11.17	2	< .001**

*significant at .05 level

**significant at .001 level

outcomes for treatment, the use of feeling statements was no longer significantly different.

In H.16.B, unspecified predicate representation was significant at the $p. < .001$ level. For this category, males were significant for having exactly one response, while females were significant for zero responses and two or more responses. Explanation of the results of significance at the $p. < .05$ level for H.11.A and H.16.B may be seen as the statements of women describing their problems in a feeling mode and expecting therapy to change these powerful feelings into something else. Both men and women use the unspecified predicate representation more frequently in discussing their desired treatment outcomes.

CHAPTER V

DISCUSSION AND RECOMMENDATIONS

The results of this study lend some support to the notion that there are some sex and/or gender differences as well as similarities in psychological crisis. In a great number of categories of comparison, the responses of men and women to the written narrative of (A) "Describe your problem" and (B) "Desired outcome for treatment," showed no statistically significant differences. Therefore, we might assume that men's and women's perceptions of life problems and their expectations for treatment intervention are similar.

However, some significant differences did appear, suggesting that women's responses to written narratives focused on their need for intrapersonal change in treatment more than did those of men. Along with this finding was the significant difference in the number of items checked on the Problem Checklist, which suggests that women have a more complex worldview in which problems and symptoms are interrelated and seen as interdependent.

Miller (1976) contended that women's status in our society was one of subordination. Subordination resulted in an inequality of power, which she believed led to a relationship of permanent inequality with men. Women were expected to provide relationships of nurturance by teaching, caring, and giving, yet they were to remain subservient in relationships of permanently unequal social status

and power. To complicate matters further, though women were subordinate in social position to men, they were expected to function equally or sometimes dominantly in intimate and intense relationships of adult sexuality and family life. Chesler (1972), Chaftez (1974), Birnbaum (1975), and Rivers, Barnet and Baruch (1979) provide further ideas which parallel and amplify Miller's conceptions. These authors suggest that women focus on intrapersonal change and use first person referents because they have been socialized to perceive themselves as powerless, and, therefore, feel unable to impact on others sufficiently to cause change.

Gilligan (1982) believed that because of women's orientation to power, as in the giving of care, women's struggles for maturity arose through a process of discovering that the responsibilities of care and giving to others, which they had accepted as their duty, must be extended to themselves. It was the acknowledgement of personal rights combined with care and giving to others which provided women a bridge to maturity.

This acknowledgement could be a reflection of women's growing understanding that their subordinate position in terms of power comes from their unrecognized need to care and give to themselves. It could also represent a cry for assistance in achieving those personal goals. Another factor might be that, somehow, through the process of women's socialization, an awareness of their own vulnerability, weakness, and helplessness is acknowledged. Therefore, when women sought counseling, they addressed that which they were reared to believe. They recognized what many of us believe is the goal of

counseling: to accept one's own vulnerability and to take personal responsibility for understanding one's feelings of weakness and helplessness as part of a process which can lead to a positive action.

Gilligan (1982), Miller (1976), and Schaef (1981) all suggested that for women, the maturational process consisted of extending the need to give and care for others (which is perceived as duty and socially sanctioned) to themselves. It was the act of nurturing themselves that led them to establish their own integrity and equality. Gilligan (1982) also spoke of the enormous struggle a woman experienced in the moral dilemma of deciding on an abortion. She had to consider what others wanted of her and at the same time come to terms with her own feelings and needs. Those women whose actions in this situation were based only on the needs and desires of others, taking no responsibility for the decision-making, found themselves left with only fragments and remnants of their former selves. Such a reaction is what crisis theorists Caplan, Rapoport, and Parad would predict when crisis resolution is unsuccessful or maladaptive.

Miller (1976) suggested that women has an intimate knowledge of and will readily admit to their feelings of vulnerability and interdependence. It was the admission to and knowledge of such feelings which enabled them to care and support significant others through times of vulnerability, though they might never be acknowledged as supportive. Miller contended that although women are socialized to respond to others' feelings of vulnerability, they are not socialized to bestow this caring ability on themselves in order to establish their own sense of integrity.

Gilligan's and Miller's ideas may well provide a framework for understanding women's desire for intrapersonal change in treatment. The acknowledgement of the struggle which heralds this awareness may be the beginning of a developmental advance in which a new sense of personal responsibility to self and others is established and a willingness to confront inner truth accepted.

In the practice of psychotherapy, a central place is given to feelings of vulnerability, weakness, helplessness, and neediness. Professionals are concerned that these feelings be acknowledged and respected, and they seek to help the client accept these feelings, thereby freeing him/her to move beyond the obstruction he/she has created. There are some obvious concerns for counseling women, if the goals of women seeking treatment are to extend their roles of care and giving to themselves.

Another unusual difference appeared after analyzing items on the Problem Checklist. Women did check more items than did men (significant at the $p. < .001$ level). An obvious explanation is that women perceive themselves as experiencing more problems or having more illnesses than do men. However, such an explanation seems inadequate. In Table 1, women did not respond in a significantly different manner from men to the intrapersonal, interpersonal, or somatic problem categories. If we examine the items included on the Checklist (Appendix C), we see intrapersonal, interpersonal, and somatic symptom categories represented.

A more subtle but appropriate explanation for this difference

may be provided by Gilligan (1981). According to this authority, a woman expects herself

> to pay attention to everything, to see and to know as much as [she] can about [herself] and others and the situation so that [she] can try to anticipate the consequences of action in a way that is not likely to cause suffering and hurt. (p. 66)

This statement was made in response to an interview question on how women make moral decisions. It may also be relevant to how they perceive, cope with, and process psychological crisis.

It was also interesting that the notion that women seek treatment for more transient disorders of an emotional or psychobiological nature than do men (Gove, 1973; Unger, 1979) was not supported by the data. Nor was there support for the notion that men had more somatic complaints as a reaction to the role stress they experience from adhering to rigid masculine values (Goldberg, 1976; Meinecke, 1981; O'Neil, 1981). There was statistical evidence that women sought treatment more frequently than did men (Unger, 1979) and for a wider variety of reasons. This does not necessarily imply that women have more mental illness, as has sometimes been construed. Except for the category of intrapersonal change as a desired treatment outcome, women's responses did not significantly differ from those of men. If women's reasons for seeking treatment are no different from men's (whether somatic or psychological), then we could suggest that what draws women into the counseling process, requesting intrapersonal change, is the promise of empathy and care-giving for their feelings of vulnerability. If Gilligan, Miller, and McClelland are correct, women's nature and priorities

for "care and giving" draw them to processes of a similar kind (the giving of care), which both medical and psychological practitioners purport to be the basis of their art.

Schaef (1981) contends that men and women not only think differently, but also process data differently. Men are socialized to think in a linear fashion, logically, from A to B to C. Conversely, women's thinking appears to be multidimensional or multivariant. Such a process takes more time and makes use of more data such as feelings, intuitions, and processes of awareness, which often seem irrelevant on the surface (p. 130-132). Linear thinking may be seen as more efficient in a patriarchal system than multidimensional thinking and may result in more rapid action or resolution. However, in the process we call counseling, and in the process we call education, professionals have always valued both processes as necessary and creative.

If the socialization of women results in a predominately multidimensional thinking process, it might better explain the study by Broverman et al. (1970) in which a healthy functioning female was viewed to be more submissive, less aggressive, less competitive, more excitable in minor crises, more easily hurt, and more emotional than her male counterpart. It may well be that multidimensional thinking results in more complexities in a decision-making process, requiring greater consideration of contingencies before resolution or action can be taken. It might also explain why Hyde and Rosenberg (1976) could have mislabeled this process of decision-making as

"ambivalence" which they characterized as the essence of the female personality.

In short, if women see more problems, both in and around themselves, perhaps this is because they also perceive more issues and can see how these problems are interrelated or interdependent.

Also of significance was the greater use by women of first person pronouns in the desired treatment outcome statements. The results suggest that in psychological crisis, women's use of "I" statements could be interpreted as women taking personal responsibility for the goals or desired changes expressed in the treatment outcomes. It is congruent with counseling theory that intrapersonal changes can occur only when the client is willing to take responsibility with "I" statements for achieving such goals. It appeared that by some method, as yet unexplained, the feminine socialization process does transmit this expectation to women.

Gilligan (1981) suggested that although women view their lives as interdependent with others, they realize that in making a moral decision, it is necessary to consider the intrapersonal aspects of their lives and desires. The same may be said for the process in which they cope with psychological crisis. The change involved in dealing with a moral dilemma or a crisis may be a move from their recognition of the relationship of interdependence to the recognition that they have rights, needs, and feelings which are as important as what others want or expect from them.

Bandler and Grinder (1975) posited that human language is a way of "representationing" the world around us. "Representationing"

is an explicit model of the process of representing and at the same moment communicating that representation of the world to oneself and to others. Bandler and Grinder believed that it is the richness of a person's representational system which allows him/her to have a range of options in choosing a course of action when change and transitions occur.

Two significant findings emerged from the analysis of the predicate representational system. Women used more kinesthetic representational predicates (feeling statements) than did men when describing their problems, but when discussing their desired outcomes for treatment, the use of feeling statements was no longer significantly different. Also, for both men and women, there appeared to be an increase of unspecified predicate representations for the desired outcome of treatment statements.

This finding suggests the possibility that both men and women expect to have cognitive insight by knowing, understanding, or reasoning differently after therapy, rather than feeling, speaking, or seeing life situations differently. Cognitive insight is not the only goal of therapy; often, insight early in the therapeutic process may produce exacerbated symptomotology. The client must integrate the cognitive insight with the feelings and perceptions of his or her present reality. Only then can change and new alternatives for action occur.

Neurolinguistics, as well as other non-psychoanalytic counseling approaches, such as Gestalt, attempts to involve the entire sensory functioning of the individual when bridging insight and action.

During analysis of the predicate representational system, it was necessary to collapse cells for statistical analysis of several of the hypotheses because response tabulations were so low.

In the written narratives of women and men in our sample, kinesthetic and unspecified predicate representations were the most frequently used. There appears to be a lack of descriptiveness in the use of other representational systems by respondents. It may be worthwhile to consider that a literary work which only addresses the thinking process and does not allow the reader to smell, feel, and see is deadly dull; the same perhaps may be said of a person's expression of life. However, it would be incorrect to assume that a similar lack of expressiveness would necessarily be found in the spoken language of this population.

Much of women's literature and women's published research findings suggest that channeling feelings into goal-oriented behaviors is very different for women and men. There is growing evidence and debate that there exists a relationship among sex bias, sex roles, and psychotherapy. Davidson and Abramowitz (1981), Green (1980), Brodsky (1980), and others, all raise issues of concern that sexism, subtle as it may be, may result in a process of abandoning therapeutic roles for sex roles.

Another concern is that of the issue of labeling. McClelland (1975) presents a notion that the term "dependency," so often referred to adjunctly with women, may well be a woman's acknowledgement of her interdependence on those significant others around her. Other such labeling misnomers have been suggested in interpreting

the data in this study. There appears to be a need for further investigation into the labeling criteria of psychology. This can be done only if serious consideration is given to women's views on the psychological dynamics of women.

New models of development are being proposed by women for women. Serious investigation of these developmental models seems to be important if there is to be any impact on present theories of human behavior. Feminist literature suggests that the present research explicitly or implicitly suggests female inferiority, mainly because of the differences between men and women.

Women's literature contends that present popular theories of behavior inadequately explain women who are experiencing anger and rage. These theories, it is argued, do not address the time when women discover that their needs for interdependence have been exploited in a socially sanctioned way. In a professional setting, coping with the needs of female clients to explore and nurture themselves may be perceived as threatening the sanctity of the home and the needs of significant others.

Research Issues

Some methodological concerns and suggestions for further exploration are presented in this section.

Methodological Issues

Since there was no research literature available which was specific to gender difference in psychological crisis, this study

was an attempt to ascertain whether or not there were gender differences and similarities in psychological crisis and to delineate possible avenues for future inquiry. Some methodological issues of concern which were raised during the investigation follow.

1. Though a great many similarities were found in the written language of males and females, linguistics research warns that there may be significant differences in how an individual verbalizes a situation as compared to how he/she writes about it.

2. Though the format of this study has been used by other researchers (Frank, Eisenthal, & Lazare, 1978; Gilligan, 1982), their research findings were based on verbal interviews and forced-choice questionnaires. If the present study had employed verbal responses, it could conceivably have produced different results.

3. In an attempt to keep the data uncontaminated, the investigator trained a technician to score the written narratives based on a clearly defined set of criteria. However, the technician was female, and so we must question whether or not a male technician trained in the same manner would have perceived and interpreted the data in exactly the same way.

4. This study found similarities between men and women in a number of response categories. This could be suggestive of an overlapping or similar socialization process for both sexes.

Further Research

There appeared to be justification for further exploration of gender differences in psychological crisis. Two possible avenues

of research could be suggested as a result of this investigation. First, the basic question of whether or not there is gender difference in psychological crisis still remains largely unanswered. This study suggests that the responses of males and females were similar for a large number of the categories chosen for inquiry, such as focus of problems, language categories, and predicate representational systems. Since these results were gleaned from a written narrative format, it would be helpful to know if the same results would have been obtained in an interview format.

The significant results achieved in women wanting intrapersonal changes as desired outcomes of treatment, the increased use of "I" and "me" referents in the treatment statements, the use of kinesthetic predicate representation (feeling statements) to describe problems, and the explanation that women checking more items on the problem checklists was an expression of an interdependent or multidimensional thinking process, led to the serious consideration of Gilligan's model of female development. Also, the relationship of the data to the theories of Miller and Schaef on the influence of gender as a psycho-social dynamic, which impacts on the psychological process of women, warrant further investigation.

It might prove interesting to replicate this study in order to gain greater information on feminine attributes by comparing working women to non-working women. Compared to working women, non-working women are reported to have lower self-esteem. Researchers have often viewed self-esteem as a measure of self-acknowledged personal power. Such a comparison could be worthwhile,

for if only non-working women responded to the need for intra-personal change as a desired outcome for treatment, one might interpret the data differently. Rather than seeing developmental issues as a pivotal factor, one could look into the issues of powerlessness or self-blaming. Also, in comparing working to non-working women, the question of the use of kinesthetic predicate representations (feelings statements) might be examined to see if any language changes occur when women enter the "marketplace."

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APPENDICES

APPENDIX A

MODIFIED PERSONAL HISTORY FORM

WILLIAM UPJOHN DELANO

OUTPATIENT CLINIC

Identifying Data:

Age _____ Sex _____

Describe your problem:

Length of statement

Intrapersonal

Interpersonal

Somatic

I and 1st person pronoun

Nominalization

Presupposition

Generalization

Deletions

Kinesthetic

Visual

Auditory

Gustatory

Olfactory

Unspecified

What would you like the desired outcome of treatment to be?

Length of statement

Intrapersonal

Interpersonal

Somatic

I and 1st person pronoun

Nominalization

Presupposition

Generalization

Deletions

Kinesthetic

Visual

Auditory

Gustatory

Olfactory

Unspecified

APPENDIX B

REPRESENTATIONAL PREDICATES

Kinesthetic	Olfactory
feels like	smell
it grabs me	stink
kick	sniff
touch	odor
pain	inhale
burden	reeks
drag	scent

Auditory	Gustatory
listen	chew
hear	eaten
speak	gnawing
talk	flavorful
whisper	lush
dialogue	crisp
state	
converse	
verbalize	
say	
yell	
scream	

Visual	Unspecified**
see	think
observe	know
notice	reason
look	decide
visualize	solve
picture	rationalize
view	
color	
glance	

**Whenever possible that an unspecified representational predicate is used, there will be an attempt to identify the representational system. For example, the statement "I know it in my guts," may be considered kinesthetic.

APPENDIX C

PROBLEM CHECKLIST

Problem Checklist:

1. _____ Headaches
2. _____ Stomach Trouble
3. _____ Dizziness
4. _____ No Appetite
5. _____ Fainting Spells
6. _____ Bowel Disturbances
7. _____ Fatigue
8. _____ Insomnia
9. _____ Nightmares
10. _____ Fast Heartbeat
11. _____ Take Sedatives
12. _____ Alcoholism
13. _____ Feel Tense
14. _____ Feel Panicky
15. _____ Tremors
16. _____ Financial Problems
17. _____ Depressed
18. _____ Suicidal Ideas
19. _____ Always Worried About Something
20. _____ Inability to Relax
21. _____ Unable to Have a Good Time
22. _____ Don't Like Weekends and Vacations
23. _____ Over Ambitious
24. _____ Sexual Problems
25. _____ Shy With People
26. _____ Can't Make Friends
27. _____ Can't Make Decisions
28. _____ Can't Keep a Job
29. _____ Inferiority Feelings
30. _____ Home Conditions Bad

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