

**AN EXPLORATORY STUDY OF
CLINICIANS' ATTITUDES TOWARDS WOMEN:
IMPLICATIONS FOR THERAPY**

by

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ABSTRACT

This study explores the attitudes of clinicians towards women and postulates that these attitudes may be transmitted in the therapeutic relationship with female patients. The rationale for exploring this aspect emanated from two factors: firstly, the view that women patients tend to be treated differently to male patients, a view seemingly supported by literature; secondly, the increasing literature supporting the view that therapy is never "value free" and that values may be influential in determining aspects of therapy. In addition, this study aimed to explore clinician's characteristics which may play a role in determining their attitudes.

A theoretical analysis of women's role in society was traced, with some mention made of the contribution by the Feminist Movement and the realities of the South African context. The literature survey further highlighted aspects of therapy with female patients that were relevant for the focus of this study. The primary method of data collection was by means of questionnaires which were circulated to the sample, which comprised 82 state-employed clinicians which included psychiatrists, psychiatric registrars, psychologists, social workers and occupational therapists. In addition, five individual interviews were conducted with the view to examining therapy with female patients.

Findings indicated that clinicians held a continuum of attitudes to women ranging from traditional to liberal. Clinicians felt that women should feel free to pursue a career, but should remain at home for a time after the birth of a baby. Task-sharing at home received a positive response. Attitudes regarding sexual behaviour expected of women, appeared to be liberal, whilst the issue of abortion evoked strong attitudes suggesting that not only women should

Both the literature and the empirical study indicated that there were differences in the therapeutic encounter between male and female patients. Implications for therapy are highlighted: these include recommendations that clinicians need to adopt a non-judgemental, objective stance, as well as a constant awareness of their own value base as it could influence and permeate the therapeutic relationship. It is recommended that training and supervision need to emphasise the importance of these aspects and it is suggested that further study be undertaken in this regard.

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CHAPTER 1:
INTRODUCTORY CHAPTER

1. Introduction

The notion of a "value-free" therapy has been questioned by many authors (Weiskopf and Joelson, 1980; Braginsky and Braginsky, 1973; Bentler, 1979; in Steere, 1984). Values of a moral, cultural or political nature are the guidelines by which a person directs his/her decision-making. These values, which derive from a variety of sources such as the family, social and political groupings, will be influential in determining a person's attitude towards other groups of people (Aponte, 1985). Clinicians, despite their training are not exempt from this process (Steere, 1984). In the therapeutic encounter there is a complex system evolving from the value base of the clinician and that of the patient. Clinicians are not outside the realm of society and are also part of various groupings. The focus of this study will be to explore the attitudes of clinicians towards women. The particular values that clinicians hold can be transferred in the therapeutic relationship and could affect the encounter between clinician and patient.

The second dimension which is being explored is that of the specific characteristics of clinicians which may play a role in determining their attitudes toward women. The clinician characteristics that receive attention in this study are inter alia, gender, age, profession, and length of practice. The last dimension being explored is the way in which these factors are influential in determining aspects of therapy and some conclusions will be drawn using theory and the findings of the study.

Data collection will be by means of a questionnaire in which clinicians' attitudes and characteristics will be surveyed. An interview schedule using a sample of clinicians, will also

be used in order to provide additional and more elaborative responses which add richness to the study.

Chapter 2 deals with the values and characteristics of clinicians and challenges the myth of a "value-free" therapy. Chapter 3 gives a historical overview of women's role with some reference to the Feminist Movement and its effect on societal attitudes. Some focus will be given to the South African situation and women's role. Chapter 4 highlights the manner in which clinicians' attitudes may influence therapy by exploring some issues pertinent to women in therapy. A discussion of the research methodology is given in Chapter 5. The results of the study are analysed in Chapter 6, while Chapter 7 discusses the findings of the study and the implications this poses for therapy.

1.2 Rationale for the Study

The purpose of this study is to explore the attitudes of clinicians towards women. This will be attempted by exploring clinicians' attitudes and perceptions toward women and their roles in society. Jane Steere (1984) purports that there has been some evidence to suggest that clinicians' values have some influence on the way in which they conduct therapy,

Values predetermine attitudes and the former may be transmitted on an unconscious level. Aponte (1985) asserts that there is a myth amongst clinicians that their work is "artistic", "scientific" or "technical", however, culture, ethnicity, race and socio-economic status interalia are bearers of value systems. This study will attempt to explore some of the dimensions such as gender, age, profession, interalia, which may be bearers of these value systems. If the assertion is made that clinicians' values may impinge on the therapeutic relationship then many of the stereotypes that prevail about women may unconsciously be transmitted in therapy. For example: in an early study conducted by Broverman et al (1970) it was found

that clinicians have different concepts of health for men and women and that these differences parallel the sex-role stereotypes prevalent in society. They were concerned that therapists could transmit sex-role stereotypes in their professional activities and reinforce social and intra-psychic conflict in this way. The author asserts that in the process of training clinicians need to become aware of their own value system so as not to impose it on their patients.

1.3 Author's Personal Interest in the Study

The researcher is a female psychiatric social worker who has worked for many years within a psychiatric hospital. Casual observation indicated that there were differences in the way male and female patients were being treated by the psychiatric personnel. There seemed to be a tendency to diagnose certain categories more often for female patients than for male patients. The content of vocabulary when discussing female patients is often filled with constructs such as "manipulative", "emotional", "hysterical", amongst others. The researcher wondered whether general attitudes towards women's role in society could be influential in determining aspects of treatment or diagnosis. The author conducted the study at a psychiatric hospital similar to the one she works in viz. Lentegeur Hospital. This psychiatric hospital caters for both male and female patients from the Cape Peninsula and outlying areas. Patients with various diagnoses, such as organic psychosis, schizophrenia and affective disorders, are admitted to the various units comprising admission wards, chronic wards, and more specialised units such as the Child and Family Unit. Therapeutic intervention comprises medication to stabilize the patient, individual therapy and inpatient group therapy, as well as some intervention with family members.

1.4 Purpose of this Study

1. This study will explore attitudes of clinicians towards women.

2. The study will also examine whether specific clinician variables such as age, gender, religion and practice experience could play a role in determining their attitudes toward women.
3. Implications for therapy and the therapeutic relationship will be discussed and some recommendations for therapeutic practice will be highlighted.

1.5 Definition of Terms

The term "clinician" will specifically refer to either a psychiatrist, psychiatric registrar, social worker, psychologist or occupational therapist. For the purpose of this study "clinicians" will refer to both male and female clinicians who are state-employed and working within a psychiatric hospital. The term "clinician" and "therapist" will be used interchangeably.

Therapist variables refer to characteristics as well as other dimensions of the therapist such as religion, age, profession, years of experience, language, interalia, which could be instrumental in determining values.

CHAPTER 2: VALUES, ETHICS, AND THERAPIST CHARACTERISTICS

This chapter discusses the values and characteristics of the clinician and debates its effect on the therapeutic relationship.

2.1 Values

It is necessary to conceptually distinguish between personal values and professional values as they can both be predictors of attitude and behaviour. Aponte (1985) concludes that values derive from a variety of sources such as the family, social and political groupings of which both the therapist and client are a part. These could be termed personal values and Aponte (1985, pg 323) defines values as "...the standards by which a person directs his actions and defines, interprets, and judges all social phenomenon." The ideal situation, where both the therapist and patient share the same value systems may not always exist. Usually we have a complex system evolving from the dynamic interaction between the value base of the therapist and that of the client.

Each profession also has values which it considers important. These values may be thought of as beliefs a profession holds about people which guide the practice of the professionals (Levy, Compton and Galaway, 1975). These values may be classified as "preferred conceptions of people, and preferred instrumentalities for dealing with people" (Compton and Galaway, 1975).

The influencing aspect of the therapeutic relationship is discussed by many writers (Compton and Galaway, 1975; Breggin, 1971; Engelhardt, 1973; Kennedy, 1973; Strupp, 1980 and Steere, 1984). They argue that a therapist's value base may act as the basis for decision-making within this relationship. Decision-making may reflect the personal value system of the therapist as therapists have been a part of family, religious and social groups even before they have been exposed to their profession's value stance (Compton and Galaway, 1975). Others propose that the clients' values will take precedence as clients will select for themselves the values which they consider important. Furthermore, the principle of autonomy, and the clients freedom is an essential element of the therapeutic process (Steere, 1984).

Other writers have questioned the notion of a "value-free therapy" (Weisskopf, Joelson, 1980; Braginsky and Braginsky, 1973 and Beutler, 1979; in Steere, 1984). In this regard Steere (1984) writes that values will be communicated in therapy, regardless of whether the therapist tries to avoid it or has intentions to the contrary. Values can also be disseminated by the therapist inadvertently, or at an unconscious level. The therapist's clothing, general appearance, and office setting communicate important values to the client. Indeed "value-free" therapy can be seen as being non-existent and clients can unconsciously be reinforced by therapists when their "autonomous" decisions meet the approval of the latter. On the other hand, Graham (1980:371) asserts that therapists are never neutral observers and that patients "must be informed at times that his/her behaviour is odious." Ultimately therapists should be aware of the values they are communicating and the influence of these values and beliefs should not be undertaken or deemed to be unimportant in the course of their practice (Ard, 1975). An awareness of those beliefs that guide practice may make for a more effective therapeutic process.

2.2 The Therapist as Expert

In the therapeutic relationship the clinician is the expert because of the specialised knowledge and skills he/she possesses (Rhodes, 1986; Compton and Galaway, 1975; and Steere, 1984). This introduces the notion that the therapist's values may also be viewed as being correct, because as experts, the values they communicate are viewed as being superior. This represents coercion of a subtle and indirect manner. This dynamic probably plays itself out on an unconscious rather than conscious level. Likewise, values of the therapist may also produce actions that are overly coercive in nature. Rhodes (1986, pg. 106) termed these actions "paternalistic" and "manipulative." The action is usually justified by its benefit to the client or if it violates the right of the client, it is justified by its benefit to society. The therapist occupies a position of power vis-a-vis the client and this gives him/her leverage in the relationship with the latter. Society does not question the authority that the therapist possesses and hence the acceptance of his/her values (Aponte, 1985).

2.3 Social Work and its Value System

Therapists may often not question the values they transmit (Samler in Ard, 1975). For some therapists this may seem akin to questioning the effectiveness of the validity of their intervention or a relinquishing of power. Compton and Galaway (1975) assert that this is not the case with the social work profession. Aptekar (1967) views the framework as a set of values. This set of values can be seen as being the main attraction for students as it presents an ideal in terms of practice behaviour (Pilsecker, 1978). Two main values are highlighted by some authors (Miller, 1985; Compton and Galaway, 1975; Solomon, 1975; Pilsecker, 1978; Vigilante, 1983), as underlying the social work profession viz.

- 1) belief in the uniqueness and inherent dignity of the individual;
- 2) belief in client self-determination.

As already indicated there are those authors who assert that values of a profession can only

be understood as fully as possible in relation to societal forces.

2.4 Values and Ethics

Ethical assumptions underlie the decision-making process conducted by clinicians. Thus, a conflict of values between the therapist and the client may lead to an ethical dilemma. Very often decisions are arrived at easily and ethical considerations do not seem to be part of the process of decision-making. This, however, is not always true as clinicians are constantly making ethical judgements with regard to decisions about treatment plans, psychotherapy, drug treatment inter alia (Rhodes, 1986).

There are guidelines which have been developed for most professions, to assist with ethical dilemmas eg. The Code of Ethics. This does not, however, always solve the dilemma as a code of ethics does not spell out responsibilities when there are conflicting claims, eg. the social work profession has the National Association of Social Workers (NASW) Code of Ethics and workers have an obligation to serve the client to the best of their ability and at the same time are told to promote the welfare of society. There are, however, no guidelines if the interests of the two are in conflict (Vigilante, 1983; Rhodes, 1986).

2.5 Negotiating Values

It would seem essential that therapists develop an awareness that their decisions, interventions, goals and thoughts regarding the client evolve from a value base. Identifying the value base also seems a prerequisite for an adequate understanding of the client i.e. therapists need to separate their values from those of their clients.

Aponte (1985) provides the following guidelines:

- 1) Therapists should develop a sensitivity that will help them to detect people's values.
- 2) Therapists should monitor and observe conflicts and mutations of their values and

those of their clients.

- 3) Therapists must allow for differences between their values and those of their clients.
- 4) The therapists' display of respect for their clients' values will permit the latter to feel comfortable to assert their differences from the therapists' values.

2.6 The Characteristics of the Therapist

There has been a plethora of literature surrounding the topic of therapist variables. In the decades of the 1970s and the 1980s two surveys systematised the literature in this regard (Barret and Wright, in Hersen, Michelson & Bellack, 1984). These surveys by Meltzoff and Kornreich (1970) and Parloff, Waskow and Wolfe (1978) examined therapist variables in relation to the process of psychotherapy and its outcome and laid the groundwork for subsequent studies on therapist variables. The variables considered were the personality of the therapist, sex of the therapist, race of the therapist, values of the therapist, personal therapy of the therapist as well as their experience and attitude towards selected groups of patients (Hersen, Michelson and Bellack, 1984).

This chapter highlights certain of the characteristics such as gender, age, experience, race and personal therapy as being particularly pertinent in determining attitudes towards women as the literature seems to emphasize these aspects. The empirical study does measure some of these variables such as age, gender and practice experience but in addition also examines some other variables such as marital status and profession inter alia.

2.6.1 Gender of the Therapist

An early study (Orlinsky and Howard, 1976 in Hersen, Michelson & Bellack, 1984) concluded that there were significant differences as a function of the gender of the therapist. Women patients in therapy with male therapists, talked more about the

opposite sex and they expressed a greater desire to achieve insight via the therapy. These women also viewed their therapists as more demanding and detached. On the other hand, women patients who had female therapists, expressed more satisfaction with regard to the encouragement they received in therapy. The patient's diagnosis also seemed to play a role with regard to satisfaction with therapy, for example women with depressive disorders were more satisfied when they had a female therapist. This study had the patients as a sample.

When therapists were the respondents in a study (Stearns, Kimmel and Penner, 1980 in Hersen, Michelson and Bellack, 1984) female therapists tended to see female patients as being more depressed than male therapists saw them. Other findings in this area indicated that female therapists viewed patients, of both genders, as having greater problems in sexual adjustment and as having more difficulties with their spouses and children.

Women therapists also had a tendency to rate their patients, regardless of gender, to have had greater success in therapy, than did male therapists. Therapists of both sexes rated same gender patients better in prognosis and described therapy as a more enjoyable experience. With regard to describing patients, male and female therapists had similar descriptions for male patients but differed significantly when describing female patients (Jones, and Zoppel, 1982 in Hersen, Michelson, and Bellack, 1984). One of the important findings of their second study (Jones and Zoppel, 1982) is that "...regardless of the gender of the therapist, women clients were more likely than men to experience being depreciated by the therapists" (p373).

In this respect the Feminist Movement has questioned whether male therapists have

the ability to understand and deal with their female patients and same sex therapeutic dyads have often been seen as a solution to this dilemma.

2.6.2 Experience of the Therapist

It seems fair to assume that therapists' length of practice experience may affect the therapeutic process in some way. Logic dictates that as a therapist becomes more experienced, there may be changes in the way he/she conducts therapy. Does this, however, have consequences for the outcome of therapy or does experience in treating patients necessarily imply success in treatment? Auerbach and Johnson (1977) feel that the therapist's experience has both practical and theoretical importance. If it was known how therapists change in the course of their experience, then desirable changes could be fostered. The work of relative beginner therapists were often used in therapy research and may in fact not be generalized across the sample of therapists, (Eds: Gurman and Razin, 1977).

Some early studies (Matarazzo, Wiens and Saslow, 1966; Pope et al, 1974 and 1976; Loo, 1979 in Herson, Michelson and Bellack, 1984) have explored the dimension of therapist experience and its effects. Inexperienced therapists were prone to make certain errors viz.

- 1) "errors of focus (eg. narrow focus or focus on irrelevant material);
 - 2) faulty role definition (eg. argues - is authoritative or dogmatic)
 - 3) faulty facilitation of communicating (eg. asking yes, no, or brief answer questions).
 - 4) and other errors (eg. irrelevant professional statements (Auerbach and Johnson in Gurman and Razin, 1977:p.84).

Pope *et al*, 1974 and 1976 and Loo, 1979 have isolated variables that change over time, for example, therapists develop increased facilitation skills, have a decreased anxiety level and increased ability to evoke self-disclosure. Therapist experience is only likely to have an effect if it is closely linked to a definable task, and its relation to outcome still remains a murky, unexplored area (Hersen, Michelson and Bellack, 1984).

2.6.3 Age of the Therapist

Barret and Wright (in Hersen, Michelson and Bellack, 1984) assert that the issue of the therapist's age in relation to the client has not received much attention. Erlich and Balsam (1974) address some aspects of the therapist's age: young therapists are often concerned about their youthfulness and this generates feelings of anxiety. This may lead to disablement when confronted with a peer who has severe psychopathology. In their dealings with an older patient their lack of life experience may again prove to be a disabling factor.

Older therapists also have certain concerns when dealing with patients of various age groups. A younger patient may be an uncomfortable reminder of the therapist's own children and over-identification may result if the therapist is struggling with a similar dilemma in relation to his/her own children. An over eagerness to assume the parental role may be one of the pitfalls. When dealing with an older patient the therapy sessions may become social occasions and real therapeutic work may not be engaged in. Younger therapists may not match the elderly patients' expectations and add to their sense of hopelessness, and worthlessness. Failing to address this issue also reinforces the myth of patient homogeneity. The lack of research in the area of therapist's age is seen as a potential problem.

2.6.4 Race of the Therapist

Several authors discuss aspects of the therapeutic relationship when the therapist and the client are not of the same race (Curry and Turner, 1976; Jones and Seagull, 1977; Gitterman and Schaeffer in Turner, 1976; d'Ardenne and Mahtani, 1989, Cheetham, 1982 and Kadushin, 1972).

Racial differences may affect the rapport between the therapist and patient (Cheetham, 1982). Racial differences are so easily visible that it may cause an immediate emotional response. As whites far outnumber blacks in the helping profession (Jones and Seagull, 1977), this suggests that more often black clients will be seen by white therapists. Some stereotypes of black patients as unmotivated and resistant and white therapists as distant, unfeeling and uncaring was noted by Gitterman and Schaeffer in Turner, 1976); "Physical" differences referred to as "race" frequently result in one person being discriminated against by another in a position of power (d'Ardenne and Mahtani, 1989:5). A number of suggestions are proposed by Jones and Seagull (1977) to minimize problems in a therapeutic dyad where there is a racial difference viz.

- i) understanding one's prejudices
- ii) examining one's motivation for working with white minority clients.
- iii) protecting against the stereotyping of others
- iv) education to dispel stereotypes
- v) learning the minority perspective through education

King, (in Cheetham, 1982) feels that there may also be problems in establishing rapport between a black therapist and black client as the black therapist may be seen as a traitor to his/her race, and as having accepted middle class values. Indeed, in

an earlier study Kadushin (1972) had concluded that although non-white workers may be necessary for non-white clients in some instances and this may be therapeutically indicated, it is not always the case as white workers can work effectively with non-white clients and the nature of the interpersonal relationship established appears to be more important than the skin colour.

2.6.5 Personal Therapy of the Therapist

Another issue which can influence attitudes is the personal therapy of the therapist. There is little evidence on which to base a conclusion of whether the personal therapy of a therapist has a significant effect on his/her practice. Two studies have addressed this issue (Garfield and Kurtz, 1967 in Hersen, Michelson and Bellack, 1984). Their main conclusion was that therapists felt they had benefitted from the experience but no relation to effect on actual practice could be recorded.

2.7 **Conclusion**

Values of a personal or professional nature may influence the attitudes of clinicians, and in this manner be transmitted in the therapeutic encounter and there appears to be a growing body of evidence that therapists are never neutral observers. It is suggested that therapists as experts need to be aware of the power they wield vis-a-vis the client and need to develop an awareness of their value system and the ethical dilemmas this may produce if the client concerns are in direct opposition to their value system. Most professions have a code of ethics, which, however, is not always helpful in solving dilemmas of an ethical nature. Identifying one's value base as a therapist seems a pre-requisite for an adequate understanding of the client i.e. therapists need to separate their values from those of their clients.

Therapist characteristics may be influential in determining their attitudes towards women in therapy. The characteristics discussed in this chapter are gender of the therapist, experience of the therapist, age of the therapist, race of the therapist and personal therapy of the therapist. The following chapter will examine societal views of women as it is within the confines of this that individual attitudes could be shaped.

CHAPTER 3: WOMEN IN SOCIETY

In this section a brief historical overview of the roles that women have occupied in society will be traced. Societal perceptions of women may have an enduring influence on perceptions that clinicians have of women. This in turn, could effect the clinicians perception of their female clients. Some emphasis will be placed on the situation within South African society.

In addition, the Feminist Movement and its influence on women's roles and societal perceptions of women's roles, will be briefly evaluated. This chapter provides a background for this study, however, and is not the main focus of this thesis.

3.1 Societal Context

The literature on women's social position seems to centre around issues of women in the workplace, women and careers, women and children, women and motherhood and women and marriage (Allen and Kalish, 1984; Hock, Gnezda and MacBride, 1984; Pinstrang, 1984 Brennan and Hozenweig, 1990; Moen, 1991; Walker, 1990). Women's sexuality was often the centre of debate and this opened discourse in other crucial issues such as the power of inequality. The themes that were explored were women's treatment as "second class citizens" with traditional attitudes placing women in an inferior position (Brennan and Rozenweig, 1990; Walker, 1990).

There are stereotypes about women which emerge, such as in relation to seeing their primary life task as that of caring for their husband and children. These studies do, however, also indicate that there have been challenges to this traditional view, with the Feminist Movement being influential in this regard.

3.2 The Cult of Domesticity

Women's role historically, was seen as being linked to the homefront, with her primary roles being those of wife and mother. Working outside of the home was frowned upon but if economic necessity demanded, then there was an element of acceptability. While economic reasons prompted women, especially those of the working class, to enter the open labour market, these actions were often disapproved of, especially if these women had children. The traditional view of women as primarily being wives and mothers was coined the "cult of domesticity" (Humphries, 1977a, b in Geschwender, 1992). Very often it was not only the economic need of the family but also the economic need of the state that prompted women into the workplace.

3.2.1 South African Society

In South African society poverty and lack of employment alternatives are factors which contributed to the oppression of women. Many of these women are employed in a domestic capacity by white households. The employers' wives in turn also had roles centred around the domestic sphere, yet they did not recognise each other as allies, being separated by race and class (Walker, 1990; Cock in Stichter and Parpart, 1988).

It appears from the literature that an historical analysis of women in South African society is a difficult task as there seems to be an absence of records regarding women's contributions to society. The lack of documentation in this regard seems to be greatest for black women. This phenomenon seems to be a result of the fact that women's contributions were often minimised and confined to the genre of "reproduction", "oppression" and "gender" (Walker, 1990) and not acknowledged as essential in the broader societal scope.

In Southern Africa including South Africa, a distinction is made between capitalist and pre-capitalist society when analyzing women's position (Walker, 1990). Oppression in the pre-capitalist societies was very different from that now experienced in capitalist society. With pre-capitalism, women's fertility gave them social status and prestige: they had a certain degree of economic independence as with marriage they were given access to land. They also worked the land and although this was hard work, it took place within a community which provided security (Walker, 1990). The face of oppression in present day, capitalist South Africa is a different one, with black women earning low wages, having long working hours and facing demeaning treatment by largely white female employers. Influx control laws had a binding effect on domestic workers as they could be sent back to their homelands as a result of non-registration once they left their employment. They are currently still not protected by legislation and lack benefits such as unemployment insurance, maternity leave or sick leave and they can also be dismissed at any stage (Cock in Stichter and Parpart, 1988). Things are changing in this regard, however, as the Domestic Workers Union has been instrumental in the past few years attempting to change working conditions of its members and bringing public attention to the issues at stake.

In the 1970s there appear to have been remarkable changes in the social roles of women in most societies, as a wider vista of opportunities and options became available to women. In the United States for eg. women were gaining in political power (Moen, 1991; Lynn, 1992). However, in South Africa women were still disadvantaged despite the expansion of employment opportunities, as there was a particularly dramatic increase of employment between 1973 and 1982 (Cock in Stichter and Parpart, 1988).

One of the important functions of domestic labour was that it released white women who could participate within the labour project. The effect was an increase in production and an extension of the labour force, producing surplus value of labour. White womens' roles were still clearly linked to the domestic front if there were not servants to perform domestic tasks. It was ultimately the wife's responsibility to see to domestic tasks and women were still economically dependent on their husbands. "Wives are bound to their husbands by contracts..." (Cock in Stichter and Parpart, 1988:211) and are not really protected by South African Law.

3.2.2 American and British Society

In the pre-war of the 1930s women in American and British society were actively seeking social and political changes. The work of these female activists were employed to eliminate racial segregation and discrimination in American society, and Lynn (1992) points out how techniques that were to be used by the civil rights and Feminist Movements of the 1960s were also evident in the 1950s. Indeed, efforts to change the racist attitudes then are reminiscent of the latter efforts to change attitudes regarding gender.

The activities of women made a big difference in the community and in organisation. Despite womens' involvement at this level, popular discourse at the time focused on the traditional ideology with women's role being linked to the domestic front. An alternative view could be gleaned from popular magazines then, in which women were encouraged to enter the political front and labour market (Lynn, 1992).

3.3 Working Mothers

In the decade of the eighties there appeared to be an increasing acceptance, in some sectors of society, of women's participation both within the workplace and within the home. However, the typically male pattern of uninterrupted labour force attachment was not emulated by women as a result of child-rearing, and women had intermittent periods of labour force participation (Moen, 1991). The role of wife and mother took priority over the role of possible worker and was always a first consideration when the decision to enter the labour force was entertained. When a woman had to work the splitting of roles of worker and mother was complex as women's increasing freedom from the home and entrance into the workplace affected the quality of family life. In this respect, for example, tasks that had traditionally been the responsibility of the woman because she was unemployed now become the domain of husband and wife (Berardo, Shehan and Leslie, 1987; Bird and Bird, 1984 in Sutor, 1991).

All too often, however, these tasks, remained the woman's responsibility and she had a double burden. The issue of joint responsibility for household tasks and parenting was hotly debated with attack and counter-attack. Describing the division of household labour became the focus of research in the early eighties (Brubaker and Hennan, 1982; Cowan *et al*, 1985; Rexroat and Shehan, 1987; White, Booth and Edwards, 1986; Yogev, 1981 in Sutor, 1991).

An interesting fact documented from research studies was that wives still had to shoulder a disproportionate share of household tasks and that, regardless of the fact that wives were employed, the husbands share of household tasks did not increase (Berardo, Shehan and Leslie, 1987 in Sutor, 1991). In this respect, satisfaction with husbands' contributions appeared to be highest in the pre-parental years than the early

child-rearing years (Cowan *et al* 1985; White *et al*, 1986 in Sutor, 1991). The findings, however, are not consistent, as a study conducted later found greater satisfaction with the division of household tasks in the post-parental years.

Working class African women have to cope with dual roles as mothers and workers, and the domestic worker serves two households, her own and that of her employers. Very often this means that a domestic worker could take responsibility for her employer's children and could neglect her own children because of her long working hours. Or the domestic worker's children could be left in the care of the daughter who is kept out of school to perform this duty, thus a cycle of "poverty, inadequate childcare and interrupted education among blacks' children especially females" (Cock in Stichter and Parpart, 1988:217) is perpetuated; on the other hand, white children could have the benefit of two mothers.

3.4 Effects of Maternal Employment on Family Conditions

Maternal employment produces a myriad of altered situations within the household, with children, husbands and wives being affected, in both positive and negative ways. Concern was expressed by some authors that maternal employment exerted negative effects on mothers' home and work lives (Heins, Styllman, Burgess and Crnic, 1984 in MacEwan and Barling, 1991). The assumption was that children are deprived of the time and energy necessary to establish a healthy mother-child relationship (Benn, 1986; Hoffman, 1986 in MacEwan and Barling, 1991).

In contrast, many other studies concluded that negative consequences did not result from maternal employment (Barling, 1990b; Parry, 1987; Warr and Parry, 1982; Hoffman in MacEwan and Barling, 1991). However it appeared that when a mother's experience of her dual role in the workplace and home is negative, there are negative

effects for her children and herself (Spita, 1988 in MacEwan and Barling, 1991).

The quality of maternal care of working mothers and the factors affecting that dimension was studied with the focus on the following issues viz. maternal working conditions, background characteristics, family circumstances and how these influence the home environment that working mothers provide for their children (Belsky, 1984 in Menaghan and Parcel, 1991). They found that occupational conditions producing distress for the working mother had a negative impact on the mother-child relationship.

The authors also concluded that mothers with fewer social supports expressed more negative attitudes towards their children and were less nurturant. While social support referred to any additional adult support, it was found that a marital partner particularly enhanced a mother's sense of well-being (Belsky, 1984 in Menaghan and Parcel, 1991).

3.5 Motherhood

Women are socialized to believe that motherhood and marriage are a woman's major source of fulfilment (Bernard, 1974 in Hock, Gnezda and MacBride, 1984). However, literature on the subject has been controversial, with some studies suggesting that the traditional idealized view of motherhood was still common (Paloma, 1972; Shwarz, 1980; Gilbert, 1981 in Hock, Gnezda and MacBride, 1984). These studies concluded that the role of mother always took precedence over that of career woman. Other studies found that traditional attitudes are changing (Hare-Mustin and Brodsky, 1979 in Hock, Gnezda and MacBride, 1984; Shainess, 1980). In this respect, Shainess (1980:384) claimed that: "The sense of priority of children, and devotion to them seems dulled." Also the issue of child abuse was explored and mothers were identified as the main perpetrators (Blumberg, 1990). However, mothers are

usually the main caregivers and this fact could boost these figures.

Feminist perspectives of motherhood have been described as controversial (Ruddick, 1980; Chesler, 1988 in Snitow, 1992). For example, Snitow (1992), a radical feminist, in a comprehensive review on feminism and its relation to motherhood, concluded that feminists were divided about whether they want men to fulfil a "mothering" role by taking on primary childcare responsibilities. She poses the question of whether women should give up this nurturant role with its denotations of power and that there is a "fear that feminism will free men first: men will have the power of the world and the nurturant experience, the centrality to their children" (English in Snitow, 1992:43).

3.6 Women and Sexuality

Research into attitudes toward women and sexuality provides conflicting views. The Kinsey Report (1953) in documenting women's new sexual morality offered liberation: this report documents a rise in pre-marital sex in the post-World War 1 period as well as an increased incidence of pre-marital petting. There seemed to be a general rise in the awareness of female sexuality. This move towards a liberalisation in attitude continued in the decade 1965 to 1975 with several studies reporting this phenomenon (Bell and Chaskes, 1970; King *et al*, 1977; Robinson *et al*, 1968 in Robinson, 1991).

This trend continued in the next decade from 1975 to 1985, when it was reported that the extent of change was particularly significant in relation to females in the area of pre-marital sex and consequently there seemed to be a decline in the double standard of sexual behaviour (Robinson, 1991). However, the double standard was not entirely removed as females who had pre-marital sex were more likely to be seen as "loose" and value was still placed on being a virgin at marriage. Despite a growing conservative atmosphere in America

in that decade in relation to the anti-abortion movement, sexual behaviour and attitudes were becoming increasingly liberal at that time. In a recent study, Robinson (1991) looked at sexual attitudes covering the two decades from 1965 to 1985 and found that there had been a steady decline in the negative attitude towards pre-marital sex. With regards to promiscuity a different picture emerges, as a greater percentage of males and females now consider promiscuity immoral than did in the 1970s. This attitude is reminiscent of attitudes held in the 1960s and may be related to AIDS. Media coverage of the HIV virus and the rampant path of destruction it weaves may have had an effect on attitudes to this extent.

In African countries sexual relations were usually regulated through various customs and laws. Colonial rule provided opportunities for women to escape from the rural areas and because of their scarcity, women could bargain with various male partners in order to improve their lifestyles. Women's newfound sexual independence proved to be alarming to African chiefs and colonial officials of the time who then created courts and new laws who "redefined sexuality in terms of patriarchal power" (Chanock, 1985; Ault, 1983; Wright, 1982 in Stichter and Parpart, 1988:115).

3.6.1 Abortion

The fertility rate among American women dropped in the nineteenth century, with a similar occurrence in the 1960s and 1970s. During the latter period, women were also delaying marriage and childbearing. More women were entering the labour force and were becoming aware of the fact that control of reproduction was critical. In African society women, although being the actual means of reproduction, could not create descent relations as progeny operates only through men. New contraceptive measures such as the intra-uterine device and the birth control pill were developed,

leading to an increasing freedom on the part of women. At the same time women's reliance on other types of fertility control, including abortion (Tribe, 1990) increased. Restrictive abortion laws were enacted in the United States in the mid-nineteenth century and were the result of lobbying by the medical profession. The medical profession's campaign for abortion laws suggested that abortion posed a threat to the traditional sex roles with women being characterized as selfish and immoral for shirking the responsibilities of motherhood (Tribe, 1990). The abortion laws enacted made provision for abortion to be performed under certain circumstances only. The "Therapeutic abortion" gave power to the medical profession whose job it was to decide where this was deemed acceptable.

Abortion was now controlled by legislature but this did not curtail the practice of abortion as illegal terminations were often the resort of the underprivileged or women who had no other resource.

In South Africa legal abortions are controlled by the Abortions and Sterilisations Act No. 2 of 1973, and abortions are only allowed under certain circumstances, for example, when a woman has been raped and a pregnancy results. Backstreet abortions are common practices amongst the underprivileged as the more privileged possess the financial power to seek legal abortions abroad. The debate of whether women only should be responsible for making decisions about abortion still rages. The medical and legal professions' have owned abortion and are protective of its interests, making the issue a complex one.

3.7 Feminism and its influence on Women's Roles

The Feminist Movement and its contribution to women's social roles is a complex one and, while this thesis will not explore this in detail, it is necessary to acknowledge the contribution of this movement.

Valentich and Gripton (1985:1) define "Feminism as a movement for the improvement of women's economic, political and social status. Its principal goal has been the equality of women and men." Feminism in itself is not a unitary range of ideological positions, and the Feminist Movement could refer to liberal feminism, socialist feminism or radical feminism. Liberal feminism focuses on the "freedom of choice, individualism and equality of opportunity" (Valentich and Gripton, 1985:1). It sees women as an oppressed sexual class whilst socialist feminism emphasises class analysis. Radical feminism calls for major reforms on every level and for a complete change in things as it views women as "economically and politically oppressed" (Valentich and Gripton, 1985:1). Some authors contend that the history of Feminism began with "The Vindication of the Rights of Women" which was first published in 1792 and authored by Wollstonecraft. In it she attacks the male-governed society of the time and asserts that women are prevented from using their full intellect and energy outside of the home. In America, feminism arose earlier than in Britain and can be traced back to the anti-slavery movement. Viola Klein (1949 in Oakley, 1981) proposed that feminism as an organised movement began in the Victorian middle-class drawing room, while Oakley (1981) viewed the working class womens' political activities throughout the nineteenth century as the origin. The role of the suffragettes in this regard is important. In the north of England women were particularly active as they were well represented in the cotton unions: they fought for womens right to work, co-operative childcare, equal pay for all women and family allowances for children. These demands were thought of as being too radical by the suffragettes. In 1918 propertied women over 30 were finally given the vote (Oakley, 1981).

As mentioned earlier, the roots of feminism in America can be traced back to the anti-slavery movement where feminists used abolition as a platform to promote women's issues. A period of silence followed once women had been granted the vote in 1920. Twentieth century feminism now contended that although women were enfranchised they were still disadvantaged. However, being granted the vote seemed to have a divisive effect on the women's movement in America as the militant women were of the opinion that women were still subordinate to men, legally, professionally, in industry and in the home. There also followed a period of anti-feminism in Europe. Despite this, however, certain laws were changed which benefitted women. In 1938 the second Women's Franchise Act was passed, and this was regarded by many as the last inequality regarding women's position.

Walker (1990:25) provides an appropriate end for this chapter when she says: "The history of Western Feminism in both the late nineteenth and the early twentieth century and the contemporary period suggests that gender-consciousness, in the sense of awareness of and opposition to women's fact, is more often a middle-class than a working class phenomenon, at least in its explicitly organised form (p25).

She adds that the history of the suffrage movement in South Africa supports this supposition as middle-class women took the lead in challenging sexist discrimination and promoting the rights of women. There was a building of bridges between the domestic and public sphere and a softening in attitude towards women in the labour market. It is felt that these developments were influential with regard to gender relations in South Africa (Walker, 1990).

3.8 Conclusion

Tracing the history of women's oppression through the decades is not an easy task, particularly for South African society as there is a lack of documentation in this regard. Literature for American society does not reflect the realities of South Africa and this chapter attempts to draw together some of these themes, in order to provide the background to this study. The literature on women's social position emphasises issues such as women in the workplace, women and careers, women and children, women and motherhood, women and marriage and sexuality. There are challenges to the traditional views which the feminist literature mainly espouses.

Oppression in South African society for black women is the triple oppression of gender, race and class. The situation of domestic workers is highlighted as economic necessity often forces black women into this type of employment. In the 1970s there was a widening vista of opportunities for women in most societies including South Africa but women were still disadvantaged in many respects.

Mothers who worked became an increasingly common phenomenon but, the typically male pattern of uninterrupted labour force participation could not be emulated by women as women's family roles still took primacy over other roles. A complex situation was created at home as their husbands and children were also affected and often had to assume additional responsibilities. More often, however, women had a double burden of career women and having to still assume full responsibility for household tasks. The impact of mothers being absent from home, as a result, was hotly debated with many opposing views and no consensus about whether children were actually disadvantaged.

In the arena of sexuality, things were also changing as attitudes became more liberal but with

the double standard of sexuality still prevailing. Value was still placed on a woman being a virgin at marriage and AIDS is felt to have had an effect in the latter decade of turning attitudes towards the more traditional, once again. Other issues debated were contraception and abortion. The role that the Feminist Movement played is highlighted, with its various ideological positions.

CHAPTER 4: WOMEN IN THERAPY

This study postulates that clinicians attitudes towards women can be transmitted in the therapeutic encounter. This chapter explores this aspect by highlighting some of the issues from the literature which describe women and therapy and three key historical events which have influenced attitudes towards women's mental health are discussed.

4.1 Historical Considerations

Women's exposure to psychiatry in the past seems inextricably linked with the witchcraft craze during the sixteenth and seventeenth century (Al-Issa, 1980; Franks and Burtle, 1974). At the time it was theological belief that persons who were "possessed" were seized against their wishes by spirits and the treatment advocated for this was exorcism. According to this belief, witches were persons who renounced God and made a pact with the devil and they were accused of causing pestilence, storms and floods (Al-Issa, 1980; Franks and Burtle, 1974). It appears that most witches were women. Once accused, witches were excommunicated, however, often they were also tortured, to extricate confessions, or were executed. In 1563, Johann Weir in his book "De Praestigiis Daemonum" stated that "witches" were in fact mentally ill. This courageous assertion put him at risk of being accused of witchcraft himself. This didn't happen and by the eighteenth century the practice of burning mad people at the stake declined. As indicated, most "witches" were women and the view of the female as inferior, sinful, dangerous and evil was emphasized in writings about witchcraft (Al-Issa, 1980; Franks and Burtle, 1974). To-day popular opinion is that many of those so-called witches were in fact mentally ill. It was suggested that women were accused of witchcraft because of their powerless position in society (Al-Issa, 1980). Another group that

was suspected of witchcraft were professionals such as midwives and nurses. Although they asserted their power and challenged the established system, their efforts to influence the powerless women made them vulnerable to victimization (Chesler, 1972).

Three events are highlighted historically as having had an effect on women's affairs. Firstly, the acknowledgement that many so-called witches were in fact mentally ill women. Secondly, the introduction of anaesthesia and its application during childbirth and thirdly, the establishment of a recognised profession of nursing for women, as introduced by Florence Nightingale. The social pressures on women were now highlighted and women's position in society was viewed in a more compassionate light, and with the recognition of a profession for women it was felt that women as a group had more power as well as control over their lives. Women now led their lives against a backdrop of social and medical progress which produced an element of hope.

4.2 Freud's Theory

It is necessary to discuss Sigmund Freud's contribution as his theory often provides the starting point for a discussion on the topic of female psychology, although there is controversy regarding his viewpoint. Friedman (1977) claims that Freud was aware of the controversial nature of his views and its prejudices against women, but ironically, the development of psychoanalysis was concerned almost exclusively with women patients. Freud's paper, **Female Sexuality** published in 1931 describes the girl's preoedipal attachment to mother (Ruderman, 1986). He asserts that this attachment is of far greater importance in women than in men. He felt that only after the girl had passed through the phallic phase, the observation of anatomical differences, the castration complex, the sense of inferiority and penis envy, was the path to the development of femininity open to her. Horney and Jones

opposed this viewpoint by asserting that femininity did not represent thwarted masculinity, but that both masculinity and femininity had preoedipal origins. Freud also believed that a girl's discovery of her sex and sexual distinction was also decisive for the development of the personality traits that he associated with femaleness: passivity, masochism and narcissism being amongst them (Ruderman, 1986).

The vehement attacks made against Freud in response to these ideas have not diminished through the decades. Friedman (1977) proposes that large amounts of energy has been expounded to prove Freud's assertions as incorrect when his theory is so blatantly incorrect that there is no need for debate.

He claims that: "On the side of what is valuable and needs to be preserved, are those statements relative to choice of sexual object, the significance of the vagina, and on the role of society in oppressing and distorting women's development. On the other side are such things as Freud's insistence on a weaker superego as a primary aspect of women's development rather than as a reflection of penis envy as a concrete occurrence and most of all the extension of the imagery of the sexual act, namely, man as the perpetrator, women as receptacle, into character traits associated with masculinity and femininity." (p.406)

4.3 Other Theoretical Issues

The literature emphasises particular issues with reference to women in therapy and these will be explored in the next section.

4.3.1 Rates of Mental Illness and Hospitalization

Studies between 1950 and 1970 indicate that there are higher rates of treatment of female patients in public and private hospitals, general hospitals, outpatients clinics,

and seen by private psychiatrists and general practitioners. The greatest gender difference was found in private practice (Gove and Tudor, 1973 in Paykel, 1991). In the pre-1950's the rates for mental illness amongst men were reported to be higher. After 1950 the rates of mental illness increased for both males and females (Dohrenwend and Dohrenwend, 1969).

The trend in Britain and the United States were similar with higher rates for females than males which contrasted with non-Western cultures where there seemed to be more mental illness amongst males than females (Ananth, 1976; Al-Issa, 1966, Rao, 1964 in Al-Issa, 1980). A factor which is to be taken into account when surveying these findings is that definitions of mental illness are different in Western cultures than for non-Western cultures (Franks and Burtle, 1974).

4.3.2 Diagnostic Categories

There seems to be a tendency to use particular diagnostic categories more often for female than male patients and vice-versa. Men are more frequently diagnosed as antisocial, alcoholic and drug addictive while female patients are more often diagnosed as neurotic or depressive (Al-Issa, 1980). In addition, Smart (1977) points out that the signs of male disturbance are much more obvious than that of female pathology eg. antisocial behaviour, and that males may in fact be reluctant to express those patterns that are considered typically female symptoms.

4.3.3 Reasons for Gender Differences

Al-Issa (1980) mentions three factors which influence the gender differences in the rates of mental illness and hospital admissions viz.

1. Women are more liable to report illness than men as it is culturally more

acceptable for them to admit to illness.

2. The sick role is more compatible with women's other role responsibilities than those of men.
3. Women have more illness because their assigned social roles are in fact more stressful than those of men.

4.3.3 Reporting Illness

Al-Issa (1980) refers to different studies that have shown that women report more illness, both physically and mentally than men. (Nathanson, 1975; Cooperstock, 1967a; Wadsworth *et al*, 1971).

While women may not actually have more symptoms than men it is socially more acceptable for them to express and report symptoms. In addition, women's expression of distress overlaps with certain of the stereotypes attributed to females eg. that they are the weaker sex so reporting psychological distress is a normal part of their behaviour repertoire. Men on the other hand are stereotyped as being strong and thus have to grin and bear their symptoms without a complaint. These different sex-role expectations may lead to an under-reporting of symptoms on the part of men.

2. **Compatibility of Social Role**

The sick role is more compatible with the role that society has prescribed for women. There have been suggestions that women have more accessibility to health services and more time to make use of these services (Al-Assa, 1980)

Nathanson (1975 in Al-Issa, 1980) found that married women, even though they have high rates of mental illness, have lower rates of reporting illness than do single, divorced or

widowed women. The conclusion drawn from this is that they have more demands on them and less time to adopt the sick role (in Al-Issa, 1980).

3. Stress in Women

The third factor advanced for the differential rates of mental illness amongst the genders, is the fact that women's social and biological roles are more stressful and predisposes them to physical and mental illness (Al-Issa, 1980). The assumption here is that women's oppressed position in society produced lower levels of satisfaction with their lifestyles and this leads to emotional problems. They had fewer alternatives open to them in order to compensate and the result was mental illness. Through the decades, women have become increasingly more dissatisfied with their role definition and as their dissatisfaction increased so did the rates of mental illness.

4.4 Countertransference Issues

Countertransference is defined as the therapist's unconsciously felt attitudes, experiences and attributes evoked by the stimulus of the psychotherapist-patient relationship (Ruderman, 1986:105) Fabrikant (in Franks and Burtle 1974) has shown that therapists can be placed on a traditional-liberal continuum regarding their views on women's role and that most therapists hold a mixture of conservative and liberal viewpoints. The way in which a therapist responds to a particular issue surrounding women's roles depends on their viewpoint, whether traditional or liberal. The problem lies in excessive counter-reaction in either direction and especially if the therapist's viewpoint conflicts with that of the patients. Studies (Broverman *et al*, 1972 and Neulinger, 1968) lend credence to the fact that sex-role stereotypes are promoted by clinical personnel.

4.4.1 Countertransference when Women treat Women

As outlined above, countertransference issues can be experienced by any clinician in

relation to any patient.

Both male and female therapists can experience countertransference when dealing with female patients. It is often assumed that only male therapists will promote certain gender stereotypes with the therapeutic relationship with a female patient. Female therapists may also display intense reactions in response to particular issues produced by their women patients and the researcher wished to emphasize this by discussing some of these countertransference issues (Eastwood, Spiegvoegel and Wile, 1989). These authors describe the following reactions to female staff members in a particular unit towards female patients who were not displaying "typically female behaviour." They found that they had intense problematic reactions to an aggressive female patient, and ran the risk of labelling assertive behaviour as aggressive. They found themselves morally condemning a patient who was a sex-trade worker. The dependent woman evoked feelings of powerlessness and depression but also evoked rejection because she represented the rejected older woman they might become. The patient perceived as the bad mother was also morally condemned.

It is important that women therapists admit to and acknowledge that there are certain female patients of whom they disapprove. "The woman therapist is confronted with an innate paradox" (Ruderman, 1986:104). A female therapist may intellectually agree with women's expanding social role, but may not have processed this and consequently the traditional experiences become activated in her countertransference. Thus, the therapist may encourage her female patient all the rights to independence allowed to men but, may at the same time be caught in her own unresolved conflicts around the same areas eg. familial, professional roles, fear of competition and success.

Five major themes amongst the women clinicians emerged (Ruderman, 1986).

They were:-

1. "the therapist's relationship with her mother." - A common theme was that therapists wanted to repair certain aspects of the relationship with her mother and in this way work with her female patients constituted a "parallel process."
2. "fear of success, as manifested by the therapist's empathic identification with her patients inhibitions, conflicts over ambition, and devaluation of self-worth."
 - Therapists give patients the scope to explore and expand while they remained "stuck" and "at home."
3. "role conflicts, with respect to family and relationship needs versus career pursuits, and conflicts over feminine-masculine role stereotypes in professional roles."
 - The issues of being a role model is important here.
4. "envy in the countertransference, as related either to dependency feelings, or to mourning."
 - Therapists compare themselves with their patients and experience the universality of the dynamics. Her dependency wishes, conflicts about autonomy and mourning for lost opportunities is reactivated.
5. "the life stage of the therapists."
 - In this regard, therapists transmit certain values and attitudes at certain phases of their lives and these may shift and change at other life stages.

4.5 Depression in Women

Because of the predominance of depression in women, it seems important to consider this as a section on its own and also as an illustration of the features compounding women's experience of therapy.

There are about two depressive females to one depressive male in the United States. Countries other than the United States report similar findings except a few developing countries eg. New Guinea and Iraq. In fact, in India, there are more depressed males than females (Al-Issa, 1980; Paykel, 1991). Many factors have been implicated as being responsible for this phenomenon (Al-Issa, 1980). Firstly, the argument has been advanced that women simply seek more help for depression than do men. Secondly, that the female biological make-up, viz. that there may be genetic differences due to the different chromosomal make-up of the sexes or that the female sex hormones somehow play a part in the high incidence of depression amongst women. Thirdly, social causes have been implicated viz. the life stress of women, social vulnerability factors, absence of support and women's role in society. Fourthly, the two sexes may differ in the way they express distress. Females may express their distress by becoming depressed while males may acknowledge their distress in other ways. These factors will now be examined.

4.5.1 Help-Seeking Behaviour

Of the four factors highlighted, this is the only argument that can be refuted as the figures for community samples are similar to hospital admissions. In an analysis of four large scale community surveys, women reported more psychiatric distress and showed a greater willingness to consult at the same level of morbidity (Al-Issa, 1980). The latter appeared to be a greater readiness to acknowledge distress as an emotional problem.

4.5.2 Biological Causes

The evidence in this regard is inconclusive. The evidence to support the theory of the female X-chromosome being responsible for depression has not emerged.

The result is a confounding picture where the X-chromosome has been linked to bipolar affective disorder (Mendlewicz *et al*, 1987) but this does not explain the sex difference for depression as the incidence of bipolar affective disorders are roughly equal between the sexes.

When the hormonal aspect is examined there is also very little evidence in support of the biological theory. The female hormones viz. oestrogen and progesterone are implicated and studying this phenomenon has proven to be difficult (Al-Issa, 1980).

Pre-menstrual tension is often associated with feelings of depression and even at times clinical depression is present, but once again the specific hormonal involvement in this regard is unclear.

Oral contraceptives were also named for causing depression but these studies are also equivocal. Childbirth does seem to produce a higher incidence of depression or psychoses and hospital admission rates of mental illness one month post-partum, in women seems to support this (Paykel, 1990).

Studies on the following life stage for women viz. the menopause has failed to provide proof for the "hormonal theory." There is no evidence to suggest that depression peaks at this stage (Winokur, 1973; Hallstrom, 1973; McKinley and Jeffries, 1974 in Paykel, 1990).

4.5.3 Social Causes

There has been more interest in this particular area recently. These studies have been concerned with life events, social support and women's roles and status. The conclusion in this regard seems to be that women do not have more stress but respond to higher intensities to the same stress, hence a higher vulnerability to life stress is postulated (Paykel, 1991; Paykel and Cooper, 1991; Unlenluth and Paykel, 1973). The absence of support has been studied by Brown *et al* (1978, 1981, 1986). Factors, which they highlight as attributing to depression are the lack of a confidante for women, the presence of young children at home, being of lower social class, not working and loss of mother at an early age.

The third social cause that has been investigated is the social role and status of women, and the role of housewife, particularly, seems to be associated with low status.

4.5.4 Acknowledgements and Expression of Distress

Women have been socialized in certain ways and the expression of conforming behaviour is considered appropriate. It is acceptable for a woman to cry but not so for a man. It is therefore more acceptable for a woman to express her distress by becoming depressed as the behaviour during depression conforms more readily with the stereotypical behaviour of women than men. Other problems are more common in men eg. alcoholism, where the expression of distress in this manner is more socially acceptable. Cultural factors also need to be taken into account in this regard eg. Paykel (1991) notes that the Amish Order in Pennsylvania have strong proscription against alcoholism and there seems to be a high rate of affective disorder amongst them.

4.6 Conclusion

Historically, certain events have been cited as being linked with the birth of a mental health service for women. Most notable was the witchcraft craze during the 16th and 17th century with most "witches" being women who were probably mentally ill. The establishment of a profession for women viz. nursing as well as other advances eg. medical, were also influential in this regard. Freud's work in the 1930s was another significant contribution to this field because he worked almost exclusively with female patients. There is still much controversy regarding his theoretical contributions in relation to women's psychology.

The literature seems to emphasize particular issues with regard to women in therapy. There seems to be different rates of mental illness for women as opposed to men and various factors have been advanced to explain this phenomenon. Studies have indicated that women more often report illness and the sick role is more compatible with their social role. Women's status and role in society also predisposes them to develop physical as well as mental illness.

Women therapists also have strong countertransference feelings when dealing with particular types of female patients and are not necessarily immune to these feelings because of their gender. They should be aware of these feelings and how it affects their therapy.

Depression is more often diagnosed in women and this warrants a mention in a section of its own. The factors contributing to this are examined viz. that women seek help more often than men, biological reasons and social reasons.

CHAPTER 5: RESEARCH DESIGN AND METHODOLOGY

This chapter will discuss the research methodology and design utilized in the study.

5.1 Research Objectives

The objectives of the study are:

1. to explore the attitudes of clinicians towards women.
2. to explore the specific variables of clinicians which may play a role in determining their attitudes towards women.
3. to explore theoretically clinicians' attitudes and their effect on women in therapy.

The study addresses the following research questions:

- i. what are the attitudes expressed by clinicians regarding women's various societal roles viz. mother, career-women inter alia.
- ii. whether there are differences in the attitudes of male and female clinicians regarding women's societal roles.
- iii. whether specific variables such as age, profession, years of training, inter alia have an impact on clinicians' attitudes.

5.2 Research Design

The study utilizes an exploratory-descriptive design. Exploratory studies lead to insights or hypotheses but do not test them (Selltiz, Wrightsman and Cook, 1976). This study was exploratory in that it not only described and quantified data about attitudes towards women but also explored aspects of women in therapy by completing five in-depth interviews with a

view to providing qualitative data. In addition to this, the exploratory method was further enhanced by a theoretical examination of the literature in regard to the latter aspect.

5.3 Assumptions of the Study

This study assumes that all psychiatric personnel that form part of the sample are clinicians. It also assumes that all clinicians have had experience of working with female patients.

5.4 Method of Study

5.4.1 Sample

The demarcated population was a group of clinicians. The group utilized was state-employed clinicians working within a psychiatric hospital. It is necessary to nominally define what is meant by "clinicians" in a psychiatric hospital, as one professional category viz. the nursing staff were excluded from this study. "Clinicians" then referred to psychiatrists, psychiatric registrars, social workers, occupational therapists and psychologists. They were included because of their clinically-orientated training. The nurses have different categories of training; in addition the numbers of nursing personnel were beyond the scope of this study and as a result they were excluded. The researcher then utilized a non-probability method of sampling viz. purposive sampling, by selecting "typical" persons for inclusion in the sample.

There are three psychiatric hospitals within the Cape Peninsula. In addition to this there are the various psychiatric clinics, out-patient departments and psychiatry departments attached to general hospitals. The researcher decided to conduct the survey at one of the psychiatric hospitals viz. Lentegeur Psychiatric Hospital.

5.4.2 Limitations of the Sample

- i. The study was limited to only one psychiatric hospital which, may have consequences for the generalizability of the results.
- ii. The nursing profession was excluded from the study which again may have consequences for the generalizability of the results.
- iii. Not all professional groups were represented equally in the study because of the varying numbers of hospital posts allocated for the different disciplines. This too could affect generalizability.

5.5 **Research Tools**

5.5.1 Review of the Literature

The literature search was a difficult one probably because of the broad scope of research as it referred to both attitudes of clinicians toward women, and female patients. The computer search produced a large amount of literature under the key note of "women." Narrowing it down to "women in therapy" proved to be more efficient but still produced much irrelevant literature, with some of the references being old. Indeed, the most appropriate literature for the particular slant of the study seems to have been published in the decades of the 70s and 80s. This posed a problem for the researcher who then perused current journals in an attempt to find more recent literature. This search was helpful for certain areas such as the Feminist literature but not for others, such as the specific issues of women in therapy. A selection of relevant literature emerged which covered the slant of the empirical research.

5.5.2 Questionnaire

Constructing the questionnaire proved to be a time-consuming task. Other methods of data-collection had been considered eg. the interview schedule but this idea was discarded as it would prove to be too time-consuming and there were time constraints for this study. The researcher considered collating data but again time constraints did not allow for this.

There were advantages to using the questionnaire method of surveying clinician attitudes, as follows:

1. there was a greater assurance of anonymity.
2. the respondents were less embarrassed and more open in their responses.
3. there was standardized wording and the questionnaire was completed at the respondent's convenience.
4. there was no interviewer bias. There are obviously disadvantages to this method of survey as probing questions cannot be used and the response rate may be low (Grinell, 1985). However, the decision to use the questionnaire seemed an expedient one as it had advantages above other methods of data collection.
5. the method was time-saving.

The literature study provided guidelines for the construction of questions, some of which had previously been utilized in studies as well as a series of original questions devised by the researcher. A five category Likert scale which measured degrees of agreement or disagreement was utilized: this five category scale was eventually collapsed to a three category Likert scale when the data was pooled and analyzed. This was done because it seemed that a three point scale would produce results of

greater validity for this study.

After a trial run of the questionnaire the researcher decided to include a section for comments on each question. A high percentage of respondents chose to ignore this section, which could then not be utilized when analyzing the data. The questionnaire consisted of two sections. The first section dealt with the demographic data of the clinicians eg. gender, age, marital status, etc. The second section comprised the questions surveying clinicians' attitudes. Questions were placed in a particular order with the various themes being clustered together. This aided the analysis of the data.

5.5.3 Interview Schedule

The researcher also had five interviews with respondents who had been randomly picked from the sample. The aim of this was to provide data on issues pertaining to women in therapy. The interview was used to add a rich, full quality to the study. One psychiatrist, two social workers, one occupational therapist and one psychologist were interviewed.

5.6 **Questionnaire Administration**

5.6.1 Testing the Questionnaire

The drafted questionnaire was piloted on six members, two social workers, two psychologists, one occupational therapist and one psychiatrist. The researcher sat with them, perusing the questionnaire while they offered comments and criticisms. As a result of the pilot study, many questions were adapted and some were discarded for the final draft.

5.6.2 Administration of the Questionnaire

The sample size was 82 members. Questionnaires were given to the Heads of various sections at Lentegeur Psychiatric Hospital to be distributed at their weekly meeting. Each questionnaire was personally addressed and enclosed a self-addressed envelope. In addition, the questionnaire had a covering letter, which assured confidentiality and anonymity and which gave a return date. Questionnaires were to be returned to the various Head of Sections.

5.6.3 Limitations of the Questionnaire

- i. Attitudes, which were being measured, may not reflect actual practice of the clinicians surveyed.
- ii. There may be a bias in that respondents could have attempted to create a good impression in their responses.
- iii. The researcher is known to many of the respondents and this may have had an effect on the response rate (63.4%) which was good.
- iv. The good response rate may also be due to the fact subjects read an obligation implicit in the fact that the questionnaires were distributed by, and were to be returned to, the Head of the Department.

5.7 **Data Analysis**

The results will be discussed in the next chapter. Data will be presented in a tabular form.

5.8 **Limitations of the Study**

1. The population used in the study was drawn from only one of the psychiatric hospitals in the Cape Peninsula. This has implications for the generalizability of the results.
2. This was an attitudinal survey and very often attitudes may not reflect actual practice.

3. Gender issues are sensitive issues and may produce heightened emotions which may interfere with the manner of responding to this survey.
4. The complexity of the subject also proved to be a limitation, as the measurement of attitudes is a difficult task.

5.9 Conclusion

The research design and methodology utilized in this empirical study were discussed. The limitations of this study have also been highlighted, with a view to discussing the findings.

CHAPTER 6: ANALYSIS OF DATA

6.1 Introduction

The results of the survey will be presented in this chapter in a tabular form. In view of the amount of data obtained, only the central data will be dealt with in the discussion. An attempt will be made to offer trends and themes, and where possible statistical significance will be highlighted. An overall discussion of statistically significant items will be offered in the next chapter.

6.2 Response Rate

A total number of 82 questionnaires were distributed and 52 were returned. This represents 63.4% of the initial mailing, which is considered a good response rate (Grinell, 1985).

6.3 Demographic Data of Respondents

Twenty four of the respondents were males (46.2%), while twenty eight were females (53.8%). This represents a good response rate from both sexes. Analysis is aided by an almost equal representation of the sexes.

6.3.2 Age:Question 2:One

Table 2

AGE in years	FREQ	%
20-29	17	32,7
30-39	24	46,2
40-49	6	11,5
50-59	2	3,8
60 and over	2	3,8
No RESP.	1	1,9
	N=52	100%

17(32.7%) of the respondents were in the age group 20-29 and 24(46.2%) were in the age group 30-39 years.

The majority of respondents were thus represented by the younger age group in this study viz. 20-39 years ie. 41(78.8%).

6(11.5%) of respondents fell in the age group 40-49, 2(3.8%) of 50-59 years of age and the 60 and over age group were represented by only 2(3.8%) respondents. The older age group viz. 40-60 and over were represented by only 10 members (19.2%), while 1(1.9%) member did not volunteer his/her age.

These findings clearly have implications for the generalizability of the results, in that a representative spread does not exist across all age groups in this study.

6.3.3 Marital Status

Table 3

MARITAL STATUS	FREQ	%
Single	27	51,9
Married	18	34,6
Divorced	3	5,8
Widowed	1	1,9
Cohabiting	2	1,9
Separated	1	1,9
TOTAL	N=52	100%

The majority of the clinicians were single viz. 27(51.9%), 18(34.6%) were married, 3(5.8%) were divorced, 1(1.9%) was widowed, 2(3.8%) were cohabiting and 1(1.9%) were separated.

6.3.4 Religion (Question 4:One)

Table 4

RELIGION	FREQ	%
Christianity	34	65,4
Muslim	5	9,6
Judaism	5	9,6
Agnostic	8	15,4
TOTAL	N=52	100%

While the questionnaire provided for the following religious groups viz. Muslim, Roman Catholic, Apostolic, Methodist, Pentecostal, Dutch Reformed and Jewish, for convenient analysis, they were placed into major religious groups: Christian, Muslim, Jewish, Agnostic.

Of the sample 34(65.4%) were Christian, 5(9.6%) were Muslim, 5(9.6%) were Jewish

and 8(15.4%) were Agnostic.

6.3.5 Language

In considering language, only three language groups were represented viz. English, Afrikaans, and other, even though the questionnaire made provision for other language groups such as Sotho, Xhosa and Zulu. The other language groups which resulted from this study was Polish.

Table 5

LANGUAGE	FREQ	%
English	37	71,2
Afrikaans	12	23,1
Other	3	5,8
TOTAL	N=52	100%

6.3.6 Educational Qualifications (Question 6:One)

Table 6

EDUCATION	FREQ	%
Diploma	3	5,8
Bachelors Degree	13	25
Honours Degree	9	17,3
Masters Degree	6	11,5
PhD	2	3,8
MBChB	15	28,8
Other	3	5,8
No Answer	1	1,9
TOTAL	N=52	100%

The final sample consisted of 3(5.8%) respondents who had a diploma, 13(25%) had

a bachelors degree, 9(17.3%) had an honours degree, 6(11,5%) had a masters degree, 2(3,8%) had a PhD, 15(28,8%) had a MBChB degree while 3(5,8%) respondents had other degrees. In addition 1(1.9%) respondents did not volunteer his/her educational qualifications.

Three groups were thus well represented viz. those with a bachelors degree, those with a Honours degree and those with a MBChB degree.

6.3.7 Profession (Question 7:One)

Table 6

PROFESSION	FREQ	%
Psychiatrists	11	21,2
Psychologists	8	15,4
Psychiatric Registrar	9	17,3
Social Worker	13	25
Occupational Therapist	10	19,2
No Answer	1	1,9
TOTAL	N=52	100%

The final sample consisted of 11(21,2%) psychiatrists, 8(15.4%) psychologists, 9(17,3%) psychiatric registrars, 13(25,0%) social workers and 10(19,2%) occupational therapists, while 1(1,9%) person did not respond. Thus, professional grouping produced a fair representative spread of clinicians.

6.3.8 Years of Training (Question 9:One)

Table 8

TRAINING in years	FREQ	%
1-3	10	5,2
3-6	23	44,23
6-9	8	15,3
9-12	8	15,3
No RESP.	3	5,76
	N=52	100%

Most of the respondents, 23(44,2%) had received 3-6 years of training. While only 10(5,2%) and 1-3 years of training, 8(%) had 6-9 years of training and 8(%) had 9-12 years of training.

6.3.9 Length of Professional Practice (Question 10:One)

Table 9

PRACTICE in years	FREQ	%
1-5	26	50
6-10	14	26
11-20	7	17,5
Over 30	2	3,8
	N=52	100%

Of the sample 26(50%) had only been practising for 1-5 years, 14(26%) had been in practice for 6-10 years, 7(13,5%) were practising for 11-20 years, 3(5,8%) for 21-30 years and 2(3,8%) were in practice longer than 30 years.

Thus, the majority 40(76%) of respondents had been in practice for 1-10 years, while only a small percentage had much longer experience.

6.4 Attitudes

The second dimension which will now be discussed was the exploration of clinicians attitudes towards women. The brief discussion in this chapter will centre around certain themes. A more encompassing discussion drawing on other facets of the study will follow in the next chapter.

The areas of themes being explored and discussed are the following:

- a) Careers
- b) Mothering including abortion
- c) Marriage
- d) Sexuality and women
- e) Gender stereotypes

The questionnaire had included a 5 point Likert scale but on examination of the results it emerged that a 3 point scale was utilized, this would yield results that were more significant. The categories "Strongly Agree" and "Agree" were collapsed to form one category of "Agree" and similarly the categories "Strongly Disagree" and "Disagree" were collapsed to form one category "Disagree." The intensity of the sentiment expressed was eventually not considered relevant for the purpose of this study.

6.4.1 Careers for Women: (Question 1,2,3: Two)

Table 10

QUESTIONS	AGREE	UNSURE	DISAGREE	TOTAL
1	30	7	15	52
	(57,6)	(13,4)	(28,8)	(100)
2	31	7	14	52
	(59,6)	(13,4)	(26,9)	(100)
3	12	6	34	52
	(23,0)	(11,5)	(65,0)	(100)

* Percentages are represented in brackets

There was more agreement that women should have a career, whether they were married or not. 34(65%) of the subjects disagreed with the fact that women had to be satisfied with the role of wife and mother, whereas 11,5% were unsure.

Discussion:

The attitude that women did not have to be satisfied with the role of wife and mother and that it was important for them to have a career, was dominant. This attitude prevailed, in relation to married women as well. There has been increasing acceptance towards women's traditional roles from being home-based towards being more career-based.

6.4.2 Mothing and Abortion (Question 4,5,6,7,8:Two)**Table 11**

QUESTIONS	AGREE	UNSURE	DISAGREE	TOTAL
4	46	2	4	52
	(88,4)	(3,8)	(7,6)	(100)
5	15	17	20	52
	(28,8)	(32,6)	(38,4)	(100)
6	9	10	33	52
	(7,3)	(19,2)	(63,4)	(100)
7	15	8	29	52
	(28,8)	(5,3)	(55,7)	(100)
8	2	6	34	52
	(3,8)	(11,5)	(84,6)	(100)

* Percentages are represented in brackets

A large percentage of subjects ie. 46(88,4%) subjects agreed that mothers should stay at home for a time after the birth of a baby.

There seemed to be a variance in attitudes indicating that children were disadvantaged when a mother works. In this respect 15(28,8%) agreed, 17(32,6%) were unsure, while 20(38,4%) disagreed that they were disadvantaged. Despite this, however, the majority of respondents, viz. 33(63,4%) did not believe that children of non-working mothers develop into mentally healthier adults.

In addition, a vast majority of respondents viz. 44(84,6%) believed that there were circumstances that justified an abortion while 29(55,7%) disagreed that abortion should only be the woman's decision.

Discussion:

Despite the fact that it is considered acceptable for married women to have a career, it is expected in most societies that they should stay at home for a period after the birth of a baby. The strong sentiment as expressed by the majority of the sample could be due to the fact that, being trained clinicians, they are aware of the importance of the bonding process between mother and child. There was a spread across the scale in terms of clinicians' attitudes regarding children being disadvantaged when a mother works, yet 33(63,4%) disagreed that non-working mothers produced "healthier" children. There thus seemed to be differences in opinion amongst the clinicians about whether the quality of home life was affected by a mother having a career.

More than half of the respondents disagreed that women only should decide on abortion and an overwhelming majority of respondents felt that there are circumstances under which an abortion should be performed. This attitude could be a function of the fact that the sample is comprised of medical personnel, and others who work with the medical model, and thus may assimilate some of this profession's values. The medical profession has played an important role in recommendation for abortion, as will be discussed later.

6.4.3 Marriage (Question 9,10,11,12:Two)**Table 12**

QUESTIONS	AGREE	UNSURE	DISAGREE	TOTAL
9	44	4	4	52
	(87,6)	(7,6)	(7,6)	(100)
10	2	5	45	52
	(3,8)	(9,6)	(86,5)	(100)
11	6	12	34	52
	(11,5)	(23,0)	(65,3)	(100)
12	4	9	39	52
	(7,6)	(17,3)	(75,0)	(100)

* **Percentages are represented in brackets**

The majority of subjects agreed that marriage should be a partnership viz. 44(87,6%), with both partners taking joint responsibility for tasks. There appeared to be general agreement however, that women need not be in control of the financial running of the household.

Discussion:

There were liberal attitudes expressed with regards to marriage. Marriage was viewed by clinicians as a partnership where both parties take joint responsibility for tasks. In this regard one wonders as to how closely attitudes express actual practice. There may also be differences in the way that males and females view "joint responsibility" with the result that women may still be shouldering the greater proportion of household tasks. (See following chapter).

6.4.4 Women and Sexuality (Questions 13,14,15,16:Two)**Table 13**

QUESTIONS	AGREE	UNSURE	DISAGREE	TOTAL
13	41	8	3	52
	(78,8)	(15,3)	(5,7)	(100)
14	39	8	5	52
	(75,0)	(15,3)	(9,6)	(100)
15	51	1	0	52
	(98,0)	(1,9)	(0,0)	(100)
16	51	1	0	52
	(98,0)	(1,9)	(0,0)	(100)

* Percentages are represented in brackets

There were very definite opinions expressed in this section with seemingly little disagreement amongst

respondents on some questions. An overwhelming proportion of respondents, 39(75%), felt that there were double standards regarding sexual behaviour expected of men and women, and 41(78,8%) felt that the same standard should apply to both sexes, however, 51(98%) felt that women should feel free to initiate lovemaking and pursue the man of their choice.

Discussion:

As reported earlier, there was a more liberal ethic towards women and sexuality in the decade between 1975 and 1985. This current survey reveals a liberal attitude amongst clinicians towards women's sexuality. This section produced the highest scores in terms of agreement, as the table indicates.

6.4.5 Gender Stereotypes (Questions 17,18,19,20,21,22:Two)**Table 14**

QUESTIONS	AGREE	UNSURE	DISAGREE	TOTAL
17	6	7	39	52
	(11,6)	(13,4)	(75,0)	(100)
18	9	13	30	52
	(17,3)	(25,0)	(57,6)	(100)
19	36	9	7	52
	(69,2)	(17,3)	(3,4)	(100)
20	19	13	20	52
	(36,5)	(25,0)	(38,4)	(100)
21 1	15	67	30	52
	(28,8)	(13,4)	(57,6)	(100)
22	27	11	14	52
	(51,9)	(21,1)	(26,9)	(100)

* Percentages are represented in brackets

There appeared to be a spread regarding attitudes surrounding general gender stereotypes with many more respondents utilising the "Unsure" category. The responses suggest a liberal attitude, and there was a rejection of gender stereotypes, such as that women are more easily influenced, have difficulty in making decisions, have a stronger need for security and enjoyed being looked after more than men.

Significantly, however, more than half 27(51,9) of the respondents felt that women were more emotional than men.

Discussion:

It does seem that most of the stereotypes posed, were rejected by the respondents. However, only one stereotype regarding women being more emotional was agreed upon by the majority of respondents.

6.5 Therapists

The next section will explore some of the characteristics of the therapist that may have an effect on their attitudes towards female patients. The characteristics that will be surveyed in this section are gender, age, length of practice, professional registration and marital status.

The items gauging religion, first language and additional specialised training were not found to be helpful in surveying the intended dimension. Question 4, (Section One) dealing with religion had been set up to include too many religious groups, rendering the resultant data unhelpful in tapping any significance. Question 5, (Section One) dealing with first language was included to gauge cultural grouping, the latter being terminology which at this stage in the current South Africa is considered unpopular, particularly on questionnaires or official forms. Question 8 (Section 1), dealing with additional specialised training could not be analyzed as there were too few responses in this regard. The researcher assumes that not many respondents had additional training. Question 6,7,9, (Section One) were collapsed into one question which surveyed professional registration. The data was analyzed by using Chi square. The Fisher Exact Test was utilised where expected cell numbers were less than five.

A wealth of information was generated by this exploration of therapist characteristics in relation to attitudes (Section Two). The computer indicated those questions where the aforementioned characteristics (gender, age, length of practice, marital status and professional registration) were of significance. The researcher will thus discuss only those items which

yielded a statistical significance.

Discussing all the items would be a laborious task, but more importantly would not provide any insights into the dimensions being surveyed.

6.5.1 Gender

There were five questions that yielded a statistical significance with regard to gender.

They were Questions 3,5,13,18 and 21. Their analysis follows:

Question 3: A woman should be satisfied with the role of wife and mother

Table 15

GENDER	AGREE	UNSURE	DISAGREE
MALES	10 (19,2)	3 (5,7)	11 (21,1)
FEMALES	2 (3,8)	3 (5,7)	23 (44,2)
TOTAL	12	6	34

* **Percentages are represented in brackets**

There was a significant difference between the number of male and female clinicians who agreed with this statement. 10(19,2%) of males agreed with it while only 2(3,8%) of the females concurred.

This indicates that although there was an overall liberal attitude towards women having careers, there still exists an attitude amongst the male clinicians that women should be satisfied with the (limited) role of wife and mother.

Question 5: Children are disadvantaged when a mother is working

Table 16

GENDER	AGREE	UNSURE	DISAGREE
MALES	12	3	9
	(23,0)	(5,7)	(17,3)
FEMALES	3	14	11
	(5,7)	(26,9)	(21,1)
TOTAL	12	6	34
TOTAL	(28,8)	(32,6)	(38,4)

* Percentages are represented in brackets

More males, [12(23%)] agreed with this statement than did female clinicians [3(5,7%)], and more female clinicians were unsure than male clinicians: 14(26,9%) of females and only 3(5,7%) of males were unsure. These results highlight the ambivalence that many women experience with regard to being a working mother.

Question 13: The same standards of sexual behaviour should apply to both men and women.

Table 17

GENDER	AGREE	UNSURE	DISAGREE
MALES	15	6	3
	(28,8)	(11,5)	(5,7)
FEMALES	26	2	0
	(50,0)	(3,8)	(0,0)
TOTAL	42	8	3
	(80,76)	(15,38)	(5,7)

* Percentages are represented in brackets

While 26(50%) females agreed with this statement, only 15(28,8%) males concurred. Only 15(28,8%) of the male respondents agreed with this statement, whereas 26(50%) of the females agreed.

The literature has indicated that the area of sexuality is one with which many people feel uncomfortable, and in which attitudes tend to be quite conservative. The results in this study may also reflect this trend: women, however, seemed to have displayed a more "liberal" ethic while men appeared more conservative in their responses in this section.

Question 18: Women are more easily influenced than men

Table 18

GENDER	AGREE	UNSURE	DISAGREE
MALES	7	9	8
	(13,4)	(17,3)	(15,3)
FEMALES	2	4	22
	(3,8)	(7,6)	(44,0)
TOTAL	9	13	30
	(17,3)	(25,0)	(57,6)

* **Percentages are represented in brackets**

A significant difference existed in the number of male and female clinicians who disagreed with this statement. Of the female clinicians 22(44%) disagreed with this statement, while the male clinicians, showed a wide dispersion in response: only 8(15,3%) disagreed with the statement while 9(17,3%) were "unsure."

A common stereotype of this nature may produce conflicting feelings. This was illustrated by the dispersion of response across the categories, and marked by the male clinicians.

Question 21: Women enjoy being looked after more than men.

Table 19

GENDER	AGREE	UNSURE	DISAGREE
MALES	11	3	10
	(21,2)	(5,8)	(19,2)
FEMALES	4	4	20
	(7,6)	(7,6)	(38,4)
TOTAL	15	7	30

* **Percentages are represented in brackets**

Twice as many 20(38,4%) female clinicians disagreed with this statement than male clinicians, 10(19,2%). Significantly almost as many male clinicians agreed with this statement viz. 11(21,2%) than did those who disagreed to be a wider variation amongst male responses.

6.5.2 Age

There were 3 questions that yielded a statistical significance with regard to age. They were questions 5,12 and 15. Their analysis follows:

Question 5: Children are disadvantaged when a mother is working.**Table 20**

AGE	AGREE	UNSURE	DISAGREE
20-29	3	9	5
	(5,8)	(17,3)	(9,6)
30-39	5	8	11
	(9,6)	(15,4)	(21,2)
40-49	3	0	3
	(5,8)	(0,0)	(5,8)
50-59	2	0	0
	(3,8)	(0,0)	(0,0)
60 and over	2	0	0
	(3,8)	(0,0)	(0,0)
TOTAL	15	17	19

- * 1 person did not give his/her age.
- * Percentages are represented in brackets

The table seems to indicate that a major proportion of the respondents disagreeing with this statement were in the age group 30-39 as 11(21,2%) disagree while 9(17,3%) in the younger age group 20-29 were unsure. This [9(17,3%)] represents a significant proportion and could reflect a lack of personal experience on which to base an opinion. It can be postulated that respondents in the age group 30-39 have children already and felt more comfortable in forming a firm opinion.

The older age group i.e. 40-60 years were under represented in this survey and thus no assumptions can be made.

Question 12: In a marriage or cohabiting relationship women should be in control of the financial direction of a house eg. working out a budget, paying accounts, etc.

Table 21

AGE	AGREE	UNSURE	DISAGREE
20-29	2	2	13
	(3,8)	(3,8)	(25,0)
30-39	1	2	21
	(1,9)	(3,8)	(40,38)
40-49	0	2	4
	(0,0)	(3,8)	(7,6)
50-59	0	2	0
	(0,0)	(3,8)	(0,0)
60 and over	1	1	0
	(1,9)	(1,9)	(0,0)
TOTAL	4	9	38
	(7,6)	(17,3)	

* Percentages are represented in brackets

The majority of respondents in all age groups disagreed with this statement indicating a high degree of agreement amongst respondents. This trend may reflect either a liberal or conservative attitude depending upon how the respondents perceived the question. Women are traditionally responsible for the household and its upkeep and controlling the finances may be viewed as just another one of the accompanying tasks rather than financial independence.

Question 15: Women should feel free to initiate lovemaking.

Table 22

AGE	AGREE	UNSURE	DISAGREE
20-29	17	0	0
	(32,6)	(0,0)	(0,0)
30-39	24	0	0
	(46,1)	(0,0)	(0,0)
40-49	6	0	0
	(11,5)	(0,0)	(0,0)
50-59	1	1	0
	(1,9)	(1,9)	(0,0)
60 and over	2	0	0
	(3,8)	(0,0)	(0,0)
TOTAL	50	1	0
	(96,15)	(1,9)	(0,0)

* Percentages are represented in brackets

None of the respondents disagreed with this statement 50(96,15 %) agreed, while only 1(1,9%) was unsure. This is significant and interesting in that this item revolves around a sexual theme.

6.5.3 Marital Status

There were 2 questions that yielded a statistical significance with regard to marital status. They were Question 9 and 13. Their analysis follows:

Question 9: Marriage should be a partnership where both parties take joint responsibility for cooking, cleaning, child-rearing etc.

Table 23

MARITAL STATUS	AGREE	UNSURE	DISAGREE
Single	24	2	1
	(46,1)	(3,8)	(1,9)
Married	15	2	1
	(28,8)	(3,8)	(1,9)
Divorced	3	0	0
	(5,7)	(0,0)	(0,0)
Widowed	0	0	1
	(0,0)	(0,0)	(1,9)
Cohabiting	1	0	1
	(1,9)	(0,0)	(1,9)
Separated	1	0	0
	(1,9)	(0,0)	(0,0)
TOTAL	44	4	4
	(84,6)	(7,6)	(7,6)

* Percentages are represented in brackets

Question 13: The same standards of sexual behaviour should apply to both men and women.

Table 24

MARITAL STATUS	AGREE	UNSURE	DISAGREE
Single	23	3	1
	(44,2)	(5,7)	(1,9)
Married	14	4	0
	(26,9)	(7,6)	(0,0)
Divorced	2	0	1
	(3,8)	(0,0)	(1,9)
Widowed	0	1	0
	(0,0)	(1,9)	(0,0)
Cohabiting	1	0	1
	(1,9)	(0,0)	(1,9)
Separated	1	0	0
	(1,9)	(0,0)	(0,0)
TOTAL	41	8	3
	(78,8)	(15,3)	(5,7)

* Percentages are represented in brackets

Once again an overwhelming majority of respondents agreed with this statement irrespective of their marital status. Again, this is an item on a sexual theme, where there is statistical significance in terms of agreement.

4 Profession

There were 3 questions that yielded statistical significance with regard to profession.

They were Question 5, 18, and 22. Their analysis follows:

Question 5: Children are disadvantaged when a mother is working.

Table 25

PROFESSION	AGREE	UNSURE	DISAGREE
Psychiatrists	7	2	2
	(13,4)	(3,8)	(3,8)
Psychologists	2	1	5
	(3,8)	(1,9)	(9,6)
Psych. Registrars	4	2	3
	(7,6)	(3,8)	(5,7)
Social Workers	0	6	7
	(0,0)	(11,5)	(13,4)
Occupational Therapists	2	6	2
	(3,8)	(11,5)	(3,8)
TOTAL	15	17	19

* Percentages are represented in brackets

On this item, the different professional groups seemed to disagree. 7(13,4%) of psychiatrists agreed with the statement while 7(13,4%) of social workers disagreed with this statement.

The psychiatrists had firm opinions on the matter while there was more uncertainty amongst social workers and occupational therapists with 6(11,5%) in each of these two groups marking the "unsure" category.

Question 18: Women are more easily influenced than men.

Table 26

PROFESSION	AGREE	UNSURE	DISAGREE
Psychiatrists	3	4	4
	(5,7)	(7,6)	(7,6)
Psychologists	0	0	8
	(0,0)	(0,0)	(15,3)
Psych. Registrars	3	4	2
	(5,7)	(7,6)	(3,8)
Social Workers	3	2	8
	(5,7)	(3,8)	(15,3)
Occupational Therapists	0	2	8
	(0,0)	(3,8)	(15,3)
TOTAL	9	12	30

* Percentages are represented in brackets

On this item there was strong agreement amongst the professional groups, in terms of disagreeing with the statement, with 30(57,6%) respondents in total agreeing with this statement.

Question 22: Women are more emotional than men.

Table 27

PROFESSION	AGREE	UNSURE	DISAGREE
Psychiatrists	7	3	1
	(13,4)	(5,7)	(1,9)
Psychologists	2	0	6
	(3,8)	(0,0)	(11,5)
Psych. Registrars	7	1	1
	(13,4)	(1,9)	(1,9)
Social Workers	5	3	5
	(9,6)	(5,7)	(9,6)
Occupational Therapists	5	4	1
	(9,6)	(7,6)	(1,9)
TOTAL	26	11	14

* Percentages are represented in brackets

In each professional group the majority of respondents agreed with this statement. Seven of the eleven psychiatrists, 7 of the 9 psychiatric registrars, 5 of the 13 social workers and 5 of the 10 occupational therapists agreed with this statement. The only professional group that disagreed was the psychologists where 6 of the 8 psychologists disagreed.

6.5.5 Length of Practice (in years)

There were 4 questions that yielded statistical significance with regard to length of practice. They were questions 5,12,15 and 17. Their analysis follows:

Question 5: Children are disadvantaged when a mother is working.**Table 28**

LENGTH of PRACTICE	AGREE	UNSURE	DISAGREE
1-5 years	5	9	12
	(9,6)	(17,3)	(23,0)
6-10 years	3	7	4
	(5,7)	(13,4)	(7,6)
11-20 years	2	1	4
	(3,8)	(1,9)	(7,6)
21-30 years	3	0	0
	(5,7)	(0,0)	(0,0)
30 years + over	2	0	0
	(3,8)	(0,0)	(0,0)
TOTAL	15	17	20

* Percentages are represented in brackets

Once again a high number of respondents were unsure about this statement. 17(32,6%) of respondents were unsure. A high percentage of those practising for only 1-5 years disagreed with the statement ie. 12(25%) which represents 46,15% of those respondents.

Question 12: In a marriage or cohabiting relationship women should be in control of the financial direction of a house eg. working out a budget, paying accounts etc.

Table 29

LENGTH of PRACTICE	AGREE	UNSURE	DISAGREE
1-5 years	3	3	20
	(5,7)	(5,7)	(38,4)
6-10 years	0	2	12
	(0,0)	(3,8)	(23,0)
11-20 years	0	1	6
	(0,0)	(1,9)	(11,5)
21-30 years	0	2	1
	(0,0)	(3,8)	(1,9)
30 years + over	1	1	0
	(1,9)	(1,9)	(0,0)
TOTAL	4	9	39
	(7,6)	(17,3)	(75,0)

* Percentages are represented in brackets

39(75%) of the respondents disagreed with this statement and this indicated a high level of agreement amongst the clinicians, irrespective of years of practice.

Question 15: Women should feel free to initiate lovemaking.

Table 30

LENGTH of PRACTICE	AGREE	UNSURE	DISAGREE
1-5 years	26	0	0
	(50,0)	(0,0)	(0,0)
6-10 years	14	0	0
	(26,9)	(0,0)	(0,0)
11-20 years	7	0	0
	(13,4)	(0,0)	(0,0)
21-30 years	2	1	0
	(3,8)	(1,9)	(0,0)
30 years + over	2	0	0
	(3,8)	(0,0)	(0,0)
TOTAL	51	1	0
	(98,0)	(0,0)	(0,0)

* Percentages are represented in brackets

Once again this item examining a sexual theme produces strong sentiments and 51(98,0%) of the respondents agreed with the statement.

Question 17: Women generally have difficulty in making decisions

Table 31

LENGTH of PRACTICE	AGREE	UNSURE	DISAGREE
1-5 years	2	6	18
	(3,8)	(11,5)	(34,6)
6-10 years	1	0	13
	(1,9)	(0,0)	(25,0)
11-20 years	0	0	7
	(0,0)	(0,0)	(13,4)
21-30 years	2	1	0
	(3,8)	(1,9)	(0,0)
30 years + over	1	0	1
	(1,9)	(0,0)	(1,9)
TOTAL	6	7	39
	(11,5)	(13,4)	(75,0)

* Percentages are represented in brackets

Once again there was strong agreement amongst the respondents with 39(75%) disagreeing with this statement.

6.6 Therapy

The next section will look at some of the comments that were made by clinicians, when interviewed, regarding women in therapy. Eight standardised questions were put to these clinicians who included a social worker, a psychologist, a psychiatrist, an occupational therapist and a psychologist.

In this section the researcher will present the questions and quote the answers in response

to them.

Question 1:

Have you filled out the questionnaire?

All of the respondents had completed the questionnaire

Question 2:

In your experience, is there a difference in the way male and female patients are treated

(Question 3 asked them to specify)

"A more caring, nurturant style is used with female patients"

"More accommodation is made for female patients"

"In the wards they are more protected and assisted in terms of settling in, while male patients are more often left on their own"

"Female patients are allowed to get away with more mood swings"

"Rebelliousness is more accepted from male than female patients"

"At ward-rounds there are often more light-hearted comments made about female patients"

"More attempts are made to modify female behaviour that is too assertive"

Question 4:

Are particular diagnoses made more often for female patients.

Most of the respondents answered affirmatively. More often females are diagnosed as dependent, borderline or affective disorders while males are more often labelled as antisocial, and narcissistic. Males more often also have substance abuse disorders as diagnosed categories.

Question 5:

Are there particular language which is used when describing female patients?

"Exist vocabulary is used jokingly"

"References are made very lightheartedly"

"More often terms which allude to emotional content are used"

"Common terms that are used are "histrionic," "Masochistic," and "hysterical"

Question 6:

Is there a difference in the length of treatment for female and male patients?

"In this regard there were varying responses."

"One respondent felt that males were normally hospitalised for longer periods than females."

"Another felt that females were treated for longer because they seemed more therapeutically accessible and easier to work with"

"Another respondent felt that ward programmes were time limited but could be extended for individual patients and more often it seemed to be extended for male patients."

Question 7:

Are there different goals set for male and female patients?

"More women are earmarked for individual therapy than males"

"With women, there seems to be a bigger need for containing nurturing, protection and support"

"More emphasis is placed on girls sorting out their relationships"

"Girls are expected to get along better with people than with boys"

"There is a bigger push for boys to return to school after hospitalisation than for girls"

"Girls are expected to be more reality-orientated"

Question 8:

Do you feel that societal attitudes are played out in the therapeutic relationship with women?

"Yes, clinicians are in fact quite intolerant of certain things which differ from their own value system"

"Yes, clinicians strive for neutrality but don't often achieve this"

"Yes, it is played out but hopefully there is an awareness of it."

3.7 Conclusion

This chapter draws together the results of the study by tabulating the findings. Certain issues are highlighted but the in-depth discussion will follow in the next chapter. Information regarding therapy is also presented with its discussion also reserved for the next chapter.

CHAPTER 7:

DISCUSSION OF RESULTS AND IMPLICATIONS FOR THERAPY

7.1 Introduction

This chapter will summarise only the findings of the study that produced statistical significance with regard to the various aspects being examined, and a discussion will follow immediately after each section. Implications for practice will be interwoven in the discussion of those results.

7.2 Career Women and Mothers

Clinicians found it acceptable for women, including married women to have a career. They did, however, feel that mothers should stay at home for a period after the birth of a baby. In addition, although clinicians were unsure whether children of working mothers were disadvantaged, they did not believe that children of non-working mothers developed into healthier adults.

The empirical study further revealed that male clinicians were more definite in their opinions about children being disadvantaged when mothers work. Female clinicians showed a more uncertain and ambivalent attitude in this regard. Significant also, in this regard, is that a high percentage of the least experienced clinicians, who were also the younger clinicians, felt that children are not disadvantaged when a mother works.

The literature about working mothers indicates that the issue is a complex one, as women have a dual role and a dual burden of caring for the home as well as occupying a position within the labour market. Attitudes about womens' entry into the labour market relaxed particularly in the 1970s and more women had careers of their own (Lynn, 1992; Moen,

1991) and in the 1990s this appears to be a less controversial issue. Clinicians seem to reflect current societal acceptance of women in the workplace.

A more controversial issue in this study revolved around the dimension of whether children were disadvantaged when a mother worked. The literature disagrees on this aspect, as various studies reflected a continuum in their findings. This ranged from the view that maternal employment had negative effects on children to the view that with adequate social support for mothers, no negative consequences would accrue to their children (MacEwan and Barling, 1991; Warr, 1992; Hoffman, 1986). In this study, clinicians' attitudes concurred with what was found in literature viz. an uncertainty : an aspect which seemed to be more marked amongst female than male clinicians. The more ambivalent attitude of female clinicians in this regard may reflect the dilemma about the roles that society expects them to fulfil as well as their own self-expectations.

A dimension which all clinicians agreed upon was that mothers had to remain at home for a period after the birth of a baby. This could be seen as a compromise between remaining at home or working. Clinicians, in their training are taught the importance of the bonding process between mother and child and promote this stance in their therapeutic contact with patients. The strong agreement amongst clinicians on this aspect may then be a reflection of their training and professional disciplines.

In terms of clinical practice, should female clinicians carry ambivalent or unresolved feelings about their dual roles this could emerge in their therapeutic practice. Countertransference risks are that female therapists could promote ideas about motherhood or have intense reactions, consciously or unconsciously should a patient raise ideas which contradict her own (Eastwood, Spiegvoegel and Wile, 1989). Male therapists are also at risk of promoting their

own ideas about the ideal mother and equally need to have a constant awareness of this lest it influence their therapeutic practice. Wellton (1991) argues that society does not easily accept different or "perverse" behaviour in mothers. She postulates that society idealizes motherhood and that differences in relation to child-rearing practice or being "atypical" in this regard, presents a challenge, particularly for clinicians.

7.3 Sexual Behaviour

The empirical study indicated strong sentiments around the sexual themes. In addition to this it appeared that there was strong agreement amongst respondents on the items that gauged attitudes towards sexual behaviour, with a majority of clinicians agreeing that there were double standards, regarding sexual behaviour, expected of men and women. Although clinicians of all ages and professional groups felt that women should feel free to be more sexually assertive, it was mainly a sentiment expressed by the female clinicians. The latter also indicated that one standard needed to be utilised with regard to judging sexual behaviour thus, what can be described as a liberal attitude towards sexual behaviour expected of women emerged from this study.

The literature has also reported on the increasingly sexual liberalisation for both males and females, with the bigger shift for females (Robinson, *et al*, 1991). This highlights a significant shift in sexual mores from the days of the *Kinsey Report* (1953) to recent empirical studies carried out by Robinson *et al* (1977, 1982, 1991).

Factors cited for this increasing liberalization are the student protest movement in the 1960s and 1970s, moreover the growing conservatism in America with the anti-abortion movement seemed to have little, if any, impact on this move (King, 1977; Bell and Chaskes, 1970; Robinson and Jedlicka, 1982 in Robinson *et al*, 1991).

It is difficult to gauge from the empirical study whether reported attitude conforms to actual practice: for while there was a general liberal attitude to sexual behaviour, more female than male respondents indicated an acceptance of a single standard to judge sexual behaviour.

Current sexual behaviour and practices needs to be assessed in the light of the increasing media attention given to AIDS although exploration of this is not within the realm of this attitudinal study.

7.3.1 Abortion

There was a strong feeling amongst all clinicians that abortion should not only be a woman's decision and that there were certain circumstances which justified abortion. A large percentage of the respondents have had medical training viz. the psychiatric registrars and the psychiatrists and their attitude in this regard may be linked to their professional stance toward abortion. The medical profession has been influential in determining societal attitudes toward abortion: the current Abortion and Sterilization Act No. 2 of 1975 relies on medical recommendation for legal terminations. In this study other professional groups' attitudes could have been influenced as they work within a medical model and thus may adopt some of the attitudes of this model.

Recently a 14 year old girl was granted a "therapeutic abortion" because she had been raped. This case is a good illustration of how a private event can become public. The teenager became a pawn in the political machinations of various interest groups as lawyers, parents, grandparents, doctors, administrators, pro-life groups and pro-choice groups became involved in this case (Cosmopolitan, February 1993). The

debate surrounding abortion and the legislation controlling this practice has only started in South Africa as there has been lobbying recently by community leaders and interest groups.

Sexual issues tend to elicit strong feelings from people, as does the issue of abortion. It could be hypothesized that clinicians will have intense feelings about these issues, either as a result of their personal values or their professional values. These feelings could be transmitted into the therapeutic encounter and therapists could display intense reactions in response to these issues produced by their patients. Fabrikant (1974) postulates that excessive counterreaction in either direction, especially if the therapist's viewpoint conflicts with that of the client's, could be a problem and would need to be guarded against (Franks and Burtle, 1984).

7.4 Marriage as a Partnership

The literature describes the aspect of marriage as a partnership as being the centre of debate in the early eighties when increasing numbers of women had entered the workplace and the division of household tasks became the focus of research (Brubaker and Hennon, 1982; Cowan *et al* 1985; Rexroat and Shehan, 1987; White, Booth and Edwards, 1986 and Yoger, 1981 in Suitor, 1991). It was documented that despite the fact that a women now had more roles to fulfil, her responsibilities in the household did not decrease, nor did that of her partner increase, so that she was shouldering a disproportionate share of the household tasks.

From the empirical study it emerged that clinicians thought that marriage should be a partnership where both parties took responsibility for household tasks and this response came from respondents of all groups and all levels of experience.

This study, therefore reflected a positive attitude towards womens roles and partnership in household tasks, which could be promoted within a therapeutic relationship.

7.5 Gender Stereotypes

The empirical study explored the gender stereotypes of womens' emotionality, decision-making ability and dependence-independence issues. There was a diverse range of responses across a continuum: more so for male than female clinicians and there did not appear to be a significant trend evident. Certain of the gender stereotypes were accepted by both male and female respondents, such as the view that women were more emotional than men. On the other hand other gender stereotypes such as the view that women generally have difficulty in decision-making and women are more easily influenced than men were rejected by both male and female clinicians.

The literature does suggest that there have been some challenges to the traditional stereotypes of women. Very often these challenges came from the Feminist Movement (Valentich and Gipton, 1985; Oakley, 1981). Many of the inequalities that women have had to endure have faded and this could perhaps account for the uncertainty there appears to be amongst the respondents on gender stereotypes.

The findings of this empirical study reflect an ambivalent attitude towards gender stereotypes. Gilbert (1976) reflects on this ambivalence in a study with women reporting conflict between their personal needs, social demands and their perceptions of sex roles. Female clinicians could experience the same conflicts and need to be aware of this in order to effectively negotiate these straits. Likewise, male clinicians need to develop an awareness of their attitudes regarding gender stereotypes, in order to provide an effective therapeutic service. Traditional attitudes, feminism and post-feminism produce a confusing picture of womens' current social role. The mass media bombards women with a myriad of conflicting

views.

Personal values, professional values, societal values and family values compete in determining attitudes and behaviour.

7.6 Effects on Therapy

The five in-depth interviews conducted by the researcher as part of the empirical study produced very interesting results, in that the findings of this study correlated very closely with what the literature survey had produced.

The findings indicated that the clinicians interviewed were of the opinion that values were transmitted in the therapeutic encounter, sometimes at an unconscious level but often also as an intolerant gesture dismissing the patient's value systems. The theoretical analysis had revealed that the notion of a "value-free" therapy was fading with many challenges to this viewpoint, posed by various authors (Steere, 1984, Rhodes, 1986).

The empirical study further revealed that a more caring nurturant, supportive stance is adopted with female patients and there appears to be a greater willingness to accommodate them. In this regard, emotionality and mood swings are more often tolerated in female patients than male patients, perhaps because it is regarded as normal behaviour for females.

The literature survey had indicated that particular diagnostic categories are utilised more often for female than male patients. The responses in the empirical study, in this regard, correlated very closely with the diagnostic categories highlighted by the literature.

Clinicians also expressed the opinion that there always seemed to be a light-hearted, jovial

quality to remarks made in regard of a female patient. There is a sense of female patients not being taken too seriously, and in regard to goals, it seems to be emphasized that their relatedness to other people, and their ability to get along with others and to conform to given expectations is important.

Finally, an aspect on which clinicians seemed to differ was the length of treatment for male and female patients but there was an opinion that females were more therapeutically accessible, easier to work with and therefore seemed to be treated for longer periods of time.

7.7 Recommendations for further Research Possibilities

The researcher recommends that further research is undertaken to examine the aspect of value systems and its effect on therapy.

The actual effects/results of therapeutic characteristics on their attitudes towards women in therapy is not gauged in this study beyond an examination of theory in this regard. Further research in this regard is necessary but a carefully constructed research design will have to be utilised because of the complexity of such a study. Using another method of data collation, for example, sitting in on ward rounds may prove to be helpful in further studies of this topic.

Further studies should also be undertaken by investigating specific clinician variables, especially those that have been under-researched, for example, age of the therapist and personal therapy of the clinician.

7.8 Conclusion

This chapter discusses the aspects of the study that produced significant results and highlights these factors as it is relevant for therapy.

his study does indicate that attitudes may be transmitted in the therapeutic relationship. There are risks attached to this as the therapeutic alliance may be influenced by this phenomenon and therapists need to be vigilant and guard against their patients experiencing therapy as a negative encounter, as a consequence. Therapists need to develop a keen awareness of their value base, whether professional, personal or social and should guard against imposing these values on their client system. To strive for a value-free, neutral, objective stance is an ideal but one which reality seldom emulates.

Guidelines in this regard should emphasize the negotiation of values while in training and in supervision this aspect should be given attention. Personal therapy of the therapist may also assist in developing an awareness of those aspects which influence his/her therapeutic relationship with clients. Through this personal therapy there may be a helpful illumination of biases, prejudices and values which would allow the therapist to become more objective in his/her stance towards patients.

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CONFIDENTIAL QUESTIONNAIRE

Dear Colleague

Enclosed please find a confidential questionnaire.

I am a registered social worker completing my post-graduate specialist training in clinical social work (M.Soc.Sc.) at the University of Cape Town. Part of the requirement for academic studies is the completion of a dissertation.

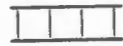
The enclosed questionnaire forms part of an empirical study which I am undertaking under the supervision of the clinical staff of the School of Social Work. The aim of my research is to explore the attitudes of clinicians towards women. The questionnaire is being directed at state-employed clinicians in a psychiatric hospital.

Your response will be completely confidential and the manner in which the information will be integrated into the thesis will not compromise this confidentiality in any way.

Your co-operation in this survey will be highly appreciated. Would you please return the questionnaire to your Section Head by 2 October 1992. If there should be any queries please contact me at 470050 Ext. 148 during office hours, or 9048517 after hours.

Yours sincerely

Marion Borchers



CONFIDENTIAL QUESTIONNAIRE

Please indicate your response by ticking the appropriate square.

Section one

IDENTIFYING DETAILS

1. Gender:	Male	<input type="checkbox"/>
	Female	<input type="checkbox"/>
2. Age in years:	20-29	<input type="checkbox"/>
	30-39	<input type="checkbox"/>
	40-49	<input type="checkbox"/>
	50-59	<input type="checkbox"/>
	60 and over	<input type="checkbox"/>
3. Marital Status:	Single	<input type="checkbox"/>
	Married	<input type="checkbox"/>
	Divorced	<input type="checkbox"/>
	Widowed	<input type="checkbox"/>
	Cohabiting	<input type="checkbox"/>
	Separated	<input type="checkbox"/>
4. Religion:	Muslim	<input type="checkbox"/>
	Roman Catholic	<input type="checkbox"/>
	Apostolic	<input type="checkbox"/>
	Methodist	<input type="checkbox"/>
	Pentecostal	<input type="checkbox"/>
	Dutch Reformed	<input type="checkbox"/>
	Other	<input type="checkbox"/>
	Please specify	<input type="checkbox"/>
5. First Language:	English	<input type="checkbox"/>
	Afrikaans	<input type="checkbox"/>
	Xhosa	<input type="checkbox"/>
	Zulu	<input type="checkbox"/>
	Sotho	<input type="checkbox"/>
	Other	<input type="checkbox"/>
	Please specify	<input type="checkbox"/>

Section two

Please indicate your response by ticking the appropriate square. In addition please comment on your response.

1. All women should have a career

- | | | |
|-------------------|-----------|--------------------------|
| Strongly Agree | | <input type="checkbox"/> |
| Agree | | <input type="checkbox"/> |
| Unsure | | <input type="checkbox"/> |
| Disagree | | <input type="checkbox"/> |
| Strongly Disagree | | <input type="checkbox"/> |

Please comment on your response
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.....
.....

2. Married women should have a career

- | | | |
|-------------------|-----------|--------------------------|
| Strongly Agree | | <input type="checkbox"/> |
| Agree | | <input type="checkbox"/> |
| Unsure | | <input type="checkbox"/> |
| Disagree | | <input type="checkbox"/> |
| Strongly Disagree | | <input type="checkbox"/> |

Please comment on your response
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3. A woman should be satisfied with the role of wife and mother.

- | | | |
|-------------------|-----------|--------------------------|
| Strongly Agree | | <input type="checkbox"/> |
| Agree | | <input type="checkbox"/> |
| Unsure | | <input type="checkbox"/> |
| Disagree | | <input type="checkbox"/> |
| Strongly Disagree | | <input type="checkbox"/> |

Please comment on your response
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4. Mothers should stay at home for a time after the birth of a baby.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response
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5. Children are disadvantaged when a mother is working.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response
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6. Children whose mothers stay at home develop into healthier adults.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response
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7. Abortion should only be a woman's decision.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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8. Abortion should never be considered.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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9. Marriage should be a partnership where both parties take joint responsibility for cooking, cleaning, child rearing etc.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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10. Women should be financially dependant on men.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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11. In marriage or a cohabiting relationship women should not be the chief breadwinner in the house.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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12. In a marriage or cohabiting relationship women should be in control of the financial direction of a house eg. working out a budget, paying accounts etc.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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13. The same standards of sexual behaviour should apply to both men and women.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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14. There are double standards regarding sexual behaviour expected of men and women.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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15. Women should feel free to initiate lovemaking.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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16. Women should feel free to pursue the man of their choice.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response
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17. Women generally have difficulty in making decisions.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response
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18. Women are more easily influenced than men.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response
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19. Women should be more assertive.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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20. Women have a stronger need for security than men.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

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21. Women enjoy being looked after more than men.

- Strongly Agree
- Agree
- Unsure
- Disagree
- Strongly Disagree

Please comment on your response

.....

.....

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22. Women are more emotional than men.

- | | | |
|-------------------|-----------|--------------------------|
| Strongly Agree | | <input type="checkbox"/> |
| Agree | | <input type="checkbox"/> |
| Unsure | | <input type="checkbox"/> |
| Disagree | | <input type="checkbox"/> |
| Strongly Disagree | | <input type="checkbox"/> |

Please comment on your response

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