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FIRST IMPRESSIONS OF THERAPISTS: THE EFFECT
OF THERAPIST GENDER, GAZE, SMILING
AND SUBJECT GENDER

DISSERTATION

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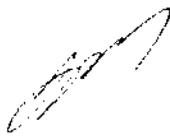
DOCTOR OF PHILOSOPHY

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Conceptualization psychotherapy as an interpersonal influence process emphasizes how a therapist is perceived by a client. Factors affecting a client's early impressions of a therapist could influence therapeutic interactions since first impressions are relatively stable.

The study investigated effects of nonverbal behavior and gender during a simulated initial meeting between a therapist and client. Undergraduates ($N = 466$) viewed a male or female therapist interviewing with a new female client. Therapist gaze (100%, 80%, 40%) and smiling (high, low) were manipulated. After subjects viewed one of 12 videotapes, they completed questionnaires rating therapist expertness, trustworthiness, attractiveness, masculinity and femininity. A comparison of the therapist with subjects' expectations of a therapist in general was obtained by pre- and post-testing utilizing a measure of client expectations.

MANOVAs were performed on all ratings except expectation scores, where an ANCOVA was utilized. Main effects for therapist gender indicated the female therapist was rated as significantly more expert, attractive,

trustworthy and feminine than the male ($p < .81$). For ratings of masculinity, subject gender interacted with therapist gender ($p < .001$).

Main effects showed that high smiling was rated as more attractive and more feminine ($p < .01$). Smiling and level of gaze interacted on ratings of trustworthiness, expertness and masculinity ($p < .04$). The 100 per cent and 80 per cent gaze levels increased expertness, trustworthiness and masculinity ratings. Smiling affected expertness at the 80 per cent level, and trustworthiness and masculinity at the 40 per cent level. Analysis of the expectation scores resulted in a three-way interaction between subject gender, smiling and gaze ($p < .02$). The results suggested that female subjects expected more responsive therapist behavior.

The results suggested that the ratings of the male and female therapist reflected both the use of sex stereotypes and the influence of the therapist role. Based on the nonverbal behavior manipulation, several recommendations for therapist behavior were suggested.

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CHAPTER I

INTRODUCTION

There appears to exist an increasing interest in identifying the common processes underlying various theoretical approaches to psychotherapy (Goldfried, 1980). Once regarded as placebo or nonspecific effects, these mechanisms have been relabeled common factors and are suggested as important ingredients affecting therapeutic change (Butler & Strupp, 1986; Frank, 1982). Social influence theory is one model addressing such factors. Originally developed by Strong (1968), this model suggests that therapists can be considered change agents deriving influence from their perceived social power.

Conceptualizing psychotherapy as an interpersonal influence process places considerable emphasis on how the therapist is perceived by the client. The influence of therapeutic interventions could be facilitated if a client perceived the therapist as a credible source of help (Strong, 1968). If therapists can manage the impression others form of them, they may increase their effectiveness as change agents (Dorn, 1986; Strong & Matross, 1973).

Research on social cognition suggests that first impressions are relatively stable and influence our

interactions with others (Asch, 1946; Jones & Goethals, 1971; Park, 1986). Thus, a therapist's early presentation to a client may have a strong effect on that client's immediate and future behaviors in therapy. The formation of impressions can involve a number of processes facilitating the perception and organization of sensory information. Stereotypes are one type of schema reflecting such an organizational process. Stereotyping allows the development of a set of expectations from which the perceiver can anticipate a target's behavior (Hamilton, 1979). Such expectations can influence how the perceiver interacts with the target (Ashmore, DelBoca, & Wohlers, 1986). In addition, stereotyping can bias perception, since individuals tend to interpret target behavior as confirming their expectancies (see reviews by Miller & Turnbull, 1986, and Snyder, 1984). Thus, an individual may develop an impression of a target that is different from the one intended. If stereotyping occurs in the therapy context, then therapists may need to consider such factors as their own gender or clients' expectancies for the counselor role when presenting themselves to potential clients.

The present investigation addresses several factors which appear to affect the impressions clients form of therapists. The identification of such factors may allow a therapist to gain greater control over the image he or she

presents. Such control could increase the therapist's perceived social power, thereby facilitating the therapeutic process.

Social Cognition

There appears to be a general consensus that when we meet an unfamiliar person, first impressions have a strong impact on how we come to view this person in our subsequent interactions with him or her. Evidence of this consensus is apparent in textbooks. Virtually all introductory social psychology texts have at least one section on early impressions, as do many general psychology texts.

Research in social psychology has addressed this issue from a variety of perspectives. Asch (1946) was one of the first researchers to investigate how early impressions are formed. Lists of adjectives were presented and subjects were directed to form impressions from this list. He found that, in general, adjectives presented first determined the direction in which an impression developed, with subsequent data used to qualify or confirm the initial information. Thus, he supported an active view of impression formation, with early information directing the interpretation of information received later.

Research on the primacy effect identified by Asch (1946) has continued. Park (1986) found that information

acquired very early within a natural social situation dominated the content of interactants' impressions. Park investigated the development of impressions between a small group of people over a series of several weeks. She found that information acquired early accounted for the majority of information included in the subjects' reported impressions at later dates. Park also found evidence suggesting that early information may not actively direct the development of an impression. Rather, later information appears to be passively disregarded either because it is inconsistent with the early information or because an adequate amount of information is perceived early, which could decrease the need for additional information.

Another approach to impression formation supports the persistence of initial impressions. Research on attribution suggests that information obtained about a target after the formation of an impression is typically attributed to superficial and transient factors. In contrast, information included in the initial impression is viewed as reflecting the target's "real" dispositions (Bill, Wicklund, Manko, & Larken, 1976; Cantor & Mischel, 1979).

Jones and Goethals (1971) suggested that if initial information about a person reflects a stable personality characteristic (e.g., ability), then such information will be taken as a good indication of the extent to which that

individual really possesses that attribute. This early information would be assumed to reflect the real person even when the perceiver was faced with later inconsistent information. However, if the initial information reflects an unstable characteristic (e.g., mood), then the perceiver would likely view this information as less reliable and be more influenced by later information. Therefore, dispositional attributes that are stable may lead to primacy effects, while unstable attributes could cause a recency effect in impression formation.

Recency effects have been demonstrated in some experimental paradigms. It appears that recency is more likely to occur if information received later is highly discrepant rather than moderately or slightly inconsistent with early information (Sherif & Hovland, 1961). Recency may also occur if the perceiver has reason to believe that information received early about a target is likely to be invalid or uncharacteristic (Jones & Goethals, 1971).

Thus, the research literature appears to support a primacy effect in initial impressions except under certain conditions. Information perceived early in an encounter apparently forms the basis of the impression either by directing the development of the impression, or by providing enough data to form an adequate picture of the target. Information received later, which is inconsistent with the

formed impression, is likely to be disregarded or attributed to extra-individual factors. Extrapolating from this literature, there are implications for therapy. The findings suggest that the therapist's behavior during the first few minutes of therapy could strongly affect the impression the client forms and leaves with at the end of the session.

During early contacts, individuals encounter many stimuli that may be used to develop an impression of their partner. Stimuli which are salient or distinctive are more likely to be encoded and available to form an impression of the target (Hamilton, Katz, & Leier, 1980). Physical characteristics (Taylor, Fiske, Etcoff, & Ruderman, 1978) and nonverbal behaviors (LaCrosse, 1975) have been found to be salient stimuli in early encounters. Once information regarding a target is available, some type of classification process appears to occur. This process involves selecting relevant information among that perceived, utilizing a type of schema or pattern to organize the information and extending it by inferring related characteristics (Cohen, 1981; Hamilton, Katz, & Leirer, 1980; O'Keefe & Delia, 1982).

Darley and Fazio (1980) developed a model of self-fulfilling prophecy describing how early impressions direct interactions and remain relatively unchanged. They utilized the concept of stereotyping to describe this process.

Stereotyping is viewed as a classification process which categorizes a person according to his or her membership in a particular group (e.g., gender, racial, occupational). The target is assumed to possess the characteristics of the average member of the group. Once identified, the classificatory attribute triggers inferences about other characteristics the person is assumed to possess or what behaviors he or she ought to display (O'Keefe & Delia, 1982). Thus, a set of expectations form which allows the perceiver to anticipate the target's future behavior (Hamilton, 1979) and guide the perceiver's interactions with the target (Ashmore et al., 1986; Snyder, Tanke, & Berscheid, 1977).

The classification of a person based on group membership can also bias perception thereby influencing what impression is formed. Judgments of an individual are more likely to be stereotypic when little additional information is available about the person. If the available information individuates the target from his or her social group, then stereotypes have minimal impact on judgments about that person. However, if the individual is categorized on the basis of a social group which is proportionately small, then social judgments will be more stereotypic because of the decreased probability of previous perceiver-target interaction (Borgida, Locksley, & Brekke, 1981). For

example, an individual seeking therapy for the first time may view a therapist stereotypically, based on gender or occupational role, simply because of his or her limited contact with this social group of therapists. Thus, the less familiar a person is with a group or situation, the more likely he or she is to utilize stereotypes and expect stereotypic behavior from the target (Darley & Fazio, 1980).

Stereotyping can also influence the encoding and storage of social information encountered in ongoing interactions (Hamilton, 1979). For example, Chapman and Chapman (1967) and Cohen (1981) found that new evidence which confirmed a stereotype was more easily noticed and more readily stored in memory than nonconfirming evidence.

Interactional context also appears to influence how information is processed and the nature of the impression formed of a target (O'Keefe & Delia, 1982). If the interaction between perceiver and target is expected to be limited, the formed impression may reflect elaboration of the target's characteristics only in this limited domain. For example, a client's impression of a specific therapist may include personality characteristics and expected behaviors relevant to the role of therapist, while remaining unelaborated in terms of the therapist's leisure activities. Studies assessing clients' evaluations of therapy have typically focused on those therapist dimensions assumed to

reflect behavior consistent with the therapist role (e.g., Barrett-Lennard, 1962).

In summary, social psychological research suggests several conclusions. Early impressions typically are resistant to change and can affect the processing of later information. They reflect a classification process whereby original information may be elaborated by reference to stereotypes or other schemata available to the perceiver. Information tends to be selectively processed to form a coherent picture of the target relevant to the perceiver's current situation. Physical attributes and nonverbal behaviors tend to be especially salient in initial encounters. Additionally, early impressions have the potential to influence the course of later interactions (Darley & Fazio, 1980).

Research on social influence processes in psychotherapy has suggested that the formation of certain impressions of therapists may facilitate the therapeutic process. Three dimensions, extrapolated from research on attitude change, have been hypothesized to form the basis of this impression (Strong, 1968), and have been the most extensively researched. These are perceived expertness, trustworthiness and attractiveness. If these dimensions are significant, the early evaluation of a therapist by a client may be important because of the tenacity of early impressions

(Asch, 1946; Jones & Goethals, 1971; Park, 1986). Since these dimensions tend to reflect stable characteristics, dimension relevant stimulus information received early may be assumed by the client to indicate the extent to which the therapist actually possesses that attribute (Jones & Goethals, 1971). In addition, Phillips (1985), in a summary of attrition research, notes that the modal number of therapy sessions for adults is one, and the median number of sessions is three to five. Thus, there may be limited time available to provide the client with appropriate cues from which to form the desired impression. If therapy is facilitated by the formation of particular impressions of the therapist, then the therapist may facilitate treatment by presenting the desired stimulus picture early.

Social Influence Theory

The conceptualization of psychotherapy as a social influence process was first proposed by Strong (1968). Strong's is a cognitive theory incorporating Festinger's (1957) concept of cognitive dissonance, which is viewed as a common factor underlying many current theories of therapeutic change (Claiborn, 1986). The theory suggests that a therapist's attempts to change a client's behavior or attitude creates dissonance in the client. Dissonance is defined as a tension accompanied by psychological discomfort, which motivates the individual to reduce the

dissonance (Zimbardo, 1960). A client could accomplish this in several ways: (a) by changing in the direction proposed by the therapist, (b) by discrediting the therapist, (c) by discrediting the issue, (d) by changing the therapist's view, or, (e) by seeking others who agree with them. Strong suggested that increasing the possibility of changing in the therapist's direction could occur through decreasing the possibility of the second and third alternatives. He proposed that increasing the therapist's perceived credibility may increase the likelihood that the client will accept the views of the therapist. He also suggested that increasing the client's involvement in the therapeutic process may decrease the possibility of the third alternative--discrediting the issue.

Strong developed a two-stage model of therapy based on attitude change principles. Initially, the therapist is viewed as enhancing his or her perceived credibility and attractiveness to facilitate the client's formation of an impression of credibility and similarity, thus increasing the therapist's social power (Strong & Matross, 1973). During this early part of therapy, the client's involvement increases. In the second stage, the therapist uses his or her influence to enhance attitude and/or behavioral change in the client. Tracey (1986) has recently elaborated this model.

The majority of the research in this area has concentrated on the dimensions of therapist credibility and attractiveness. Therapist credibility has been conceptualized in terms of perceived expertness and trustworthiness. Expertness is defined as "the extent to which a communicator is perceived to be a source of valid assertions" (Hovland, Janis, & Kelley, 1953, p. 21). Extrapolating from research on persuasion, Strong (1968) asserted that the perception of a target's expertness could be enhanced by (a) objective evidence of specialized knowledge or training, such as diplomas and titles, (b) target behavior, such as provision of information, or confident presentation of arguments, and (c) the target's reputation as an expert. In the social influence research, impressions of expertness have been obtained through the use of rating scales incorporating conceptually related adjectives (e.g., prepared, experienced, skillful).

Trustworthiness is regarded as "the degree of confidence in the communicator's interest to communicate assertions he considers most valid" (Hovland et al., 1953, p. 21). Strong (1968) suggested that the evaluation of a target's trustworthiness could be influenced by his or her (a) reputation for honesty, (b) social role, such as counselor or minister, (c) sincerity and openness, and (d) apparent lack of motivation for personal gain.

Trustworthiness measures include adjectives such as reliable, honest and sincere.

Attractiveness is considered to reflect perceived similarity to and compatibility with a communicator (Strong, 1968). Strong suggested that evaluations of attractiveness could be enhanced by a therapist's self-disclosure and display of facilitative conditions, such as warmth and positive regard. Researchers in the area of therapists' social influence have utilized measures of perceived attractiveness including concepts such as likable, friendly and warm.

Social influence research has focused on discovering those therapist and client characteristics and behaviors, and situational cues which enhance the perceived expertness, trustworthiness and attractiveness of the therapist. For example, therapist attire (Kerr & Dell, 1976), nonverbal behavior (Fretz, Corn, Tuemmler, & Bellet, 1979; Haase & Tepper, 1972; Siegel & Sell, 1978), and verbal behavior (Atkinson & Carskaddon, 1975; Kleinke & Tully, 1979) have been found to influence a client's ratings of a stimulus therapist's characteristics. Extensive reviews of this literature are available (Corrigan, Dell, Lewis, & Schmidt, 1980; Dorn, 1986; Heppner & Dixon, 1981; Strong, 1978). However, as Corrigan et al. (1980) indicated, a minority of studies have addressed counselor gender as a factor

influencing therapist credibility and attractiveness, with most of the research focusing on the perception of male therapists. Since stereotypes may be utilized when forming an impression of another, gender could be an important variable to incorporate into studies of clients' impressions of therapists. In addition, a greater number of females appear to be entering the fields of clinical and counseling psychology (Howard et al., 1986). Research on gender stereotypes indicates that men and women are perceived and evaluated differently (Kaschak, 1977; Lott, 1985). Thus, it is unclear whether research exploring the perceptions of male therapists can be generalized to female therapists.

The social influence research has focused on the initial exposure to or interaction with a therapist. Various stimulus cues are manipulated and their effect on subjects' impressions of the counselor are recorded. Most of the studies have focused on impressions reflecting the dimensions of expertness, trustworthiness and attractiveness. Since these impressions are thought to influence therapy process, this research should be explored in detail. Where possible, this review is limited to those studies which incorporated therapist gender as a variable. This research has utilized situational and status cues, physical attractiveness and verbal and nonverbal behavior as independent variables.

Situational and Status Cues

A few studies investigating the effect of situation or status cues on the perception of therapist characteristics incorporated therapist gender as a variable. Bloom, Weigel, and Trautt (1977) investigated the effect of office decor on students' ratings of a male or female therapist. Their measure of credibility, developed by Widgery and Stackpole (1972), contains dimensions of qualification, dynamism (potency) and safety (trustworthiness), and yields scores for each dimension, as well as an overall credibility score. Subjects rated the presumed male or female occupant of an office decorated either in a "traditional professional" or "humanistic" mode. Results showed that overall ratings interacted with therapist gender. The female therapist was perceived as more credible and dynamic in the traditional office, while the male therapist was seen as more credible and safer in the humanistic office. Bloom et al. (1977) associated the "traditional" office with stereotypic masculine characteristics and the "humanistic" office with stereotypic feminine characteristics. Thus, the results suggested that the therapists were perceived as more credible when in a situation that was counter to their traditional roles. This appears to be related to other findings which demonstrate that a communicator is perceived

as more credible when delivering a statement counter to his or her own ideological view (Koeske & Crano, 1968).

Heppner and Pew (1977) investigated the effect of status cues on ratings of therapist expertness. Subjects were interviewed by a male or female therapist in rooms in which framed degrees were either present or absent. Subjects then rated the interviewer's expertness. While the presence of the degrees significantly increased the ratings of therapist expertness, there was no effect for counselor gender. It appears that in the presence of objective evidence of status and competence, male and female therapists were perceived as experts.

In contrast, Kunin and Roden (1982) found that perceptions of high status male and female therapists were different when status was manipulated via introductions. In their study, therapists were introduced via written descriptions as either graduate students in training (low status) or experienced professionals with Ph.D.s (high status). After the introductions, subjects participated in a role playing situation in which they evaluated their potential therapist. High status therapists were rated as more empathic (able to understand feelings) than the low status therapists, regardless of therapist gender. However, the male therapist was rated as more intelligent than the female therapist. In addition, subjects self-disclosed more

to high status males than high status females. In the low status condition, therapist gender had no effect on self-disclosure.

A recent study (Angle & Goodyear, 1984) found that perceived expertness and attractiveness were significantly influenced by a manipulation of introduction. Counselors who received an expert introduction (i.e., experienced Ph.D. level counseling psychologist) were rated as more expert and more attractive than those receiving a nonexpert introduction (teacher, B.A. in English) or no introduction. These researchers did not find effects for counselor gender. It is difficult to draw conclusions from these two studies because of methodological differences. Kunin and Roden (1982) utilized a role-play situation, while subjects in Angle and Goodyear's (1984) study listened to audiotapes. It appears that therapist gender may be more salient, thereby influencing perceptions, in situations that are more similar to an actual counseling session.

Physical Attractiveness

Another series of studies has addressed the effect of counselor physical attractiveness and gender on the perception of therapist characteristics. Carter (1978) had subjects listen to an audiotape while viewing a photograph of either a male or female therapist. She found that the female therapist was rated more positively than the male

therapist on relaxation, warmth, friendliness and trustworthiness, regardless of her attractiveness. Ratings were also affected by subject sex. Female subjects rated attractive female therapists higher on relaxation than male subjects rated attractive or unattractive male therapists. Male subjects also rated the attractive male therapists lowest on the dimensions of warmth and friendliness.

Cash and Kehr (1978), using a method similar to Carter (1978), found that attractive therapists were evaluated more favorably than unattractive therapists, regardless of gender. Physically attractive male and female therapists were rated as more expert, attractive, trustworthy, empathic and genuine. These researchers concluded that their results were due to the debilitating effects of unattractiveness rather than the facilitative effects of attractiveness. The authors also indicated that their manipulation of attractiveness was more effective than that of Carter (1978) and may explain the difference in results.

Kunin and Roden (1982) also manipulated therapist attractiveness and found that subjects disclosed more to attractive males than to attractive females. Counselor gender did not influence ratings when the therapist was unattractive.

Paradise, Conway, and Zweig (1986) had subjects watch videotaped simulated counseling interviews. They found that

therapist physical attractiveness influenced the attribution of professional and personal characteristics. Ratings of professional attributes (e.g., competent, knowledgeable, confident) and personal attributes (e.g., likable, warm, sociable) were higher when the therapist was attractive rather than unattractive, regardless of therapist gender.

It appears that in situations similar to actual therapy sessions, physical attractiveness is likely to facilitate positive evaluation of therapists in terms of stable counselor-relevant and positive personality characteristics. This is consistent with other research finding that physically attractive individuals are more likely to be attributed with positive characteristics (Dion, Berscheid, & Walster, 1972). It is less clear whether physical attractiveness actually affects client behaviors, such as disclosure level. Kunin and Roden (1982) reported that the interactive effects of therapist gender, physical attractiveness and status accounted for only six per cent of the variance in client disclosure in their study. Thus, other variables appear to be operating in this situation.

Verbal Cues

The effect of therapist verbal behavior on subsequent evaluations has also been investigated. Kleinke and Tully (1979) found that therapists who engaged in a low level of talking were rated as more attractive than those who engaged

in a high level of talking. However, therapists who talked frequently were rated as more potent (i.e., domineering and inattentive). Counselor gender did not influence subjects' ratings.

Merluzzi, Banikiotes, and Missbach (1978) manipulated therapist verbal behavior and experience level. They utilized the Counselor Rating Form (Barak & LaCrosse, 1975), to evaluate therapist attractiveness, expertness, and trustworthiness. Subjects read transcripts of a counseling session in which therapists, introduced as either high (Ph.D. level Counseling Psychologist, experienced) or low in experience (teacher with B.A. in English, no counseling experience), either self-disclosed frequently or infrequently. Results showed that therapist gender interacted with disclosure and experience level for ratings of expertness and trustworthiness. Female therapists introduced as highly experienced were rated as more expert than highly experienced males or inexperienced males and females. In regard to disclosure level, high and low disclosing male therapists were perceived as similar in trustworthiness. In contrast, low disclosing females were viewed as highest in trustworthiness, while high disclosing females were rated as least trustworthy.

Gender effects in the Merluzzi et al. (1978) study were dependent upon the dimension measured. A highly experienced

female may be perceived as more of an expert than a similarly qualified male because of the, perhaps stereotypic, impression that women must be overqualified and substantially better than their male counterparts. The effect of gender on the ratings of trustworthiness may also reflect stereotyped expectations. Low disclosure by males may be expected since it is consistent with the masculine stereotype. In addition, high self-disclosure by a male may be perceived as voluntary openness and sincerity. However, females who are highly disclosing could be perceived as emotional and insecure, attributes consistent with the feminine stereotype, but suspect in a professional therapist. Females who are low disclosing may present an image of professionalism and be trusted to concentrate on their client's problems rather than their own.

Atkinson and Carskaddon (1975), Barak, Patkin and Dell (1982), and Kratz, Marshall, and Young (1985) investigated use of psychological jargon on clients' perceptions of therapists. The assumption underlying these studies was that the decision to engage in such verbal behavior may be influenced by the particular client and the impression believed to facilitate therapy with this specific individual. In the first study (Atkinson & Carskaddon, 1975), therapists using psychological jargon were rated by students as having a greater knowledge of psychology than

therapists using lay terminology. Barak et al. (1982) found that male therapists using psychological jargon were rated as more expert than those who did not. However, use of jargon was rated as less attractive than use of everyday language.

Recently, Kratz, Marshall, and Young (1985) found that the use of psychological terminology by female therapists was rated as less attractive than the use of lay terminology. In addition, these therapists were rated as higher in instrumental-masculine traits. Thus, the use of psychological terminology appears to differentially affect various impressions.

Nonverbal Cues

Research on nonverbal behavior has important implications for therapy. Generally, this body of literature has focused on other contexts (e.g., persuasion, leadership, job interviews). Research in nontherapy settings suggests that more information in a social interaction is communicated nonverbally than verbally (Birdwhistle, 1955; Philpott, cited in Burgoon, 1985). In addition, the content of impressions appears to be greatly affected by the target's nonverbal behavior (Argyle, Salter, Nicholson, Williams, & Burgess, 1970; Graham & Argyle, 1975; Mehrabian & Williams, 1969; Sherer, 1974; Walker, 1977). Burgoon (1985) suggests that nonverbal cues may have a

greater impact in initial encounters and take on more importance in the shaping of expectations since verbal exchanges are more likely to be viewed as regulated by convention. The effect of nonverbal cues appears to be dependent on the nature of the cue.

Some research has investigated the effect of nonverbal cues on ratings of attributes similar to those identified as important in therapy settings. Two of the most thoroughly examined behaviors are eye gaze and facial expression. Eye contact or gaze has been associated with ratings of dominance (Thayer, 1969), potency (Zimmerman, 1977), power (Dovidio & Ellyson, 1985) and persuasiveness (Mehrabian & Williams, 1969). The frequency of direct gaze tends to be greater for individuals in high status and power positions (Henley, 1977). Steady gazing or staring is typically perceived as a dominance cue and may be regarded as threatening (Ellsworth, Carlsmith, & Henson, 1972). However the specific interpretation of staring may be influenced by context (Ellsworth & Langer, 1976) and gender (Ellsworth & Ross, 1975). For example, Ellsworth and Ross found that constant gaze promoted intimacy between female and reticence between male dyads. In contrast, gaze aversion had the opposite effect.

Other researchers have investigated the relationship between gazing and communicative behavior (Ellyson, Dovidio

Montreaux, & Fridell, cited in Ellyson, Dovidio & Fehr, 1981). They found that while a high proportion of gazing while speaking is associated with high dominance or status ratings, high gazing when listening leads to low ratings. As for gender differences, females actually tend to look more at others (Ellyson & Dovidio, cited in Dovidio & Ellyson, 1985; Exline, Gray, & Schutte, 1965). However, their gazing behavior is typically modulated by slight incline of the head or indirect facial orientation (Hall & Halberstadt, 1986; Henley, 1977). This combination of behaviors may decrease the perceived dominance of direct gazing by a female (Henley, 1977).

Facial expressiveness has been found to influence ratings of persuasiveness (Mehrabian & Williams, 1969). Smiling has been associated with ratings of attractiveness (Lau, 1982) and persuasiveness (Keating, Mazur, & Segall, 1977). The absence of smiling behavior appears to increase ratings of dominance (Edinger & Patterson, 1983) and social power (Henley, 1977; Young, 1985). Females have been found to engage in smiling behavior with greater frequency than males (Frances, 1979; Ickes & Turner, 1983; LaFrance & Carmen, 1980; Morse, 1982; Pollio & Edgerly, 1976), and, in general, are more facially expressive (Pearson, 1985). Facial expressiveness also appears to have a greater effect

on the evaluation of females than males (Deutsch, LeBarron, & Fryer, 1987; Shulman & Hoskins, 1986).

In summary, gazing and smiling appear to be two nonverbal behaviors which differentially affect the impression formed of an individual. Graham and Argyle (1975) suggest that gaze affects judgments of potency or control and intensity, while facial expression affects ratings of liking and evaluation. Judgments of activity (e.g., active-passive) appear to be affected by both behaviors.

Nonverbal behavior appears to contribute significantly to the process of developing an impression of a therapist. Consistent with research in nontherapy settings, counselor nonverbal behavior has been found to account for almost twice the amount of variance in ratings of specific therapy-relevant characteristics (e.g., empathy) as compared with the therapist's verbal message (Haase & Tepper, 1972). Investigators utilizing the social influence model of therapy have approached this area of research by categorizing nonverbal behaviors into responsive and unresponsive sets. Behaviors classified as responsive have included a high level of gazing (80-100% of the time), forward shoulder and body lean, hand gesticulations, facial expressiveness, direct body orientation and head nodding. Unresponsive cues have included a low level of gazing

(25-40% of the time), reclining trunk lean, lack of hand gesticulations, expressionless face, flat tone of voice and indirect shoulder orientation. The researchers in this area have typically manipulated entire sets of behaviors rather than systematically varying individual nonverbal behaviors.

Research limiting their investigations to client evaluations of male therapists have found that those who display responsive nonverbal behaviors are rated as more credible (Siegel & Sell, 1978), expert, attractive and trustworthy (Claiborn, 1979) than those displaying unresponsive behaviors. However, different combinations of nonverbal behaviors appear to lead to different results. Barak, Patkin, and Dell (1982) found that a male therapist who displayed unresponsive nonverbal behaviors but maintained eye contact 70 per cent of the time, was rated as more expert, though less attractive, than one displaying responsive behaviors.

Several researchers have included therapist gender as a variable in studies of therapist nonverbal behavior. LaCrosse (1975) had subjects view videotapes of male and female therapists displaying responsive or unresponsive nonverbal behaviors. Behaviors in the responsive condition included smiles, gesticulations, 80 per cent eye contact, direct shoulder orientation and forward body lean. The unresponsive behaviors consisted of 40 per cent eye contact,

shoulder orientation away from the client, a reclining body lean and an absence of the other categories of nonverbal behaviors. Results showed that therapists displaying responsive nonverbal behaviors were rated as more attractive and persuasive, regardless of gender. In addition, responsive female therapists were rated as more persuasive than the responsive male therapists. Subjects reported that duration of eye contact, smiles and gesticulations were the most salient cues influencing their ratings.

Fretz, Corn, Tuemmler, and Bellet (1979) also utilized two sets of nonverbal behaviors. Female subjects viewed videotapes of male or female therapists interacting with a female client. Counselors displayed either responsive (eye contact 90% of the time, forward trunk lean and direct body orientation 100% of the time) or unresponsive (eye contact, forward lean and direct body orientation all less than 40% of the time) behavior. Subjects rated responsive therapists as more empathic, congruent and possessing a higher level of regard than unresponsive therapists. Responsive therapists were also described as more poised, friendly, trusting, warm attentive, patient, intelligent, capable, considerate, concerned and expressive. However, female therapists in each nonverbal condition were rated as less attentive, patient and concerned and more disinterested than their male

counterparts. That is, the male therapists in the two conditions were rated more similarly than the female therapists.

A limitation of the previous studies is the simultaneous manipulation of several nonverbal behaviors. The research on nonverbal behavior in nontherapy settings indicates that specific behaviors differentially affect the evaluation of various characteristics (Burgoon, Buller, Hale, & deTurck, 1984). When utilizing a set of behaviors it is difficult to determine which cue or cues account for the effects. At least one investigation in the therapy literature indicates that specific nonverbal behaviors can mediate the effect of others (Barak et al., 1982). In this study, systematic manipulation of level of gazing mediated the effects produced by sets of responsive and unresponsive behaviors.

Two studies have manipulated individual nonverbal cues rather than employing sets of behaviors (Smith-Hanen, 1977; Young, 1985). Smith-Hanen (1977) found that counselor posture (various arm and leg positions) affected ratings of counselor warmth and empathy. Young (1985) manipulated therapist smiling and posture. She found that a female therapist displaying a neutral expression was rated as more powerful than a male therapist with a neutral expression. In addition, the male and female therapists were rated as

more attractive when smiling than when neutral in expression. Posture was found to interact with subject gender for perceived attractiveness. Male subjects rated counselors displaying an open posture and neutral expression as more attractive, while female subjects considered a closed posture and neutral expression more attractive. Both these experiments suggest that studies employing sets of behaviors may be obscuring the effects of specific nonverbal behaviors.

Summary

The social influence research has focused on those initial impressions thought to influence the therapist's social power. An increase in power should facilitate client change by enhancing the credibility and attractiveness of the therapist. Various cues appear to influence these dimensions, and have different effects depending on the dimension being rated. However, the process by which an individual incorporates the available cues into an impression, coherent enough to allow evaluation, is unclear. Some of the findings suggest that subjects may utilize stereotypes to form an impression and evaluate the therapist. For example, the results obtained by several researchers appear to reflect the use of gender stereotypes (Bloom et al., 1977; Carter, 1978; Kunin & Roden, 1982; Merluzzi et al., 1978). The content of the impressions of

the male and female therapists in these studies is similar to cultural gender stereotypes. For example, male therapists would be rated as higher in intelligence than female therapists. Other findings suggest the use of occupational stereotypes to organize available information (Angle & Goodyear, 1984; Fretz et al., 1979; Kleinke & Tully, 1979; LaCrosse, 1975). The resulting impressions in these studies reflect attributes typically associated with the role of therapist (e.g., trustworthy, expert, empathic).

As noted previously, stereotypes are schemata facilitating the organization and extension of information about a target (O'Keefe & Delia, 1982). Impressions of others are more likely to be stereotypic if the perceiver has had little contact with individuals in the relevant social group, as may be likely with therapists, or if little individuating information is available (Locksley, Hepburn, & Orwitz, 1982). Both of these conditions appear to exist in the experimental paradigms utilized in the social influence research. In addition, these conditions may exist in actual therapy situations, where many first time clients have had little exposure to realistic expectations regarding therapists and therapy. Thus, impressions may be more stereotypic. Further, because of the limited nature of their contact, an individual's schema of therapists is unlikely to be as well-developed as his or her schema for

males and females. Therefore, gender stereotypes may be more available to facilitate the formation of an impression.

Stereotypes

Gender stereotypes have been extensively researched and appear to be relatively stable in content. Evidence for the existence of a stereotype of therapists comes indirectly from research on client expectations of therapy.

Gender Stereotypes

The content of gender stereotypes has been well researched. Various methods, including open-ended descriptions (Sherriffs & McKee, 1957), adjective checklists (Williams & Bennett, 1975), and rating scales (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968) have been utilized to elicit characteristics typically associated with males versus females. Research by Broverman and her colleagues (Broverman, Broverman, Clarkson, Rosenkrantz, Vogel, 1970; Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972; Rosenkrantz et al., 1968) is representative of the findings in this area.

In the development of their Sex-Role Stereotype Questionnaire, Broverman et al. (1972) discovered that two different clusters of characteristics were used to describe males and females. For males, valued characteristics included being independent, objective, active, competitive, logical, skilled in business, worldly, adventurous, able to

make decisions easily, self-confident, a leader, and ambitious. A relative lack of these traits characterized the stereotypic female. Female valued items included being gentle, sensitive to the feelings of others, tactful, religious, quiet, neat, interested in art and literature, and able to express tender feelings. Males were characterized as lacking these traits. Recently, Ruble (1983) replicated Broverman et al.'s findings, except for one item on the questionnaire (intellectual), suggesting that the nature of gender stereotypes has remained relatively stable.

Researchers have attempted to summarize previous findings by investigating the common structure underlying the various trait lists obtained in the stereotype research (Ashmore, 1981; Ashmore & Tumia, 1980). These researchers utilized various scaling methods and found that beliefs about the sexes could be represented along two orthogonal dimensions, roughly equivalent to Osgood, Suci and Tannenbaum's (1957) dimensions of potency and evaluation. Based on their review of the literature, Ashmore, Delboca, and Wohlers (1986) concluded that potency appears to be the central dimension differentiating between the sexes with women more often described with "soft" traits and men with "hard" traits.

Gender stereotypes do appear to be utilized to some extent when forming an impression of a therapist. Evidence for this comes from the social influence literature discussed earlier and from research on client preference for particular therapists. The preference literature suggests that gender of subject and therapist may have an effect on the development of expectations even prior to actual contact between therapist and client. Such expectations may subsequently influence what impression is formed and affect initial behavior with the therapist. The findings in this area suggest that information about therapist gender is used in a stereotypic manner. Fuller (1964) found that male and female subjects expressed a preference for male counselors for assistance with vocational problems. He maintained that this preference reflected the greater prestige and competence attributed to the masculine sex-role. Chesler (1971) found that the gender and marital status of actual clients influenced therapist preference. Single men and women and married men indicated a preference for male therapists. Frequent reasons cited for this preference included a greater respect for a man's intelligence, greater confidence in a man's competence and a general mistrust of women. Married women, who were more likely to express a preference for a female, gave fewer reasons for their

preference and tended to cite similarity of experience as their reason.

Greenberg and Zeldoro (1980) had subjects describe their ideal therapist using an adjective checklist. They found that female students preferred therapists whose characteristics were stereotypically masculine, while male students preferred therapists who were stereotypically feminine. In addition, males more than females preferred therapists of the other sex. The males preference appears to reflect greater stereotyping since feminine characteristics were associated with the female therapist.

Occupational Stereotypes

Stereotypes involving occupational role may also be available when attempting to form an impression of a particular therapist. Eagly and Steffen (1984) have found that preconceptions regarding one's occupation can overpower stereotypic evaluations based on gender. Little research has directly assessed the existence of a stereotype of "therapist" or "counselor." Research on client expectations for counseling indirectly addresses this issue. Corrigan (1978) found that subjects expected a "mental health professional" to be trustworthy and expert. Subich (1983) found that female subjects expected a "counseling psychologist" to be more accepting, confrontive, genuine, nurturant, tolerant and trustworthy than did male subjects.

Specification of counselor gender did not affect the ratings. Hardin and Yanico (1983) found similar results, with female clients expecting counselors of either gender to be accepting, confrontive, genuine, attractive and trustworthy. Male subjects expected counselors to be directive and self-disclosing. Again, counselor gender did not affect the ratings. In a related study, Hardin and Subich (1985) found that student nonclient expectations generalized to student client and nonstudent client populations.

Research appears to indicate that the impression a client forms of a particular therapist can be influenced by the extent to which sex or role stereotypes are utilized. Stereotypes would facilitate the processing and organization of information about the individual. However, as a result of variations in methodology, it is difficult to determine when gender and when therapist role will have a greater influence on the content of impressions. The current investigation sought to address this issue as well as extend previous findings on the factors differentially affecting the formation of therapy-relevant impressions of therapists.

Rationale for the Present Study

The present study was developed to address the effect of various factors on the nature of the impressions formed of two therapists. The social cognition research suggests

that information perceived early about an individual has the potential to influence impression formation, bias perception and guide later interactions with the individual. For this reason, the current investigation focused on the initial meeting between a therapist and client. An analogue design employing videotapes of simulated therapy interviews was used. Subjects viewing the videotapes were asked to rate the therapists along several dimensions including expertness, attractiveness and trustworthiness. Several variables were manipulated to determine their effect on the ratings of the therapists. Level of gazing and smiling are two nonverbal behaviors reported in the literature to consistently affect how individuals are perceived. Thus, these nonverbal behaviors were selected for the present study over other possible cues.

Research indicates that therapist gender has inconsistently affected ratings of various attributes. Investigators finding differences in the ratings of male and female therapists suggest that gender is a salient factor when rating a therapist and may reflect the use of sex stereotypes to process and organize information about individuals. Those researchers failing to find gender differences suggest that the role of therapist is more salient or influential than gender. Role cues are believed to overpower gender cues in impression formation situations.

The ratings of a male and female therapist were compared in the present study to determine whether therapist gender or the role of therapist appeared to be influential. Thus, therapist gender, subject gender, level of therapist gazing (100%, 80%, 40%) and level of therapist smiling (high, low) were manipulated in the current investigation.

The present state of the research limited the nature of the hypotheses for this experiment. Several specific main effects were hypothesized and are discussed below. In addition, interactions were expected. Unfortunately, the literature is not well enough developed to allow a confident statement of all expected interactions. One area of consistent findings involves the influence of eye contact and facial expression on impression formation. Therefore, it was possible to predict a specific interaction for these variables. The results involving the other variables appear to vary between studies, depending on experimental methodology and context. Thus, it was difficult to predict beyond main effects and an attempt to do so may have reflected overgeneralization of the available data.

The following effects were hypothesized:

1. A main effect for therapist gender was expected on ratings of masculinity. The male therapist would be rated as higher in masculine traits than the female therapist.

2. A main effect for therapist gender was expected on ratings of femininity. The female therapist would be rated as higher in feminine traits than the male therapist.

3. A main effect for smiling was expected on ratings of attractiveness. Therapists in the high smiling condition would be rated as more attractive than those in the low smiling condition.

4. A main effect for level of smiling was expected on ratings of trustworthiness. Therapists in the high smiling condition would be rated as more trustworthy than those in the low smiling condition.

5. An interaction was hypothesized between level of smiling and level of gazing on perceived expertness. Therapists engaged in a low level of smiling would be perceived as more expert when displaying high levels of gaze. In contrast, therapists engaged in a high level of smiling would be rated as less expert than those engaged in a low level of smiling, across levels of gaze.

6. A level of smiling by level of gazing interaction was hypothesized for perceived masculinity. Therapists in the low smiling condition would be perceived as more masculine when displaying higher levels of gaze. In contrast, therapists engaged in a high level of smiling would be perceived as less masculine than those displaying a low level of smiling, across levels of gaze.

7. An interaction was also hypothesized between level of smiling and level of gazing on perceived femininity. Therapists engaged in a low level of smiling would be rated as less feminine when displaying high levels of gaze, rather than a low level of gaze. Therapists displaying a high level of smiling would be perceived as more feminine than those displaying a low level of smiling, across gaze conditions.

8. A main effect for smiling was also expected for ratings of role congruence. The therapists in the high smiling condition would be perceived as more congruent with the role of therapist than those in the low smiling condition.

CHAPTER II

METHOD

Subjects

The subjects were 242 female and 224 male undergraduates enrolled in social science courses. Individuals 27 years old and younger were used. Only those subjects whose first language was English were used in the analyses. Subjects received extra credit for their participation.

Design

The experiment was a 2(therapist gender) X 2(subject gender) X 3(level of gazing) X 2(level of smiling) design. All variables were between-subjects.

Pilot Study

A pilot study was conducted to select one male and one female stimulus therapist rated similarly along several dimensions. Videotapes of four male and four female students were shown to 25 undergraduate subjects (9 male, 16 female). Subjects received extra credit for their participation. Each videotape presented the individual displaying a neutral expression for seven seconds and a smile for seven seconds. Only the head of the individual was shown to reduce the possible effect of clothing.

Subjects rated both male and female sets of videotapes, the order of which was counterbalanced. After viewing each individual, subjects rated the person on a brief questionnaire (see Appendix A). The items used were two eight-point scales evaluating the attractiveness and warmth of the therapist. In addition, subjects were asked to indicate their estimate of the individual's age.

The means for the two photographs rated most similar are presented in Table 1 (Appendix B). Analyses indicated that the two selected individuals were rated similarly on attractiveness and warmth (female: $\bar{M} = 4.92$ and $\bar{M} = 4.80$; male: $\bar{M} = 4.40$ and $\bar{M} = 5.28$, respectively). They were not rated similarly on age (female: $\bar{M} = 26.08$; male: $\bar{M} = 24.24$). T tests were performed to determine the significance of the mean differences. Results indicated that the two individuals were not rated significantly different in terms of level of attractiveness, $t(24) = 1.83$, $p > .079$, or warmth, $t(24) = -1.54$, $p > .136$. However, they were rated significantly different in terms of age, $t(24) = 3.19$, $p < .004$). Despite the perceived difference in age, these individuals were selected as stimulus therapists. It was assumed that make-up and professional clothing would decrease the perceived discrepancy in age. The female therapist was a 24-year-old master's level clinical

psychology student. The male therapist was a 23-year-old experienced actor.

Stimulus Materials

The stimuli for the current study consisted of 12 eight and one-half minute videotapes. Six videotapes were made of the female and six of the male stimulus therapist. Each therapist wore a dark suit, light-colored shirt, and dark tie. The therapists' arms were visible from above the wrists. Thus, legs and hands were not visible. Arms remained resting on the chair arms during all videotapes. Each videotape presented the initial portion of a typical intake interview. The script was developed by the current investigator and two psychologists. It consisted of an initial section in which the therapist questioned the client regarding her state of mild depression and a later segment in which the client queried the therapist as to what she was to expect from therapy (see Appendix C). Six nonverbal conditions were varied in the videotapes. Three levels of gazing (100%, 80%, 40%) and two levels of smiling (high, low) were employed.

Appendix D describes the procedure used to create the six conditions. Gaze level represented the proportion of spoken words during which the therapist gazed at the client. Phrases and natural conversational breaks (e.g., commas, sentence endings) accompanied shifts of gaze. Level of

smiling reflected number of smiles incorporated into the script. The script for the high smiling utilized 28 smiles, the low smiling condition incorporated seven smiles. All smiles occurred at times in the script judged appropriate to the context. Care was taken so that the variables of gazing and smiling were balanced with each other and across speaking and listening. The client in all the videotapes was a female psychology professor whose face was not visible. Videotaping was done by shooting directly over the client's right shoulder toward the counselor. Part of her shoulder and the side of her hair showed to increase the appearance of a therapist looking directly at a client, while actually looking at the camera. Appendix F describes the methods used to train the stimulus therapists and client. Stimulus therapists were unaware of the hypotheses.

Procedure

Subjects were randomly assigned to one of 12 treatment conditions. Participants were run in groups with a maximum of 18 members. The order of videotape presentation was randomly determined prior to the start of the experiment. A male experimenter, blind to the hypotheses, greeted the participants and explained the study's purpose as the evaluation of a therapist. Subjects then completed an informed consent form (see Appendix F). The experimenter then passed out the pretest questionnaire and said "First,

I'd like you to complete the following questionnaire. Read the instructions and begin." The experimenter collected the forms upon completion. The subjects were then told the following: "You are about to view a brief interview between a therapist and a client. After the videotape, you will be asked to record your impressions on some questionnaires."

The experimenter then began the selected videotape and positioned himself so he could not view the content of the videotape. At the end of the tape, the experimenter handed out the remaining dependent measures and instructed the subjects to complete the questionnaires. After completing the forms, the subjects were debriefed by this researcher.

Dependent Measures

The Counselor Rating Form - Short Version

The Counselor Rating Form - Short Version (CRF-S; Corrigan & Schmidt, 1983) was used to assess perceived therapist expertness, attractiveness and trustworthiness. The CRF-S is a shortened version of the Counselor Rating Form (CRF; Barak & LaCrosse, 1975). The CRF-S consists of 12 adjective scales, four each representing the dimensions of expertness, attractiveness and trustworthiness (see Appendix G). Subjects are asked to rate the therapist in terms of how much the item describes him or her. In the original form of the CRF-S, each adjective was presented in a Likert scale from 1, not very, to 7, very. However,

research findings indicate that subjects do not utilize the entire scale range, being more likely to employ only the positive end of the scale (Epperson & Pecnik, 1985). Ponterotto and Furlong (1985) suggested that the scale be revised to allow finer discriminations within the positive end of the rating continuum, since subjects appear to attribute at least some amount of each attribute to therapists. A therapist's behavior may need to be extremely inappropriate to be rated on the lower end of the original scale. Thus, the rating scale for the present study ranged from 1, somewhat descriptive, to 7, very descriptive. Scores for the three dimensions of expertness, attractiveness, and trustworthiness, were obtained by summing across items for each dimension and calculating a mean rating.

Barak and LaCrosse (1975) developed the original CRF by instructing expert judges to classify 86 adjectives according to three dimensions--expertness, attractiveness, and trustworthiness. Thirty-six adjectives, for which there was at least 75 per cent agreement regarding classification, were chosen for the questionnaire. For each adjective, an antonym was selected to form the bipolar scale. (The CRF-S utilizes only the positive adjective from each of these scales.) Following item selection, undergraduate subjects viewed films of counseling interviews by Carl Rogers,

Frederick Perls, and Albert Ellis and rated each therapist along the 36 dimensions. Factor analysis of the ratings support the three dimension structure of the CRF.

Corrigan and Schmidt (1983) utilized two criteria when selecting items to incorporate into the short version of the CRF: the extent to which the item loaded on the appropriate dimension in previous factor analyses, and the comprehension level required for understanding the item. Both of these criteria reflect criticisms of the original version of the CRF. The first criterion was accomplished by inspecting six factor analyses reported previously (Barak & LaCrosse, 1975; Corrigan, 1977; Zamostny, Corrigan, & Eggert, 1981). Items were selected by comparing the number of times an item was among the highest five loadings in each of the six factor analyses. A 50 per cent (3 of 6) criterion was used. The second criterion for item selection was the educational level required for item comprehension. An eighth-grade level of comprehension was selected as criterion. Items were included if their comprehension ratings, as assessed by Dale and O'Rourke (1979), were at this grade level or lower. These two criteria resulted in the 24 item scale.

Corrigan and Schmidt (1983) validated the CRF-S using a sample of 133 college students and 155 clients from various outpatient community mental health centers. Mean split-half reliabilities across student and client populations were .90

for expertness, .91 for attractiveness and .87 for trustworthiness. These coefficients are higher than those reported for the CRF (LaCrosse & Barak, 1976). A confirmatory factor analysis found that a three-factor oblique model, with separate expertness, attractiveness and trustworthiness dimensions, best fit the data. Factor loadings across dimensions ranged from .72 to .95.

The Personal Attributes Questionnaire

The Personal Attributes Questionnaire (PAQ; Spence, Helmreich, & Stapp, 1974) was used to assess the perceived masculinity (instrumentality) and femininity (expressiveness) of the stimulus therapist. Originally developed as a self-report measure of sex-role, the questionnaire was used in the present study to determine the degree to which the therapist was perceived as possessing masculine and feminine personality traits. Support for this adaptation comes from Gillen (1981) who used a similar instrument, the Bem Sex-Role Inventory (Bem, 1974), to measure self-rated sex-roles and perceived masculinity and femininity of a target individual.

The PAQ was selected as the measure of gender stereotyping for two reasons. First, its items were taken directly from the Sex-Role Stereotype Questionnaire (SRSQ), the measure most frequently cited as addressing the content of gender stereotypes (e.g., Asmore et al., 1986; Ruble &

Ruble, 1982). However, it is shorter and easier to administer than the SRSQ. Second, the instructions given to subjects during the development of the PAQ (i.e., rate a typical or ideal male or female) are similar to those in other studies of gender stereotypes (Sherriffs & McKee, 1957; Williams & Bennett, 1975). This is in contrast to the instructions used in the development of the Bem Sex-Role Inventory (Bem, 1974) which asked subjects to rate the social desirability of a list of traits for American males and females. For these reasons, the PAQ was selected as the measure of choice.

The PAQ consists of 55 five-point bipolar semantic differentials describing personality characteristics (see Appendix H; Spence & Helmreich, 1978). The questionnaire is divided into three scales: Masculinity (M), Femininity (F) and Masculinity-Femininity (M-F). The items in the M scale consist of instrumental traits found to be socially desirable in both sexes, but more characteristic of males. The F scale consists of socially desirable expressive traits found to be more characteristic of females. Items in the M-F scale consist of instrumental and expressive traits found to be more desired for one sex but not the other.

To obtain the original PAQ items, male and female students were asked to rate either the typical or ideal male and female on 138 bipolar personality traits, taken largely

from Rosenkrantz et al. (1986). Fifty-five items which exhibited consistent stereotypes about sex differences were selected to form the PAQ. The items were assigned to one of the three scales on the basis of the ideal ratings. The M scale contains items for which the mean ratings of the ideal male and ideal female fell toward the stereotypic masculine pole. Items which fell toward the stereotypic feminine pole were assigned to the F scale. Items for which the mean ratings of the ideal male fell toward the masculine pole, and the mean ratings of the ideal female fell toward the feminine pole formed the M-F scale.

Research has investigated the reliability and validity of the PAQ. Cronbach alphas (for college students of .85, .82, and .78 for the eight item M, F, and M-F scales, respectively, have been reported (Spence & Helmreich, 1978). Correlations between the short scales and the original scales are, .93, .93, and .91, M, F, and M-F, respectively (Spence & Helmreich, 1978). Factor analysis of the PAQ from several samples has indicated that the M and F scales are unifactorial and the correlation between the two factors is near zero in both sexes (Helmreich, Spence, & Wilhelm, 1981). Research by Spence and Helmreich (1978, 1980) has also demonstrated the predictive validity of the PAQ.

For the present study, three items from the M scale (good at sports, skilled in business, interested in sex) and

one item from the F scale (enjoys art and music) were omitted because of their apparent inappropriateness to the context of the study. The M-F scale was also omitted because of the difficulty in interpretation and its high factor loadings on the M and F scales (Helmreich, Spence, & Wilhelm, 1981). Thus, the modification resulted in a 20 item M scale and a 17 item F scale.

Modified Expectations About Counseling

Two versions of the Expectations About Counseling questionnaire (EAC; Tinsley, 1980) were used in the current study in order to provide a measure of the extent to which the impressions formed of the stimulus therapists reflected those qualities expected in a therapist. One version was administered as a pretest to obtain a measure of subjects' general expectancies regarding characteristics and behaviors attributed to individuals in the role of therapist (see Appendix I). A second version was completed after viewing the videotapes and provided a measure of the impression formed of the stimulus therapist (see Appendix J). All items from the ten scales reflecting expectations of counselor attitudes and behaviors (acceptance, genuineness, confrontation, directiveness, empathy, nurturance, self-disclosure) and characteristics (attractiveness, expertise, tolerance, trustworthiness) were utilized from the EAC. Each scale consisted of three items that were modified to

allow the rating of a target individual or a therapist in general. Each item was presented along a 7-point continuum. Subjects were instructed to indicate the extent to which each item was true for the stimulus therapist, from 1, not true, to 7, definitely true. A difference score was calculated for each subject in the following manner: The absolute difference between a subject's pretest and posttest rating was obtained for each item on the questionnaire. The mean difference was then obtained across all items and finally across all subjects. This resulted in a value indicating the mean amount of change which occurred in subjects' ratings from pretest to posttest. Thus, a larger value indicated less role congruence or less similarity between the stimulus therapist and a therapist in general.

The EAC questionnaire was originally constructed to measure theoretically important expectations a prospective client might have about counseling (Tinsley, 1980). Item analysis of 205 items, obtained from clients, colleagues and theoretical writings reflecting expectations for counseling, was performed to select items with maximum convergent and discriminant validity. Seventeen expectancy scales resulted from the analysis. Reliability coefficients for the scales range from .77 to .89, with a median value of .82 (Tinsley, Workman, & Kass, 1980). Several studies have provided evidence that the questionnaire reflects prospective client

expectations (Hardin & Subich, 1985; Hardin & Yanico, 1983; Sipps & Janeczek, 1986; Subich, 1983; Tinsley & Harris, 1976). While male and female subjects appear to differ in the degree to which certain expectations are held, across all studies ratings exceed the midpoint of the scales, suggesting an agreement on those attitudes, behaviors and characteristics that are appropriate for counselors.

Additional Questions

Several questions were asked in addition to the formal questionnaires (see Appendix K). Subjects were requested to indicate their age, gender, and several other demographic characteristics, as well as their previous contact with therapists or counselors. Questions were also added to assess the subjects' awareness of the nonverbal manipulations in the videotapes. Finally, subjects were asked what they thought it was about the therapists which most influenced their ratings of him or her.

CHAPTER III

RESULTS

Manipulation Checks

One-way analyses of variance were performed on the two manipulation checks (how often did the therapist smile/look at the client) to determine if the subjects' ratings of level of gazing and smiling varied across conditions. A main effect for condition was found on ratings of level of therapist gazing, $F(2, 465) = 16.78, p < .001$. Post hoc analyses indicated that subjects rated therapists in the 100 per cent ($M = 4.50$) and 80 per cent ($M = 4.45$) gaze conditions as looking at the client significantly more often than therapists in the 40 per cent condition ($M = 3.30$). However, subjects did not perceive the therapists in the 100 per cent and 80 per cent conditions as differing in the amount of looking at the client.

Informal content analysis of the open-ended question, regarding subjects' report of variables thought to influence their ratings, was performed to facilitate explanation of this finding. Subjects in the 40 per cent gaze condition were found to be more likely to indicate level of therapist looking as influential in their ratings than subjects in the other conditions. LaFrance and Mayo (1978) and Burgoon

(1983) suggest that nonverbal behavior is so overlearned that individuals fail to be aware of it or its influence unless what occurs disconfirms expectancies as to what is appropriate. Hence, 40 per cent gaze may have appeared inappropriate in this therapy setting and therefore, more salient, increasing the likelihood of accurate approximation. Subjects may have expected high levels of therapist gaze to occur in a therapy setting. Thus, their approximation of gaze in the 100 per cent and 80 per cent conditions would be less accurate due to its lower salience. This manipulation check appeared to serve more as an indication of the extent to which subjects were aware of the gaze manipulation rather than a check on the actual amount of gaze, since careful production of the videotapes resulted in the appropriate amount of gaze for each condition.

For level of therapist smiling, the high and low smiling conditions were rated as significantly different, $F(1, 465) = 109.9, p < .001$. The therapists in the high smiling condition were rated as engaging in a greater amount of smiling ($M = 4.53$) than the therapists in the low smiling condition ($M = 2.96$). Thus, subjects in each condition were able to accurately judge the level of therapist smiling.

The questions regarding specific seven point ratings of the videotapes and therapists were also analyzed. Across conditions, the therapists were perceived as moderately

experienced ($M = 3.55$). The videotape was perceived as moderately believable ($M = 2.60$) and representative of a first interview with a therapist ($M = 3.70$). Analyses of variance were performed on each of these variables with therapist gender, subject gender, level of smiling and level of gaze as independent variables. Main effects were found for gaze, $F(1, 464) = 5.55, p < .004$, and subject gender, $F(1, 464) = 7.50, p < .006$, on how experienced the therapists appeared. Therapists who engaged in 100 per cent gazing were viewed as more experienced ($M = 3.85$) than those who gazed 80 per cent ($M = 3.52$) or 40 per cent ($M = 3.21$) of the time. In addition, the female subjects rated the therapists as more experienced ($M = 3.76$) than the male subjects ($M = 3.32$).

For the believability of the videotapes, significant smile by gaze, $F(2, 465) = 2.96, p < .05$, and smile by subject gender, $F(1, 465) = 4.44, p < .03$, interactions were found. Analysis of simple effects was performed utilizing Newman Keuls procedures. When the therapists engaged in 100 per cent gazing and a high level of smiling, the videotape was perceived as more believable ($M = 2.94$) than when they engaged in 100 per cent gazing and a low level of smiling ($M = 2.59$). However, when the therapists engaged in 80 per cent gazing and a low level of smiling, the videotape was rated as more believable ($M = 2.75$) than when a high level

of smiling was displayed ($\underline{M} = 2.32$). There was no difference in ratings of believability at the 40 per cent level of gaze for high ($\underline{M} = 2.54$) or low smiling ($\underline{M} = 2.42$).

For the smile by subject gender interaction, analyses determined that there was no difference in ratings of videotape believability for male and female subjects when therapists engaged in a high level of smiling ($\underline{M} = 2.67$ and 2.54 , respectively). However, when therapists exhibited a low level of smiling, females perceived the videotape as more believable ($\underline{M} = 2.78$) than did male subjects ($\underline{M} = 2.36$).

For the question "how well did the videotape represent an initial therapy interview," a smile by subject gender interaction was found, $F(1, 464) = 7.43, p < .007$. Post hoc analyses indicated that both male and female subjects perceived the videotape similarly when the therapists engaged in a high level of smiling ($\underline{M} = 4.01$ and 3.66 , respectively). However, when the therapists engaged in a low level of smiling, female subjects perceived the videotape as more representative of therapy ($\underline{M} = 3.77$) than did the male subjects ($\underline{M} = 3.34$). This finding is consistent with the earlier finding on videotape believability.

In summary, the videotapes were rated relatively low in believability, but moderately representative of an initial

therapy interview. Despite the stringent control of extraneous variables, some level of mundane realism was, therefore, retained. The believability of the videotape was affected by the level of gaze and smiling exhibited by the therapist. The combination of 100 per cent gaze and high smiling was rated as most believable, while 80 per cent gaze and high smiling was rated as least believable. The reason for this finding is unclear, but seems to reflect a nonsignificant trend for later gaze by smile interactions. In all cases, 80 per cent gaze and low smiling is rated lower in the specific characteristic than 80 per cent gaze and high smiling. This result reverses for other gaze levels. Therapists were also rated as moderately experienced and perceived experience increased with level of gaze. Finally, it appears that the female subjects were more flexible in how they perceived the videotapes and therapists. They rated the therapists in general as more experienced than the male subjects, and variations in the therapists behavior affected their ratings to a lesser degree.

Subjects' responses to the question "would you go to this therapist for counseling?" were also analyzed. Across conditions, 44 per cent of subjects indicated they would seek therapy from the therapist they viewed, while 56 per cent indicated they would not. Chi-square analyses were

performed on the frequency data for each of the independent variables. A significant chi-square was found for therapist gender $\chi(1) = 11.52, p < .001$. A significantly greater proportion of subjects indicated they would seek help from the female therapist (62%) than from the male therapist (38%). A significant effect was also found for level of gaze, $\chi(2) = 13.77, p < .001$. A greater percentage of subjects indicated they would be likely to seek counseling from the therapist if they viewed the therapist displaying 100 per cent gaze (47%) rather than 80 per cent (29%) or 40 per cent gaze (24%).

The tendency of subjects to indicate they would not seek help from the therapists may reflect variables inherent in the experimental manipulation. Informal content analysis of subjects' comments suggested that decreased control over the therapists' nonverbal behaviors and decreased rigidity would increase the desirability of the therapists as future counselors. The greater likelihood of seeking help from the female therapist suggests that she appeared more natural than the male therapist. High levels of gaze, in contrast, may have increased the desirability of the therapist by increasing perceived experience, as noted in an earlier finding.

To test the possibility that a subject's previous contact with therapists or knowledge of another person's

experience with a therapist influenced the dependent measures, ANOVAs were performed for each dependent measure using previous contact or knowledge as independent variables. For previous therapeutic contact with a therapist, no differences were found for subjects who had seen a therapist versus those who had not on ratings of expertness, $F(1, 463) = .25, p < .64$, attractiveness, $F(1, 463) = .05, p < .83$, trustworthiness, $F(1, 463) = .25, p < .62$, masculinity, $F(1, 465) = 1.02, p < .31$, or femininity, $F(1, 465) = 1.03, p < .31$. However, a significant difference was found on the role congruence score, $F(1, 435) = 5.68, p < .02$. There was a lesser degree of similarity between therapists in general and the stimulus when subjects had had previous contact with a therapist ($M = 1.39$) than when they had not ($M = 1.29$). This finding suggests that subjects with previous therapy experience had different expectations for therapists' behavior or the interview than subjects without prior experience. For the analysis of congruence scores, discussed later, previous contact with a therapist was used as a covariate in the ANOVA analysis.

For subjects' knowledge of someone else's experience with therapy, no significant differences were found on ratings of expertness, $F(1, 463) = 2.61, p < .10$, attractiveness, $F(1, 463) = .40, p < .53$, or

trustworthiness, $F(1, 463) = .40, p < .53$. In addition, significant results were not found for ratings of masculinity, $F(1, 465) = 1.30, p < .26$, femininity, $F(1, 465) = .39, p < .53$, or role congruence, $F(1, 435) = 1.97, p < .16$. Thus, this variable was not utilized as a covariate in subsequent analyses.

Counselor Rating Form

A multiple analysis of variance was performed on the three scales of the Counselor Rating Form, using expertness, attractiveness and trustworthiness as dependent variables and therapist gender, subject gender, gaze and smiling as independent variables. This analysis addressed hypotheses 3, 4, and 5. Significant main effects were found for therapist gender, multivariate $F(3, 438) = 4.27, p < .005$, and level of therapist smiling, multivariate $F(3, 438) = 6.35, p < .001$. In addition, a significant smile by gaze interaction was found, multivariate $F(6, 874) = 2.19, p < .042$.

Univariate ANOVAs were performed to determine which dependent variables were involved in these effects. The main effect for therapist gender involved ratings of expertness, $F(1, 463) = 8.18, p < .004$, attractiveness, $F(1, 463) = 13.25, p < .001$, and trustworthiness, $F(1, 463) = 12.05, p < .001$. Subjects rated the male therapist as less expert ($M = 4.18$), less attractive ($M = 3.68$) and less

trustworthy ($M = 4.35$) than the female therapist ($M = 4.55$, 4.22, and 4.77, respectively).

The main effect for level of smiling involved ratings of attractiveness, $F(1, 463) = 15.37$, $p < .001$. Supporting hypothesis 3, therapists who engaged in a high level of smiling were perceived as more attractive ($M = 4.24$) than those displaying a low level of smiling ($M = 3.67$). Hypothesis 4, predicting a main effect for smiling on trustworthiness was not directly supported.

The smile by gaze interaction involved ratings of expertness, $F(2, 463) = 4.60$, $p < .01$, and trustworthiness, $F(2, 463) = 4.06$, $p < .02$. Newman Keuls procedures were used in all analyses to investigate simple effects. For expertness, across levels of smiling, therapists engaging in 100 per cent gaze and 80 per cent gaze were viewed as significantly more expert ($M = 4.67$ and 4.48, respectively) than those engaging in 40 per cent gaze ($M = 3.90$). Only partial support was found for hypothesis 5. Level of smiling only significantly affected ratings of expertness at the 80 per cent level of gaze, with therapists engaging in a low level of smiling being perceived as more expert ($M = 4.76$) than those engaging in a high level of smiling ($M = 4.23$) (see Figure 1, Appendix M).

For ratings of trustworthiness, across levels of smiling, 80 per cent gaze was perceived as more trustworthy

($\bar{M} = 4.68$) than 40 per cent gaze ($\bar{M} = 4.32$). Gazing 100 per cent of the time was not significantly different in terms of trustworthiness ($\bar{M} = 4.68$) from 80 per cent or 40 per cent gaze. Level of smiling affected ratings of trustworthiness only at the 40 per cent level of gaze, with therapists engaging in a high level of smiling being perceived as more trustworthy ($\bar{M} = 4.60$) than those displaying a low level of smiling ($\bar{M} = 3.99$) (see Figure 2, Appendix M). Thus, at one level of gaze, hypothesis 4 was supported.

Personal Attributes Questionnaire

A second multiple analysis of variance was performed on data from the Personal Attributes Questionnaire, using masculinity and femininity as the dependent variables. Hypotheses 1, 2, 6, and 7 were tested with this analysis. Significant main effects were found for therapist gender, multivariate $F(2, 441) = 18.15, p < .001$, and level of smiling, multivariate $F(2, 441) = 4.88, p < .008$. In addition, significant therapist gender by subject gender, multivariate $F(2, 441) = 8.56, p < .001$, smile by gaze, multivariate $F(4, 880) = 2.52, p < .04$, and therapist gender by smile interactions, $F(2, 441) = 3.29, p < .038$, were found.

Univariate ANOVAs were performed to determine which dependent variables were involved in the effects. Hypothesis 1, stating that the male therapist would be

perceived as more masculine, was not supported. Across other conditions, the male ($M = 3.17$) and female ($M = 3.47$) therapists were not rated significantly different in terms of masculinity. The main effect for therapist gender involved ratings of femininity $F(1, 465) = 12.08, p < .001$, which supported hypothesis 2. The female therapist was rated as more feminine ($M = 3.47$) than the male therapist ($M = 3.28$). The main effect for level of smiling also involved ratings of femininity, $F(1, 465) = 9.01, p < .003$. Therapists who engaged in a high level of smiling were perceived as more feminine ($M = 3.46$) than those engaged in a low level of smiling ($M = 3.30$).

The therapist by smile interaction involved ratings of femininity. Although significant at the multivariate level, the interaction was not significant with univariate analysis, $F(1, 465) = 3.35, p < .068$. The separate main effects have already been discussed. The multivariate interaction may have been significant due to the combined effects of masculinity and femininity in the analysis. Hypothesis 7, predicting a smile by gaze interaction on femininity ratings was not supported.

The remaining interactions involved the masculinity rating. The therapist gender by subject gender interaction was significant for masculinity ratings, $F(1, 465) = 12.55, p < .001$ (see Figure 3, Appendix M). Male and female

subjects rated the male therapist similarly on masculinity ($\bar{M} = 3.20$ and 3.14 , respectively). Male subjects also rated the female therapist ($\bar{M} = 3.33$) as similar to the male therapist. However, female subjects rated the female therapist as significantly more masculine ($\bar{M} = 3.60$) than the male therapist ($\bar{M} = 3.14$). Hence, the highest ratings of masculinity were made by the female subjects for the female therapist.

The smile by gaze interaction also involved ratings of masculinity, $F(2, 465) = 3.16, p < .04$. Across levels of smiling, therapists engaging in 100 per cent gaze were perceived as more masculine ($\bar{M} = 3.45$) than those engaging in 80 per cent ($\bar{M} = 3.32$) or 40 per cent ($\bar{M} = 3.19$). Therapists engaging in 80 per cent gaze were also perceived as significantly more masculine than those displaying a 40 per cent level of gaze. Level of smiling affected masculinity ratings at the 40 per cent level of gaze (see Figure 4, Appendix M). In contrast to hypothesis 6, at 40 per cent gaze therapists displaying a high level of smiling were rated as more masculine ($\bar{M} = 3.29$) than those engaging in low level of smiling ($\bar{M} = 3.07$).

Expectations About Counseling

As a result of prior analyses, an analysis of covariance was used on the role congruence difference scores. Subjects' previous personal exposure or lack of

exposure to a therapist served as the covariate. This analysis addressed hypothesis 8, predicting a main effect for smiling which was not found. ANCOVA indicated a significant subject gender by smile by gaze interaction, $F(2, 435) = 4.11, p < .02$ (see Figure 5, Appendix M). Analysis of simple effects indicated that when the therapists engaged in 40 per cent gaze and a low level of smiling, both male ($M = 1.58$) and female subjects ($M = 1.41$) rated them as less like therapists in general than when engaged in 40 per cent gaze and a high level of smiling ($M = 1.18$ and 1.33 , respectively). When the therapists displayed an 80 per cent level of gaze, neither level of smiling nor subject gender affected how similar they were to a therapist in general. However, they were rated as less similar ($M = 1.39$) than those engaging in 100 per cent gaze ($M = 1.23$). The rating of the therapists engaged in 100 per cent gaze was influenced by level of smiling and subject gender. When displaying 100 per cent gaze and a low level of smiling, male subjects rated the therapists as more similar to a general therapist ($M = 1.14$) than did the female subjects ($M = 1.28$). When engaged in 100 per cent gaze and a high level of smiling, female subjects rated the therapists as more similar to a therapist in general ($M = 1.17$) than did the male subjects ($M = 1.30$).

CHAPTER IV

DISCUSSION

The results of the current study provided full or partial support for five of the eight hypotheses. All independent variables were found to affect ratings of various therapist characteristics. The manipulation of gaze differentially affected ratings of the therapists despite subjects apparent lack of awareness resulting in an inability to differentiate the two high gaze levels. Before discussion of the results, limitations due to the methodology should be addressed. First, like other research on perceptions of therapists (e.g., Fretz et al., 1979; LaCrosse, 1975; Paradise et al., 1986), this study utilized an analogue design employing videotapes of a simulated therapy interview. The use of videotapes was an improvement over earlier research employing photographs, audiotapes or transcripts (Carter, 1978; Cash & Kehr, 1978; Kratz, 1985; Merluzzi et al., 1978). The purpose of the present research was to exert greater control over the independent variables to delineate more precise effects of the manipulations. The presence of several interaction effects suggests that such control allowed the discovery of relationships which may be obscured when variables are not manipulated systematically.

Thus, while the analogue design decreased the ability to generalize the findings to actual therapy settings, it allowed greater experimental control. Research in other contexts has shown that when several confederates try to vary separate nonverbal behaviors, confederate has to be used as a covariate due to differences in enactment (Burgoon, Coker, & Coker, 1986). This has included attempts to vary gaze level. Thus it appears extremely difficult to manipulate behavior in role-playing experiments and may be impossible or inadvisable in an actual therapy context.

Second, the methodology utilized in the study influences the ability to generalize the nonverbal behavior effects to other situations. Level of gaze represented the proportion of time spent looking, which is easily generalized to other situations. However, level of smiling referred to the frequency of smiles within the eight minute videotapes, thus making the effects more dependent on the specification of a time frame. "High" smiling involved smiling approximately 3.5 smiles per minute, while "low" smiling represented about one smile per minute. It is likely that the current results are not limited to these frequency rates. Future research may determine the applicability of the current results to other frequency levels.

Third, the generalizability of the results may be limited to young (24-30 years), moderately attractive therapists, due to the therapists employed in the study. Further research may determine the effects of perceived age on the evaluation of therapist characteristics. Low level of physical attractiveness has been found to decrease ratings of expertness, attractiveness and trustworthiness (Cash & Kehr, 1978). Thus, the present findings may not be applicable to extremely unattractive therapists.

Fourth, it is unclear how the apparent low believability of the videotapes, as perceived by the subjects, affected the obtained results. However, the videotapes were rated as moderately representative of an initial therapy interview. This suggests that something other than the setting or content of the interview accounted for the believability ratings. It is possible that the systematic manipulation of specific therapists' nonverbal behaviors and control of extraneous behaviors decreased the videotapes' believability due to unrealistically rigid therapists. Since the therapists' execution of the nonverbal behaviors was similar across videotapes, differences in ratings between conditions remain valid. However, it is unknown how increasing the believability of the videotapes would affect the dependent variables employed in the current study.

Finally, the utilization of one male and one female therapist limits the strength of the conclusions. This makes it difficult to attribute the obtained effects to gender alone. Some other characteristic varying between the therapists may have accounted for the differences by gender. The pilot study was employed to decrease the possibility that the two therapists varied along two dimensions (warmth and attractiveness) previously found to influence the evaluation of individuals (Asch, 1946; Carter, 1978; Cash & Kehr, 1978). However, differences in enactment of the nonverbal behaviors could have accounted for the ratings or interacted with actual gender effects. Stereotype and counseling research has indicated that gender can be an important variable affecting how males and females are perceived and evaluated (Bloom et al., 1977; Broverman et al., 1972; Carter, 1978; Kunin & Roden, 1982; Merluzzi et al., 1978). In light of this literature, therapist gender is discussed as the variable differentiating the therapists and accounting for the results, although the possibility of a confound is acknowledged.

Effect of Therapist Gender

Hypotheses 1 and 2 involved the effects of therapist gender on ratings of masculinity and femininity. Hypothesis 1, stating that the male therapist would be rated as higher in masculinity-instrumentality than the female therapist,

was not supported. Rather a significant therapist gender by subject gender interaction was found. Males rated the male and female therapist similar in terms of masculinity. Female subjects did not differ from the males in their ratings of the male therapist. However, the females rated the female therapist as more masculine than the male therapist.

Research with the Personal Attributes Questionnaire and other stereotype measures has found that while males and females, in general, are both attributes with masculine traits, males are given higher ratings than females (Ashmore et al., 1986; Spence & Helmreich, 1980). In the present study, both male and female subjects rated the female therapist as more masculine than would be expected based on the sex stereotype literature. It appears that the attributed role of counselor, or some other contextual cue, led to an increase in the perceived masculinity of the female therapist. However, this increase was most dramatic for the female subjects whose rating of the female therapist exceeded that of the male therapist. Perhaps for females, who may be more aware of the obstacles traditionally present for women professionals, the greater attributed masculinity-instrumentality reflected those qualities assumed to be required to successfully pursue a career. Therefore, not only could the females attribute masculine

traits to the female therapist due to her counselor role, but also to her apparently successful engagement in a career.

Hypothesis 2 was supported, with the female therapist rated higher in feminine-expressive traits than the male therapist. This finding is consistent with the research on sex stereotyping (Ashmore et al., 1986; Spence & Helmreich, 1980). This result also suggests that even in the role of therapist, males are perceived as less feminine-expressive than female therapists. Perhaps an additive effect occurred whereby the male therapist was rated as more feminine than males in general, but less so than the female therapist. Thus, the counselor role could have actually increased the male's perceived femininity. This is a possibility given the expectations of clients for therapists to be warm and nurturant (Greenberg & Zeldoro, 1980; Hardin & Yanico, 1983; Subich, 1983).

The ratings of the male and female therapist did not reflect traditional sex stereotyping. While the female therapist was rated as more feminine than the male, the male therapist was not rated as more masculine. The role of therapist appeared to have the effect of increasing the female's masculinity. However, the role of therapist did not overpower the effect of therapist gender, since the two therapists were rated differently.

Therapist gender was also found to affect ratings of expertness, attractiveness and trustworthiness. The female therapist was rated higher in these characteristics than the male therapist. Merluzzi et al. (1978) found that female therapists were rated as more expert than males when both were introduced as experienced, rather than inexperienced therapists. This suggests a relationship between experience level and perceived expertness. A moderate level of experience was attributed to the therapists in the present study, thereby replicating Merluzzi et al.'s results.

The difference in expertness may be due to age differences between the therapists. In the pilot study, the female therapist was rated as two years older than the male. This difference could have been maintained in the present study, where professional clothing was assumed to decrease the perceived age difference. If the female was still perceived as older, this may have resulted in the higher expertness rating. However, both therapists were rated similar in terms of experience level, decreasing the likelihood that age accounted for the results.

The findings regarding expertness were also highly similar to results found for masculinity. The female therapist was rated higher than the male on both attributes. As with the masculinity rating, stereotypic assumptions

regarding a female's required expertise for career success may have increased the expertness ratings.

Less research has focused on the dimension of trustworthiness. Therapist credibility is defined as including expertness and trustworthiness (Strong, 1968; Strong & Matross, 1973). Factor analytic studies have found trustworthiness to be highly correlated with expertness (Barak & LaCrosse, 1975). Thus the higher trustworthiness attributed to the female therapist is consistent with her high perceived expertness.

The finding for attractiveness appears to reflect the high degree of similarity between the adjectives involved in this rating (e.g., sociable, warm) and the feminine stereotype. Thus, the high attractiveness rating for the female therapist is consistent with her high femininity rating. The present result is also similar to recent findings by Marshall and Kratz (1988) who found that a "female psychologist who provides therapy" was rated as more attractive than a male. Note that the attractiveness variable in the present research was conceptually different from the physical attractiveness rating employed in the pilot study, on which the male and female therapist were rated similarly.

In summary, the findings that the female therapist was perceived as more expert, attractive and trustworthy than

the male therapist suggests that being in the role of therapist did not eliminate the effects of gender. However, the effect of role is implied since the result for expertness is not consistent with the stereotypic view of females. These results indicate an interactive effect of role and sex stereotypes on evaluative ratings. This suggests that earlier research by Eagly and Steffen (1984), indicating that preconceptions about one's occupation can overpower sex stereotyping, may be dependent on the particular occupation.

Effect of Nonverbal Behavior

The manipulation of the nonverbal behaviors was found to differentially affect ratings of the therapists' characteristics. Level of smiling affected attractiveness. High smiling was perceived as more attractive than low smiling, thereby supporting hypothesis 3. Counseling researchers manipulating smiling with other responsive behavior report similar findings (Barak et al., 1982; Claiborn, 1979; LaCrosse, 1975). In the current study, therapists who engaged in a high level of smiling were perceived as attractive even when other nonverbal behaviors associated with responsiveness were controlled. Other studies which have manipulated smiling independently have found level or presence of smiling to be associated with increased attractiveness in therapy (Young, 1985) and

nontherapy contexts (Graham & Argyle, 1975; Lau, 1982). Smiling behavior, therefore, appears to be a major factor independently influencing perceptions of attractiveness. Only one other variable in the current study, therapist gender, affected ratings of this specific characteristic. Level of gaze failed to affect perceived attractiveness. Thus, the finding of previous researchers (Claiborn, 1979; LaCrosse, 1975), that responsive nonverbal behaviors (including smiling and high gaze) increase attractiveness ratings, may be due to the effect of smiling rather than the manipulation of gaze or other nonverbal behaviors.

Level of therapist smiling affected ratings of trustworthiness. However, hypothesis 4, proposing that high smiling therapists would be perceived as more trustworthy than those engaged in less smiling, was only partially supported. The interaction found between level of smiling and level of gaze indicated that the proposed effect occurred only with a low (40%) level of gaze. Therapists exhibiting little smiling and gazing were perceived as least trustworthy, while therapists in the other smile and gaze conditions were perceived as relatively similar and more trustworthy. This finding is supported by Claiborn (1979) who reported that male therapists engaged in unresponsive behaviors, including expressionless face and gaze less than 50 per cent of the time, were rated low in trustworthiness.

It appears that individuals in the role of therapist are regarded as relatively trustworthy, as was suggested by Strong (1968), unless they display few behaviors associated with openness or responsiveness. In the present study, the low gaze and low smiling condition was the least responsive condition.

Hypothesis 5 was partially supported by the smiling by gaze interaction for ratings of expertness. Therapists displaying a low level of smiling were rated as more expert when they also engaged in either 100 per cent or 80 per cent rather than 40 per cent gaze. This finding is supported by Barak et al. (1982) who found that a male therapist exhibiting several unresponsive behaviors (e.g., little facial expression and no gestures), but maintaining 70 per cent gaze was rated as more expert than one engaged in responsive behaviors (e.g., high level of smiling).

The therapists rated least expert, overall, were those engaged in a low level of smiling and a low amount of gaze. These behaviors may appear uncharacteristic and unexpected for individuals in the role of counselor, perhaps because they suggest a lack of openness or interest. Thus, the attribution of low expertness to therapists in these conditions, may have reflected the effect of the role they occupied.

Although the hypothesis suggested a concurrent main effect for smiling, a main effect for gaze was obtained. Across levels of smiling, therapists exhibiting greater levels of gaze were regarded as more expert. Actually, smiling had little effect at the highest (100%) and lowest (40%) levels of gaze. However, low smiling increased ratings of expertness at the 80 per cent gaze level. Perhaps the 100 per cent and 40 per cent levels of gaze were extreme enough to suggest relative expertness or lack of expertness, while with a moderate level of gaze, additional cues (i.e., little smiling) were required to affect the attribution.

In summary, ratings of attractiveness appear to be influenced by manipulations in level of smiling, while being resistant to alterations in gaze level. Trustworthiness ratings tend to be relatively stable for individuals in the role of therapist except when behavior associated with inattentiveness or unresponsiveness (e.g., little gaze or smiling) are exhibited. Ratings of expertness, in contrast, appear to be more dependent on level of gaze. At very high or low levels of gaze, level of smiling has little effect, but at a moderate gaze level, smiling increases perceived expertness.

For ratings of masculinity-instrumentality, the level of smiling by level of gaze interaction partially supported

hypothesis 6. Therapists engaging in a low level of smiling were perceived as more masculine when they also displayed higher (100% or 80%) levels of gaze. This finding is consistent with the frequency rates of smiling between the sexes, that is greater frequency among females (Frances, 1979; Ickes & Turner, 1983; Morse, 1982; Pollio & Edgerly, 1976), and a typical interpretation of direct gaze (e.g., dominant, aggressive; Ellsworth et al., 1972). Contrary to the hypothesis, therapists exhibiting more smiling were not rated as low in masculinity compared to those in the low smiling condition. Therapists in all conditions were perceived as relatively similar, in terms of masculinity-instrumentality, except for those in the low smiling and low gaze condition. Thus, therapists engaging in a low level of gaze who also rarely smiled were perceived as low in masculine traits. This combination of behaviors suggests an apparent lack of confidence in one's actions or uninvolved in what is occurring. Related characteristics such as passive, inferior, not ambitious and not outspoken, may be attributed which would lead to the therapist being viewed as low in masculine-instrumental traits.

The interaction of level of smiling and level of gaze on ratings of femininity, proposed in hypothesis 7, was not supported. Rather, a main effect was found for level of smiling. Therapists engaged in more smiling were perceived

as higher in feminine-expressive traits than those exhibiting less smiling. The hypothesis was proposed based on previous research on nonverbal behavior. Smiling is a behavior displayed with greater frequency by females (Frances, 1979; Ickes & Turner, 1983; Morse, 1982; Pollio & Edgerly, 1976). In addition, while females tend to look at others more, their gaze may be less direct than that of males (Henley, 1977). These behaviors are also associated with submissiveness, low status and the traditional feminine role (Henley, 1977). In contrast, less facial expressiveness and higher levels of direct gaze are found for individuals with greater control and status and appear to be associated with traditional masculinity (Henley, 1977). Failure to obtain an interaction suggests that either the dimension of femininity, as measured by the Personal Attributes Questionnaire (PAQ), does not reflect the traditional feminine role dimension of submission-dominance or that the therapists were not perceived as members of the traditional categories of male and female. The former possibility is likely because the PAQ was designed to tap dimensions other than submission-dominance (e.g., sociability). The later explanation is also possible since, at least for the masculinity rating, the therapists were not rated according to traditional or sex stereotypes. Thus, in a therapy context, smiling, rather than level of

gaze, appears to be associated with greater femininity-expressivity.

The effects found in the gaze by smiling interactions on evaluations of masculinity and femininity can be viewed in light of the stereotype literature. Rather than a control dimension, suggested earlier, research on sex stereotypes indicates that the dimensions of masculinity and femininity differ most along the dimension of potency (Ashmore et al., 1986), with masculinity correlated with greater potency. Level of gaze or eye contact also appears to affect ratings of potency or intensity compared to other nonverbal behaviors (Graham & Argyle, 1975). Thus, the current absence of an interaction effect with femininity, but the presence of an interaction for ratings of masculinity supports the conclusion that gazing is more likely to affect ratings of masculinity. In contrast, facial expressiveness and smiling have been associated with the evaluative dimension (Graham & Argyle, 1975). The evaluative component has not been found to differentiate between ratings of masculinity and femininity, and appears to be related to both (Ashmore et al., 1986). Thus, it is more likely that smiling would have an effect on both masculinity and femininity, a conclusion again supported by the current findings.

Finally, hypothesis 8, stating that therapists engaging in a high level of smiling would be perceived as more congruent with the role of therapist than those displaying a low level of smiling was supported only in the presence of little gaze (40%). Thus, the least responsive therapists, those exhibiting the least smiling and gaze, were perceived by both male and female subjects as dissimilar to what they expected of therapists in general. This is consistent with the research on client expectations, which indicates that clients and students expect counselors to be genuine, nurturant and attractive (Hardin & Yanico, 1983; Hardin & Subich, 1985; Subich, 1983). Such attributes would seem to require nonverbal responsiveness on the part of the therapist.

When the therapists engaged in 80 per cent gaze, level of smiling had no effect on perceived similarity to a general therapist. Role congruence scores of therapists engaging in constant gaze (100%) were affected by both level of smiling and subject gender. Therapists who displayed constant gaze and a low level of smiling were viewed by male subjects as more similar to the way in which they viewed therapists in general. For female subjects, therapists engaging in constant gaze and high level of smiling were more similar to what they expected of a general therapist. Thus, females appear to expect more responsive, friendly

behavior from a therapist compared to male subjects. This, also, is consistent with research on client expectations, finding that female clients and subjects, rather than males, are more likely to expect these qualities from therapists (Hardin & Yanico, 1983; Hardin & Subich, 1985; Subich, 1983).

Examining the three-way interaction overall, it appears that male subjects were affected by alterations in therapist behavior to a greater extent than females. Role congruence scores for male subjects indicated greater variability across conditions than the female subjects' scores. Males perceived a moderate level of responsiveness (either high gaze or high smiling) as more congruent with the role of therapist than too much or too little responsiveness. For females, the combination of high gaze and high smiling more closely approximated the level of responsiveness they expected. Thus, these subjects may have been influenced by the absence of responsive behaviors typically accompanying an interaction (e.g., head nodding and gesticulations). This is consistent with research indicating that individuals are more aware of nonverbal behavior if what occurs disconfirms their expectancies.

Conclusions and Implications

Three important conclusions are suggested by the results of the current research. First, the study

underscores the importance of the systematic manipulation of nonverbal behavior. While limiting the ability to generalize to the therapy context, it facilitated the isolation of effects for those behaviors studied. Level of gaze was found to have an overall effect on ratings of expertness, trustworthiness, masculinity, experience level and congruence with the role of therapist. Only one of these ratings, experience level, was not mediated by level of smiling. In addition to its interactive effects, level of smiling affected perceptions of attractiveness and femininity. Several of these effects are consistent with Graham and Argyle's (1975) suggestion that gaze affects ratings of potency and control (i.e., expertness, masculinity and experience level) and smiling affects judgments of liking or evaluation (i.e., attractiveness). Such findings are obscured in research manipulating sets of responsive and unresponsive behaviors. The systematic incorporation of other nonverbal behaviors into the current design could uncover the presence of interactive effects. For example, forward lean, used as a responsive behavior in previous research (Fretz et al., 1979; LaCrosse, 1975), may be perceived as attentive and friendly at one level of gaze, but threatening at another.

A consistent finding in the current study was the negative effect of engaging in a low level of smiling and

gaze. This combination of behaviors was perceived as least expert, trustworthy, masculine and least congruent with the role of therapist. Low smiling alone was perceived as least attractive and feminine. These findings are consistent with research utilizing sets of four or five unresponsive behaviors (Claiborn, 1979; LaCrosse, 1975), and suggests that their results may be due primarily to the effects of smiling and gaze. The negative evaluation of low gaze also supports research in nontherapy contexts (Burgoon et al., 1986). However, since low gaze alone did not consistently lead to the lowest ratings, the current findings indicate the importance of simultaneous manipulation of other nonverbal behaviors (i.e., smiling) to uncover interactive effects.

To facilitate the development of specific impressions, the most legitimate recommendations for the nonverbal behavior of therapists appear limited to use of gaze and smiling. Recall that level of gaze is based on proportion of time, while level of smiling reflects frequency rate. The current suggestions include a "high" level of smiling for the perception of attractiveness and femininity-expressiveness, high to moderate gaze and "high" smiling for trustworthiness, and high to moderate gaze and "high" smiling for expertness. The display of low levels of gaze and smiling appear least likely to lead to impressions

desirable for a therapist and least likely to be perceived as expected therapist behaviors. Future research may determine how resistant these effects are to the concurrent manipulation of other nonverbal behaviors.

Secondly, the results from the manipulation of therapist gender indicate that when forming an impression, both gender and occupation appear to affect how the therapist is perceived. The male and female therapist were rated differently in terms of masculinity, femininity, expertness, attractiveness and trustworthiness. The ratings of femininity and attractiveness were consistent with sex stereotypes, while the other ratings were not. This suggests the influence of the therapist role in impression formation. The absence of a three-way interaction between gaze, smiling and therapist gender on any dependent variable also suggests that for individuals in the role of therapist, gender has little effect on the interpretation of different levels and combinations of gaze and smiling. It is still possible that the existing differences between therapists were the result of an uncontrolled variable associated with the individuals, rather than gender. Determining methods to incorporate more than one therapist of each gender without making the design too cumbersome would address this issue. However, this may be difficult to accomplish while

maintaining the level of experimental control achieved in the current study.

Finally, the present findings support the continued use of subject variables in research on the perception of therapists. Subject gender affected perceived experience level and masculinity-instrumentality. The role congruence results suggest that male and female subjects have different expectations for therapists' behavior, which may be reflected in how they interpret and rate actual behavior. In addition, a subject's previous contact with therapy appears to affect expectations of therapist behavior. Personal experience with a therapist, rather than indirect or no experience, appears to lead to the development of different expectations. Future researchers may consider previous therapy as a useful variable in research on expectations and evaluations of therapists.

The present research found that therapist gender and nonverbal behavior, perceived early in a therapeutic context, influenced the evaluation of the therapists. This occurred for the perception of personality characteristics and judgments of consistency with previously held expectations for therapists. The systematic manipulation of the therapists' behavior allowed greater confidence in determining the effects of specific nonverbal behaviors. This facilitated the suggestion of ways to influence

specific impressions by altering gaze and smile level. Given the tenacity of early impressions and their ability to affect later interactions, such recommendations are useful to affect the development of impressions likely to facilitate the therapeutic process. Future research designs with greater similarity to the therapy context, while sacrificing experimental control, are needed to build on the current study and allow greater application to the therapy situation.

APPENDIX A

Pilot Questionnaire

Pilot Questionnaire

1 2 3 4 5 6 7 8
Not at all Very
attractive attractive

1 2 3 4 5 6 7 8
Warm Cold

How old do you think this therapist is? _____

APPENDIX B

Pilot Study Table

Table 1

Pilot Study: Mean Ratings of Stimulus Therapists

Item	Male	Female
Attractive-not attractive	4.40	4.92
Warm-cold	5.28	4.80
Estimated Age*	24.24	26.08

* $p < .004$.

APPENDIX C

Script

Script

Therapist: Today I'd like to get a better idea of your current problem and answer any questions you may have regarding counseling.

Client: O.K.

Therapist: (Pause) You mentioned on the phone that you've been feeling depressed lately. And this sometimes involves sadness, crying and hopelessness.

Client: Uh huh.

Therapist: I'd like to know what has happened lately that got you to seek therapy at this time.

Client: I don't know really. I always thought my depression would go away. I guess I just got tired of trying to deal with it by myself.

Therapist: I can certainly sympathize with that. Sometimes feelings of depression affect day to day life and sometimes they don't. How do these feelings you've been having affect you on a day to day basis?

Client: Well, I find it difficult to do everything I have to at home and at school. My friends don't understand what's been going on so they've been leaving me alone.

Therapist: Your social life has been affected?

Client: (Pause) Well, yes. Since my friends don't understand, I don't really talk to them very much anymore. And I haven't felt like going out lately.

Therapist: That's often what happens when you're depressed. How has your home life been affected?

Client: Well, since I live alone I'm not really bothering anyone else. But I haven't been keeping the apartment clean. You know, things like laundry and dishes don't get done. I used to be really neat. It's like I don't care about that anymore.

Therapist: Uh huh. (Pause) You mentioned that your school work has also been affected by your feelings.

Client: Yeah. I don't think my grades have been affected yet. It's just that my work seems to take me longer to finish.

Therapist: It's good that your grades aren't suffering, but it sounds like your energy level has been affected.

Client: It really has. I feel like I don't have a lot of energy. Things take so long to accomplish. Sometimes my work seems so overwhelming that I just give up. Then later, I get upset about letting it go so long.

Therapist: It sounds like you almost feel caught in that vicious circle that we all hear about. You try to accomplish something, become frustrated and give up, and that only makes you feel upset later.

Client: Right. And when I get upset, I try hard again. It's all so depressing. I just can't seem to stop it. Sometimes I feel like life is pretty hopeless.

Therapist: You lose hope?

Client: Yeah, I do. When I start feeling like that, nothing gets done--I just stay home and sleep alot.

Therapist: So it's when you give up that you start feeling hopeless.

Client: Right. I guess when I start to feel better, that's when I get upset about having given up. But before that, I just don't care.

Therapist: There's part of that circle again. I'm wondering what point you feel you're at today.

Client: Mm. I'm feeling upset because I let things go so long.

Therapist: O.K.

Client: I guess I just don't want to give up this time. Maybe that's why I decided to see someone for help.

Therapist: You know, you've taken a first step toward stopping the pattern.

Client: Yeah, I guess I have.

Therapist: O.K. We've explored some of the feelings you've been having and how this has been affecting your life.

Later on we'll discuss where these problems may be coming from, but I'm wondering now what you are hoping to get out of therapy. What is it you want to change?

Client: Well, I guess I'd like to figure out why I am so depressed. I'd also like to be less depressed.

Therapist: Uh huh.

Client: You know, even though I'm here, I'm not really sure

that talking with you will help me. Do you think you can help me with my problems?

Therapist: Probably. Basically, the purpose of therapy is to help a person get over emotional difficulties and adjust to life better. By coming to see me today, you've shown a desire to be helped and to work on your problems. Since you want to be helped, therapy may work well for you.

Client: Mm. How does therapy actually work? I don't know too much about it.

Therapist: Well, emotional problems and symptoms of depression can be caused by a number of different things. These can include emotional conflicts, unadaptive learning or even specific situations. In therapy, you are helped to understand your troubles.

Client: But, I don't see how just understanding my problems will help me.

Therapist: Well, it's really just a necessary first step. If we can understand your difficulties, it will help us figure out alternative ways to resolve them.

Client: You know, I've heard about some kinds of therapy, like hypnosis and biofeedback. Will we do these kinds of things?

Therapist: With the information you've given me so far about your difficulties, I'd say no. As a therapist, I know and use alot of different techniques to help people work through their problems. Each person is different.

Sometimes something works well with one person and problem, and isn't as good with another. The techniques we use will be suited to your specific needs and goals.

Client: What am I going to have to do?

Therapist: It will be important for you to feel comfortable talking honestly and openly with me like you've been doing today. It will be your job to do most of the talking. I will be helping you to understand and clarify your experiences and feelings.

Client: But, how will talking help? I've already thought about my problems alot and have talked to my friends.

Therapist: I'm sure you've talked to others. It can really help to talk over problems with friends. Alot of friends will even give us advice. But sometimes, people are so involved with us that it's difficult for them to step back and see alternatives. However, at times an objective observer is useful. Since I'm outside of your life, I'm better able to be objective and provide you with different perspectives. In this way we can see your problems more clearly.

Client: I see what you mean, sometimes my friends aren't very helpful.

Therapist: Well, we'll have a different kind of view here which may help suggest possible solutions to your difficulties.

Client: When we try to solve my problems will I get better pretty fast?

Therapist: Actually, you should expect to have ups and downs during treatment just as you do in everyday life. In therapy, it's important to regard this as part of the process. Try to take the attitude that your symptoms won't just disappear. Occasionally they may reappear. You may learn something important about yourself each time the symptoms come back.

Client: Mm, you know, I've heard that some people are in therapy for years and years. How long do you think it'll take for me?

Therapist: It's really pretty difficult to estimate this ahead of time. The length of therapy is partly determined by the number of aspects of your life you would like to change. The greater the number, the longer therapy may take. The time it takes also depends on the specific problem. If the problems underlying your depression are not too complicated, you may be helped in a short time. On the other hand, if your difficulties have been long-standing and are complex, it may take somewhat longer. In our therapy sessions, we will try to figure out what some of the underlying problems might be.

Client: O.K.

Therapist: Is there anything else that you are immediately concerned about and want to discuss with me today?

Client: No, not really.

Therapist: Then I'd like to fill you in on how we'll proceed for the first couple of sessions. Next time, I'd like to gather some information about your background and your family. Then we'll spend some time attempting to form a goal for treatment; that is we'll try to figure out more exactly what you would like to change through therapy. After that, we'll get started on exploring your difficulties in depth. (Pause) So, we'll set up an appointment for next week and begin our regular sessions. Alright?

Client: Alright.

APPENDIX D

Videotaping Procedures

Videotaping Procedures

The levels of gazing (100%, 80%, 40%) were chosen on the basis of previous research which found these levels to be salient factors affecting impression formation (Fretz et al., 1979; LaCrosse, 1975). The level of gazing reflected the proportion of spoken words during which the therapist gazed at the client. Two-thirds of the words spoken by the therapist were accompanied by gazing. One-third of the words spoken by the client were accompanied by therapist gaze. This proportion was similar to that identified in normal discourse (Brembreck & Howell, 1976). Phrases and natural conversational breaks (e.g., commas, sentence endings) accompanied shifts of gaze. Gaze was broken during the videotapes by the therapist looking down. It was determined that this looked most natural and decreased the perception that the therapist was looking at people behind the camera.

Level of smiling was selected on the basis of experimenter judgment during development of the script. The level of smiling was initially determined by fitting smiles into the text of the script. During training of the therapist, several smiles were moved to more appropriate phrases. High smiling tapes included all smiles regarded appropriate for the script. This resulted in 22 per cent of lines of text (spoken by either therapist or client)

containing a smile by the therapist. Low smiling tapes included one fourth of those smiles used in the high smiling tape. This reflected one smile per page of text. Therefore approximately 6 per cent of lines in the low smiling tape contained a smile by the therapist. These percentages translated to 28 smiles in the high and 7 in the low smiling condition. Care was taken to balance the smiles with the gaze manipulation.

APPENDIX E

Training

Training

Approximately 100 hours, over a four month period, were spent training the stimulus therapists. One problem evident from the beginning, was the possibility of contamination from the nonverbal behavior of stimulus therapists. It is not possible to state definitively that no systematic difference existed in the final videotapes of the two therapists. However, care was taken during training and filming to decrease such differences. For example, early practice sessions determined that the female therapist used a questioning style of intonation, especially apparent at the end of sentences. Simultaneous practice with the male therapist reduced this behavior. Initial training focused on memorization of the script and word emphasis. Later training involved matching the male and female therapist for pacing and tone of voice. This was accomplished by sessions requiring both individuals to verbalize the script simultaneously. Training focused directly on the verbalization of the script occurred prior to the practice of cuing smiles and gazing.

The variation of gazing and smiling was practiced separately and together. Cuing of nonverbal behavior was accomplished through the use of hand signals from behind the camera. Both before and after practice with the mechanics of cuing, the meaning and aesthetic quality of the gazing

and smiling was discussed and changes were made to facilitate the realistic quality of the behaviors. Originally, all extraneous nonverbal behavior was controlled. However, initial filming determined this to produce unrealistic rigidity in the therapist. Therefore, for the final videotapes, slight movements of head and body were allowed. Both therapists were matched for similarity in amount of extraneous movement.

The stimulus client was trained to deliver the script with similar tone, emphasis and pacing across videotapes. Amount of head movements and hair style was also controlled across tapes. All videotapes utilized a fade-in and fade-out style of presentation. Across conditions, videotape length was 8:23 to 8:28 for the female and 8:23 to 8:28 for the male therapist.

APPENDIX F

Informed Consent Form

Informed Consent Form

Your part in this research is quite simple. After everyone has arrived the person who gave you this form will go over the description of the research to make sure you understand what is expected of you. You will then watch a videotape. Afterwards, you will be asked to individually fill out some questionnaires.

After your part in the research is over, you will learn more about it and will have the opportunity to ask questions. You will be given two points of extra credit for your participation.

You are free to withdraw from the research at any time and for any reason. No negative sanctions will accrue to you if you withdraw. Due to our research questions, there are no alternative procedures that would be more advantageous to you.

Name (print) _____

ID # _____

I have read and understand the informed consent form.
My signature below is indication of my understanding.

Signed, _____

APPENDIX G

Questionnaire 1

Questionnaire 1

In this questionnaire, you are asked to give your impression of the therapist you just watched. Circle the number on each scale that most closely indicates your impression. For example:

fair						
1	2	3	4	5	6	7
somewhat						very

If you felt that the therapist was somewhat fair, you would circle number 1. If you felt that the therapist was very fair, you would circle number 7.

Work as quickly as you can without looking back and orth through your answers. Your first impression is the best answer.

friendly						
1	2	3	4	5	6	7
somewhat						very

experienced						
1	2	3	4	5	6	7
somewhat						very

honest						
1	2	3	4	5	6	7
somewhat						very

likeable						
1	2	3	4	5	6	7
somewhat						very

			expert			
1	2	3	4	5	6	7
somewhat						very

			reliable			
1	2	3	4	5	6	7
somewhat						very

			sociable			
1	2	3	4	5	6	7
somewhat						very

			prepared			
1	2	3	4	5	6	7
somewhat						very

			sincere			
1	2	3	4	5	6	7
somewhat						very

			warm			
1	2	3	4	5	6	7
somewhat						very

			skillful			
1	2	3	4	5	6	7
somewhat						very

			trustworthy			
1	2	3	4	5	6	7
somewhat						very

APPENDIX H

Questionnaire 2

Questionnaire 2

Instructions: In this questionnaire, you are asked to indicate what kind of person you think the therapist is. Each scale consists of a pair of characteristics. You are to circle the number which describes where the therapist falls on each scale.

For example:

1	2	3	4	5
not at all artistic				very artistic

If you think the therapist has no artistic ability, you would choose number 1; if you think the therapist is pretty talented artistically you would choose number 5.

Now, go ahead and complete the questionnaire. Remember to circle the appropriate number.

1	2	3	4	5
not at all excitable in a minor crisis				very excitable in a minor crisis

1	2	3	4	5
very independent				not at all independent

1	2	3	4	5
not at all emotional				very emotional

1	2	3	4	5
very passive				very active

1 not at all able to devote self completely to others	2	3	4	5 able to devote self completely to others
1 very rough	2	3	4	5 very gentle
1 not at all helpful to others	2	3	4	5 very helpful to others
1 very competitive	2	3	4	5 not at all competitive
1 not at all kind	2	3	4	5 very kind
1 not at all aware of feelings of others	2	3	4	5 very aware of feelings of others
1 can make decisions easily	2	3	4	5 has difficulty making decisions
1 gives up very easily	2	3	4	5 does not give up easily
1 not at all self-confident	2	3	4	5 very self-confident
1 feels very inferior	2	3	4	5 feels very superior
1 not at all understanding of others	2	3	4	5 very understanding of others

1 very cold in relations with others	2	3	4	5 very warm in relations with others
1 goes to pieces under pressure	2	3	4	5 stands up well under pressure
1 not easily influenced	2	3	4	5 very easily influenced
1 does not hide emotions	2	3	4	5 hides emotions
1 does not know the ways of the world	2	3	4	5 knows the ways of the world
1 not considerate	2	3	4	5 considerate
1 adventurous	2	3	4	5 not adventurous
1 not grateful	2	3	4	5 grateful
1 not outspoken	2	3	4	5 outspoken
1 tactful	2	3	4	5 not at all tactful
1 outgoing	2	3	4	5 not at all outgoing
1 does not have a strong conscience	2	3	4	5 has a strong conscience

1 intellectual	2	3	4	5 not intellectual
1 not at all neat	2	3	4	5 neat
1 does not act as a leader	2	3	4	5 acts as a leader
1 creative	2	3	4	5 not at all creative
1 takes a stand	2	3	4	5 does not take a stand
1 not at all ambitious	2	3	4	5 ambitious
1 forward	2	3	4	5 not at all forward
1 does not like children	2	3	4	5 likes children
1 not timid	2	3	4	5 timid
1 does not express tender feelings	2	3	4	5 expresses tender feelings

APPENDIX I

Pretest

Pretest

Instructions: For each item below, indicate the extent to which you believe each item is true for therapists (i.e., individuals who provide therapy). Circle the appropriate number.

Use the following scale:

1	2	3	4	5	6	7
not true	slightly true	somewhat true	fairly true	quite true	very true	definitely true

Therapists tell clients what to do

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Therapists explain what is wrong to clients

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Therapists are liked by their clients

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Therapists know how clients feel even when they cannot say quite what they mean

1	2	3	4	5	6	7
---	---	---	---	---	---	---

The clients therapists see enjoy their interviews with the therapists

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Therapists give encouragement and reassurance

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Therapists help clients know how they are feeling by putting their feelings into words for them

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Therapists are "real" people, not just people doing a job

1	2	3	4	5	6	7
---	---	---	---	---	---	---

The clients therapists see enjoy being with the therapists

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Therapists inspire confidence and trust

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Therapists frequently offer clients advice	1	2	3	4	5	6	7
Therapists are honest with clients	1	2	3	4	5	6	7
Therapists are people who can be counted on	1	2	3	4	5	6	7
Therapists are warm and friendly toward clients	1	2	3	4	5	6	7
Therapists help clients solve their problems	1	2	3	4	5	6	7
Therapists discuss personal attitudes and relate them to clients' problems	1	2	3	4	5	6	7
Therapists give clients support	1	2	3	4	5	6	7
Therapists decide what treatment plan is best	1	2	3	4	5	6	7
Therapists know how clients feel at times, without them having to speak	1	2	3	4	5	6	7
Therapists respect clients as people	1	2	3	4	5	6	7
Therapists discuss personal experiences and relate them to clients' problems	1	2	3	4	5	6	7
Therapists praise clients when they show improvement	1	2	3	4	5	6	7
Therapists make clients face up to the differences between what they say and how they behave	1	2	3	4	5	6	7
Therapists freely self-disclose	1	2	3	4	5	6	7
Therapists have no problem getting along with people	1	2	3	4	5	6	7
Therapists like clients	1	2	3	4	5	6	7

Therapists are people clients can really trust

1 2 3 4 5 6 7

Therapists like clients in spite of the bad things they know about them

1 2 3 4 5 6 7

Therapists make clients face up to differences between how they see themselves and how they are seen by others

1 2 3 4 5 6 7

Therapists are calm and easygoing

1 2 3 4 5 6 7

Therapists point out to clients the differences between what they are and what they want to be

1 2 3 4 5 6 7

Therapists get along well in the world

1 2 3 4 5 6 7

APPENDIX J

Questionnaire 3

Questionnaire 3

Instructions: In this questionnaire you are to indicate the extent to which you believe each item is true for the therapist in the videotape.

Use the following scale:

1	2	3	4	5	6	7
not true	slightly true	somewhat true	fairly true	quite true	very true	definitely true

This therapist tells clients what to do
 1 2 3 4 5 6 7

This therapist will explain what is wrong
 1 2 3 4 5 6 7

The clients this therapist sees like the therapist
 1 2 3 4 5 6 7

This therapist knows how clients feel even when they cannot say quite what they mean
 1 2 3 4 5 6 7

This therapist knows how to help clients
 1 2 3 4 5 6 7

The clients this therapist sees enjoy their interviews with the therapist
 1 2 3 4 5 6 7

This therapist gives encouragement and reassurance
 1 2 3 4 5 6 7

This therapist helps clients know how they are feeling by putting their feelings into words for them
 1 2 3 4 5 6 7

This therapist is a "real" person not just a person doing a job
 1 2 3 4 5 6 7

The clients this therapist sees enjoy being with the therapist	1	2	3	4	5	6	7
This therapist inspires confidence and trust	1	2	3	4	5	6	7
This therapist frequently offers clients advice	1	2	3	4	5	6	7
This therapist is honest with clients	1	2	3	4	5	6	7
This therapist is someone who can be counted on	1	2	3	4	5	6	7
This therapist is warm and friendly toward clients	1	2	3	4	5	6	7
This therapist helps clients solve their problems	1	2	3	4	5	6	7
This therapist discusses personal attitudes and relates them to clients' problems	1	2	3	4	5	6	7
This therapist gives clients support	1	2	3	4	5	6	7
This therapist decides what treatment plan is best	1	2	3	4	5	6	7
This therapist knows how clients feel at times, without them having to speak	1	2	3	4	5	6	7
This therapist respects clients as people	1	2	3	4	5	6	7
This therapist discusses personal experiences and relates them to clients' problems	1	2	3	4	5	6	7
This therapist praises clients when they show improvement	1	2	3	4	5	6	7
This therapist makes clients face up to the differences between what they say and how they behave	1	2	3	4	5	6	7
This therapist freely self-discloses	1	2	3	4	5	6	7

This therapist has no problem getting along with people
1 2 3 4 5 6 7

This therapist likes clients
1 2 3 4 5 6 7

This therapist is someone clients can really trust
1 2 3 4 5 6 7

This therapist likes clients in spite of the bad things the
therapist knows about them
1 2 3 4 5 6 7

This therapist makes clients face up to differences between
how they see themselves and how they are seen by others
1 2 3 4 5 6 7

This therapist is someone who is calm and easygoing
1 2 3 4 5 6 7

This therapist points out to clients the differences between
what they are and what they want to be
1 2 3 4 5 6 7

This therapist gets along well in the world
1 2 3 4 5 6 7

APPENDIX K

Questionnaire 4

Questionnaire 4

Please answer the following:

_____ Last four numbers of your student ID number

_____ Gender, put '1' if male, '2' if female

_____ Age (in years)

_____ Is English your first language?

'1' if yes, '2' if no

_____ Were you born in the United States?

'1' if yes, '2' if no

_____ What is your major?

1. Social Science (e.g., history, psychology, government)
2. Math or Science (e.g., chemistry, biology)
3. Education
4. Fine or applied arts (e.g., art, music, drama)
5. Other Liberal arts (e.g., English, philosophy)
6. Business
7. Other (please specify) _____

_____ Have you ever been to a therapist or counselor?

'1' if yes, '2' if no

_____ Do you know anyone who has been to a therapist or counselor? '1' if yes, '2' if no

_____ Would you go to this therapist for counseling?

'1' if yes, '2' if no

What about the therapist do you think most affected your ratings on the questionnaires? (Please write below)

Please answer the following questions:

How much counseling experience do you think this therapist has had?

1	2	3	4	5	6	7
very little experience						alot of experience

How believable was the videotape?

1	2	3	4	5	6	7
not at all believable						very believable

How well does the videotape represent a typical first interview with a therapist?

1	2	3	4	5	6	7
poor representation						good representation

How often do you think the therapist smiled?

1	2	3	4	5	6	7
not at all						frequently

How often do you think the therapist looked at the client?

1	2	3	4	5	6	7
not at all						all the time

How often do you think the therapist gestured?

1	2	3	4	5	6	7
not at all						frequently

How relaxed did the therapist look?

1	2	3	4	5	6	7
not at all relaxed						very relaxed

APPENDIX L

Experimenter Instructions

Experimenter Instructions

Make sure everyone is seated at least one chair apart.

- 1) Pass out the Informed Consent forms. Say: "Before we begin I'd like you to fill out the following forms. These forms just indicate that you voluntarily participated in this experiment."
- 2) Collect Informed Consent forms. Pass out the pretest saying "First, I'd like you to complete the following questionnaire. Read the instructions and begin." Then collect the completed forms.
- 3) Say: "Now you will be viewing a brief interview between a therapist and a client. Afterwards you will be asked to record you impressions on some questionnaires."
- 4) Start the videotape.
- 5) After the videotape is finished, pass out the other questionnaires. Say: "At the top left corner of the first questionnaire, put a ____, a ____, and a ____ (will be the number of the condition). Now fill out each questionnaire. Please complete them in the order you found them. When you're finished, raise your hand and I will collect them."
- 6) Collect the questionnaires and say "Please stay seated while one of the researchers tells you a little more about the experiment."
- 7) Experimenter leaves to wait for the next group of subject. Researcher enters, debriefs.

APPENDIX M

Figures

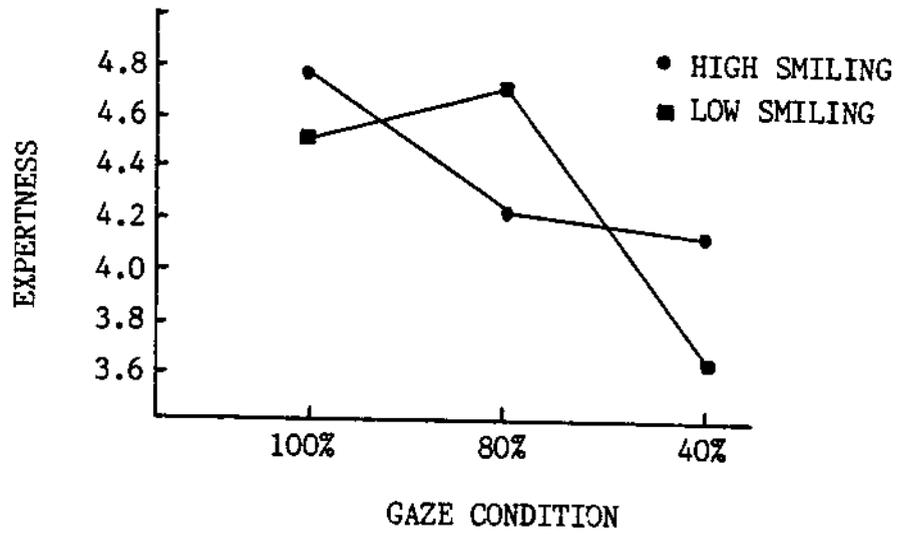


Figure 1. Graphic representation of two-way gaze by smiling interaction for expertness scores.

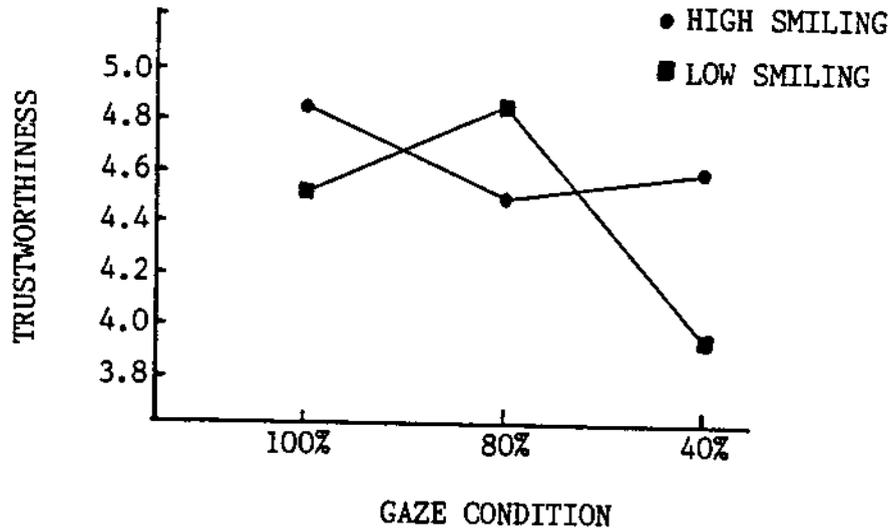


Figure 2. Graphic representation of two-way gaze by smiling interaction for trustworthiness scores.

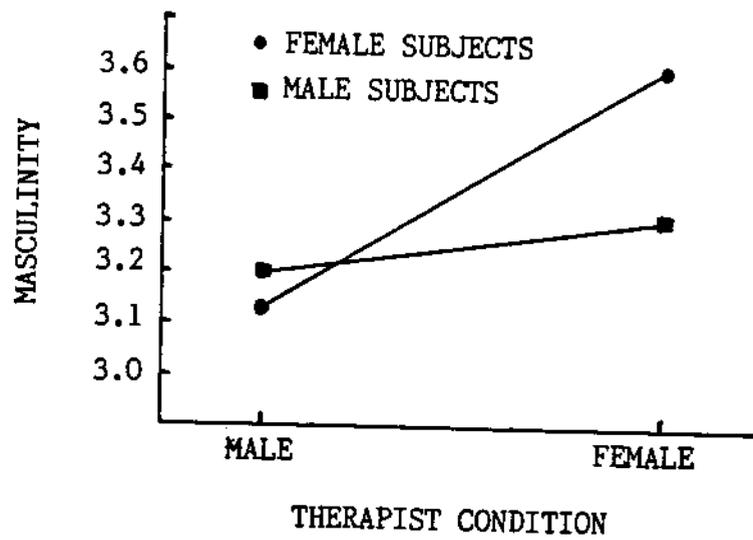


Figure 3. Graphic representation of two-way therapist by subject sex interaction for masculinity scores.

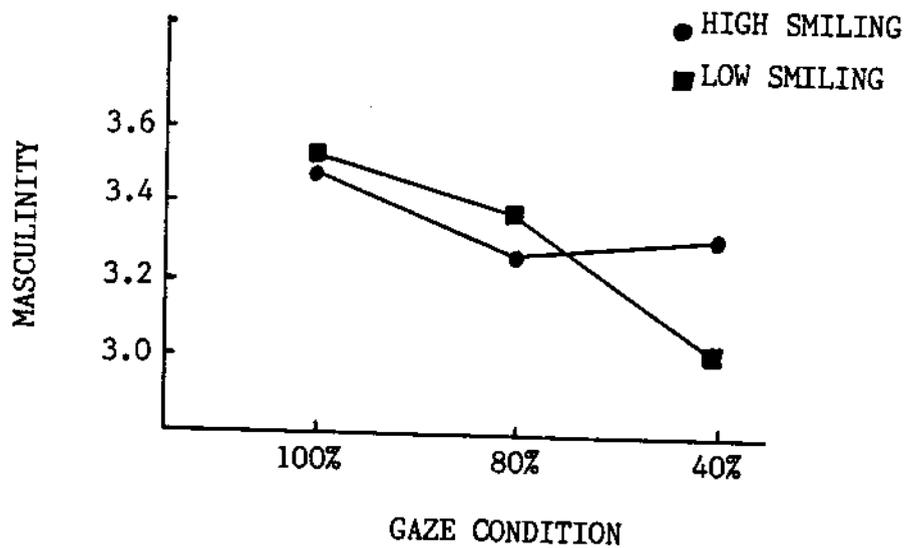


Figure 4. Graphic representation of two-way gaze by smiling interaction for masculinity scores.

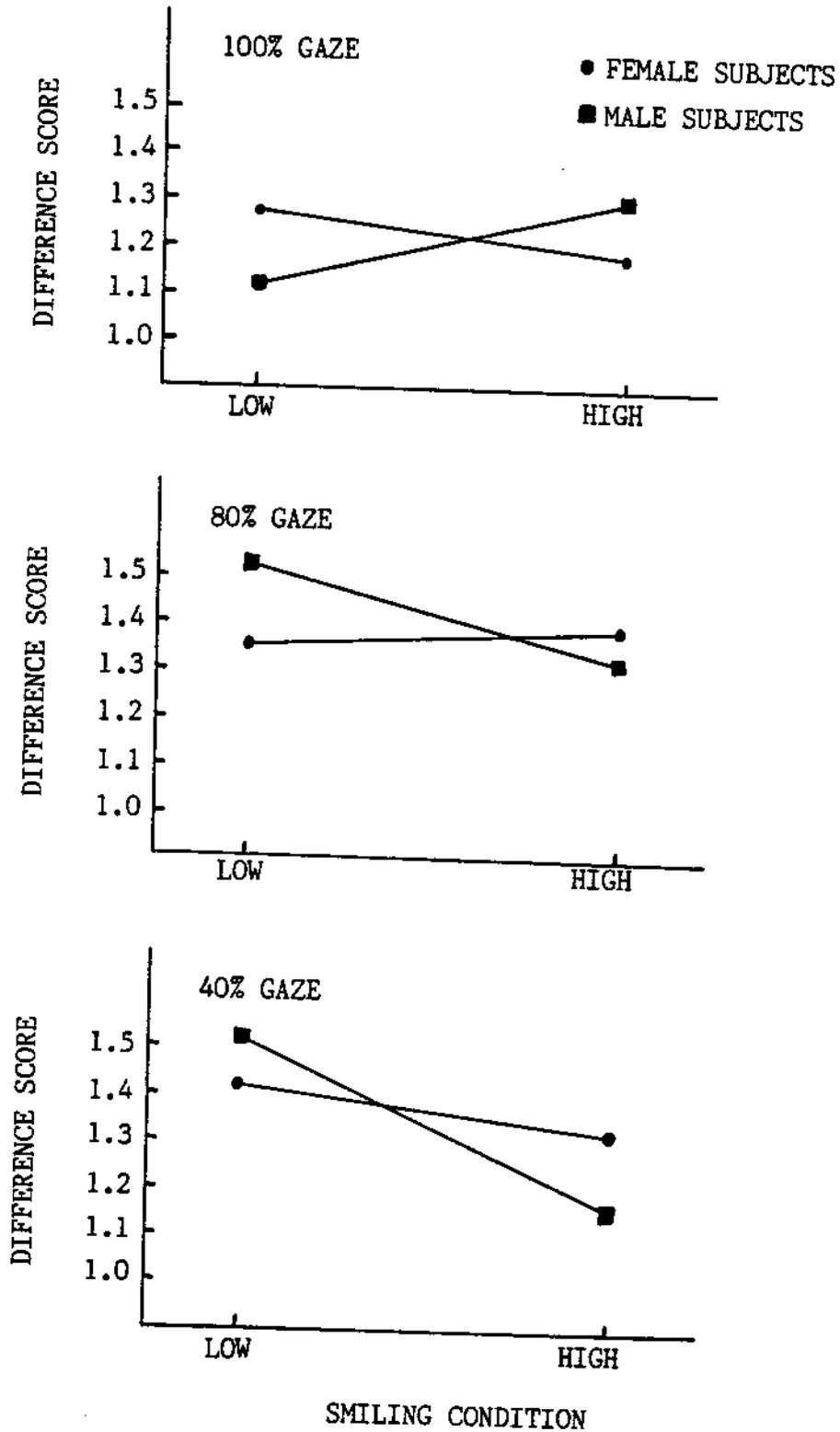


Figure 5. Graphic representation of three-way subject sex by gaze by smiling interaction for role congruence scores.

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