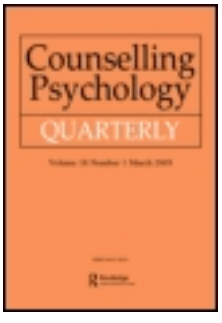

Counselling Psychology Quarterly
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/ccpq20

Gender role and empathy within different orientations of counselling psychology

Itai Ivtzan [a], Emily Redman [b] & Hannah E. Gardner [b]

[a] Department of Psychology, University East London, London, UK

[b] Department of Psychology, UCL (University College London), London, UK

Version of record first published: 23 Aug 2012

To cite this article: Itai Ivtzan, Emily Redman & Hannah E. Gardner (2012): Gender role and empathy within different orientations of counselling psychology, Counselling Psychology Quarterly, DOI:10.1080/09515070.2012.711520

To link to this article: http://dx.doi.org/10.1080/09515070.2012.711520

Counselling Psychology Quarterly
2012, 1–12, iFirst

RESEARCH REPORT

Gender role and empathy within different orientations of counselling psychology

Itai Ivtzan[a]*, Emily Redman[b] and Hannah E. Gardner[b]

[a]*Department of Psychology, University East London, London, UK;* [b]*Department of Psychology, UCL (University College London), London, UK*

(*Received 3 March 2012; final version received 7 July 2012*)

Person-centred and cognitive-behavioural therapies are two divergent theoretical orientations and students of each may offer systematically different personality traits. In this study, potential variations in empathy and gender roles between postgraduate student groups (person-centred, cognitive-behavioural and social sciences) were examined. Seventy participants from UK educational institutions completed the Bem Sex-Role Inventory and two subscales of Davis' Interpersonal Reactivity Index. Results revealed that the person-centred group had higher empathic concern, and more individuals classified as androgynous, while the cognitive-behavioural group scored higher on perspective taking. Empathy was strongly associated with femininity, regardless of the group or gender. Knowledge of how trainee therapists differ across orientations could potentially be of use in improving the working alliance, as clients could be better matched to therapists according to their personal need.

Keywords: gender role; empathy; counselling psychology; person-centred; cognitive behavioural therapy

Counselling and psychotherapy are designed to produce constructive behavioural and personality change (Truax & Carkhuff, 2007). There are multiple counselling styles relying on different theoretical bases. These can vary considerably from one to another in the means, and even aims, of the therapy. The style that trainee counsellors are drawn to depends on a number of factors, including their own personality (Sumari, Mohamad, & Ping, 2009), philosophical assumptions and interpersonal style (Murdock, Banta, Stromseth, Viene, & Brown, 2009). In order for successful intervention, counsellor characteristics (Corey, 2004) and counsellor styles (Howard, Nance, & Myers, 1986) have to be taken into account. Thus, for consistent, effective clinical treatment, the counsellors' personality must be taken into account.

Counsellors can practise a number of different therapeutic orientations, and the humanistic and cognitive-behavioural orientations are two particularly divergent examples.

*Corresponding author. Email: itaiivtzan@awarenessisfreedom.com

ISSN 0951–5070 print/ISSN 1469–3674 online

http://dx.doi.org/10.1080/09515070.2012.711520
http://www.tandfonline.com

Person-centred therapy (PCT) is a therapy style based upon humanistic theory. Here the therapeutic relationship fundamentally relies on the therapist being congruent, accepting and empathic towards the client, in addition to experiencing unconditional positive regard for them (Casemore, 2011; Rogers, 1957). Cognitive-behavioural therapy (CBT) differs in that its aims are to help people identify and change their thinking (i.e. cognitions) and behaviour. Socratic questioning, where the therapist questions the client in a systematic and analytical way, is one of the key methods used in this type of therapy (e.g. Beck, Rush, Shaw, & Emery, 1979) which suggests a qualitatively different approach from person-centred therapy.

The focus on rationality and purpose-driven methods in cognitive-behavioural therapy contrasts with humanistic operating values, which are centred on an individual's emotional and interpersonal needs. The differences in these orientations could conceivably be reflected in the counsellors' personality and/or empathy levels. However, cognitive behavioural therapy is not, strictly speaking devoid of empathy. It is recognized that cognitive behavioural therapists also appreciate the significance of the core conditions for therapeutic progress and build on their use in therapy, including empathy.

Within the wider field of psychology, systematic variations in empathy by subfield have been reported. In self-reported measures of empathy, psychology practitioners displayed higher levels of empathic concern and perspective taking (two subscales of the Interpersonal Reactivity Index for measuring empathy; Davis, 1980) than experimental psychologists (Hall, Davis, & Connelly, 2000). Such variations in empathy may systematically occur in the different subfields of counselling psychology, as well as between practitioners and experimental psychologists, and individual therapists. Since there seems to be a greater emphasis on therapist empathy in the humanistic orientation, one might find that trainees or practitioners of it report higher levels of empathy than those orientated towards the cognitive-behavioural approach.

The styles involved in these counselling orientations could also relate to masculine and feminine personality traits. Feltham (2010) argued that women are more naturally intuitive and emotionally responsive – traits which are, according to him, crucial for some types of counselling. Due to the emphasis on emotional skills he argues that women may be more inclined to opt for humanistic and psychodynamic, rather than cognitive-behavioural, approaches. However, the present study proposes that femininity, rather than gender, drives the choice of a person-centred approach. Using the Bem (1974) Sex-Role Inventory (BSRI) one can measure masculine and feminine traits, or whether they are both endorsed simultaneously (known as androgyny), on independent scales. As stated above, person-centred therapy has a greater emphasis on empathy and acceptance, and these traits can be associated with some stereotypically feminine attributes; on the BSRI, these include "sympathy," "compassion" and "understanding." In addition, many studies have found femininity to be associated with higher empathy scores (Eisenberg et al., 1988; Karniol, Gabay, Ochion, & Harari, 1998). Thus if the hypothesis is to be supported, one would also expect higher femininity scores in individuals orientated towards the person-centred approach. If these individuals report higher empathy levels but not higher femininity, this can imply that they do not actually feel this way, but only perceive themselves to do so because of the requirements of their therapy training.

The cognitive-behavioural approach, with its emphasis on analysing thinking and behaviour, represents a more masculine approach. Instrumentality and

expressiveness (Bem, 1974; Helmreich, Spence, & Wilhelm, 1981) are often represented as masculine and feminine traits respectively (although are not necessarily mutually exclusive, hence the concept of androgyny). Instrumental methods are regarded as central to cognitive-behavioural therapy (Kubacki & Chase, 1998), and although the term "instrumental" in this context has a different definition (involving "mastery, success and control"); the two definitions are related, with instrumentality on the BSRI denoted by assertiveness and self-reliance. Individuals from this therapeutic orientation may therefore embody "instrumentality," or masculinity, in their personal attributes as well as in therapeutic practice.

The evidence therefore suggests that out of the two orientations, the humanistic is more likely to display femininity and cognitive-behavioural, masculinity. Men based in the humanistic approach may have higher levels of androgyny or femininity than those in the cognitive-behavioural orientation. Conversely, women studying the cognitive-behavioural approach may have higher levels of androgyny or masculinity than females in the humanistic approach.

As stated above, a number of studies reveal that femininity, rather than gender, predicts empathy levels. It is expected that this study will reveal the same pattern, regardless of group membership. If this is not the case, it may imply that self-reported empathy levels are related to stereotypical expectations of sex roles (i.e. that women have higher empathy), rather than femininity itself.

As there is only limited research that has explored if and how therapists' traits differ according to theoretical orientation, this study will investigate whether there are any notable personality traits between individuals orientated towards person-centred and cognitive-behavioural therapy, with specific emphasis on empathy and gender roles. The study aims to understand the traits of people who are attracted to different subtypes of counselling psychology, and thus help clarify how therapy and the client-therapist alliance may differ across orientations. It may also predict how well suited clients are to particular therapy types, with respect to their own personalities and needs, in order to maximise the quality of the working alliance.

In order to investigate these issues, the perspective-taking and empathic concern subscales of Davis' (1980) Interpersonal Reactivity Index (IRI) and Bem's (1974) BSRI were used. Students training for postgraduate qualifications in the relevant counselling orientations were regarded as more suitable participants than practising therapists. Trainees on a course focused specifically on one therapeutic orientation are likely to embody the values of that orientation. In contrast, and as stated in a review on NHS psychotherapy services (Department of Health, 1996), therapists, despite primarily practising one orientation, may also practise "eclectic" therapy (i.e. drawing upon various therapeutic orientations based upon a client's individual case). The control group was comprised of postgraduate students from a variety of social science courses (other than psychology), so that differences could be interpreted as distinctions between the two counselling orientations, or as characteristic of counselling students in general.

It was predicted that participants in the person-centred group would score higher on self-reported empathy than those in the cognitive-behavioural and control groups. Secondly, men in the person-centred group were expected to score higher on femininity/androgyny than men in the cognitive-behavioural and control groups. Women in the cognitive-behavioural group were predicted to score higher on masculinity/androgyny than women in the person-centred and control groups.

Finally, it was expected that for all participants, femininity scores would be positively associated with empathy scores.

Method

Participants

Participants for this study were recruited from postgraduate courses in the UK (which focused exclusively either on person-centred therapy or cognitive-behavioural therapy) and other postgraduate courses in the social sciences (for the control group). Participants were approached through course administrators and were recruited on a voluntary basis, via email, or in person at the institution. 70 participants took part altogether; there were 48 women (mean age = 36.01, SD = 10.40, range 22–64 years) and 22 men (mean age = 33.85, SD = 11.70, 21–63 years) who participated, with an overall mean age of 35.33 (SD = 10.78, 21–64 years). In the three groups, there were 31 in the person-centred group (F = 38, M = 26), 21 in the cognitive-behavioural group (F = 31, M = 24) and 18 in the control group (F = 29, M = 22). Participants' highest previous qualifications were also recorded; 60.0% had a BSc/BA, 22.9% had an MSc/MA, 5.7% had a PhD/doctorate and the remaining 11.4% had other qualifications (e.g. diploma).

Measures

The BSRI (Bem, 1974) consists of 60 adjectives, separated equally as masculine, feminine and neutral. Each is individually rated on a 7-point scale, from 1 (never true) to 7 (always true). Bem (1974) reported reasonably high internal consistency (Masculinity alpha = 0.86, Femininity alpha = 0.82). The test-retest reliability was also high, when 28 females and 28 males were tested four weeks apart (Masculinity $r = 0.90$, Femininity $r = 0.90$, Androgyny $r = 0.93$). Although due to societal changes since the 1970s the validity of the BSRI has been questioned, it has subsequently been verified by Holt and Ellis (1998), who replicated the original study and found comparable internal consistency (Masculinity alpha = 0.95, Femininity alpha = 0.92). In the present study the masculinity and femininity scores were the sums of scores from their respective sets of items. In addition, participants were classified as feminine if they were above the sample median in femininity and below the sample median in masculinity, masculine if they were above the median in masculinity and below the median in femininity, androgynous if they were above the median on both scales and undifferentiated if below the median on both scales.

Two of the four scales from the Interpersonal Reactivity Index (IRI: Davis, 1980) were used to measure the construct of empathy. Both scales (perspective taking and empathic concern) comprise of 7 items, to which responses were given on a 5-point Likert-type scale, ranging from 1 (does not describe me at all) to 5 (describes me very well). The items were sentences aimed to tap the sub-constructs of empathy. An example from the empathic concern scale was "I often have tender, concerned feelings for people less fortunate than me" and from the perspective taking scale, "I try to look at everybody's side of a disagreement before I make a decision." Davis (1980) reported satisfactory internal consistency for the empathic concern scale (Males: alpha = 0.68, Females: alpha = 0.73), and for the perspective taking scale (Males: alpha = 0.71, Females: alpha = 0.75). Satisfactory test-retest reliabilities

were also reported, with intervals of 60–75 days between tests (Empathic concern: Males $r = 0.72$, Females $r = 0.70$; Perspective taking: Males $r = 0.61$, Females $r = 0.62$). The responses were summed to get the scores for each scale, plus an overall score for both scales. There was a moderate correlation between the empathic concern and perspective taking subscales ($r = 0.37$), verifying that they measure related constructs, but that they are not redundant.

Procedure

Students who volunteered to take part were asked to fill in a questionnaire which included basic profiling (age, gender, highest previous qualification and current course), the BSRI and the two subscales of the IRI. These were returned either by post, email or in person. The demographics came first in all of the questionnaires and the order of the scales was counterbalanced so that in half the questionnaires the BSRI was first and in the other half the IRI.

Results

The results from the IRI subscales were analysed – in relation to the three groups of students – to examine whether participants in the person-centred group revealed higher levels of empathy than those in the cognitive-behavioural and control groups. The mean and standard deviation for the empathy scores are shown in Table 1 below.

A 2×3 ANOVA, using the total empathy scores, was performed to see whether the group or gender had an effect or whether there was an interaction between the two. The ANOVA revealed that the most notable effect was of the course group: $F(2, 64) = 3.76$, $p < 0.03$, suggesting that there are differences in total empathy scores

Table 1. Mean and standard deviation for empathy scores.

		Empathic concern		Perspective taking		Empathy total	
		Mean	SD	Mean	SD	Mean	SD
Person-centred	Female	21.86	2.26	20.38	2.92	42.24	3.82
	Male	21.80	2.82	19.40	3.41	41.20	5.77
	Total	21.84	2.41	20.06	3.07	41.90	4.47
Cognitive-behavioural	Female	19.76	3.47	19.18	4.35	38.94	6.43
	Male	18.75	3.30	24.75	2.06	43.50	3.11
	Total	19.57	3.38	20.24	4.56	39.81	6.15
Control	Female	20.10	4.58	17.90	4.23	38.00	8.08
	Male	19.13	4.16	16.63	5.26	35.75	7.98
	Total	19.67	4.30	17.33	4.61	37.00	7.88
All groups	Female	20.75	3.36	19.44	3.80	40.19	6.02
	Male	20.27	3.57	19.36	4.82	39.64	6.83
	Overall total	20.60	3.41	19.41	4.11	40.01	6.24

between the three. There was no notable impact of gender, and no significant interaction between gender and course group.

Comparing groups with empathy scores using pairwise *t*-tests revealed that there was a significant difference (with the Bonferroni correction applied for this family of tests) between the person-centred and control groups: $t(47) = 2.79$, $p < 0.01$. However, there was no difference between the person-centred and cognitive-behavioural groups: $t(50) = 1.42$, n.s., or between the cognitive-behavioural and control groups: $t(37) = 1.25$, n.s. Although two of these comparisons were not significant, the total empathy scores between the groups decreased, such that the person-centred mean was highest, followed by cognitive-behavioural, and finally the control group.

In order to see whether the pattern of results was different when treating the two empathy subscales separately, the 2×3 ANOVA was repeated using each of these measures as the dependent variable. For empathic concern, the course group had a significant effect: $F(2, 64) = 3.68$, $p < 0.04$. Again, there was no effect of gender, and no interaction between course group and gender.

Pairwise *t*-tests for the empathic concern subscale showed that there were significant differences between the person-centred and cognitive-behavioural groups: $t(50) = 2.83$, $p < 0.01$, and between the person-centred and control groups: $t(47) = 2.27$, $p < 0.03$, but not between the cognitive-behavioural and control groups. With the Bonferroni correction for these three tests, however, only the first comparison remained significant ($p = 0.017$).

For the perspective-taking subscale, a different pattern of results emerged. The 2×3 ANOVA again revealed the significant main effect of the course group: $F(2, 64) = 5.81$, $p < 0.01$. There was no main effect of gender, but there was a significant interaction between gender and course group: $F(2, 64) = 3.80$, $p < 0.03$.

Pairwise *t*-tests, taking males and females together, showed a significant difference between the person-centred and control groups: $t(47) = 2.50$, $p < 0.02$, with the Bonferroni correction. There was a marginally significant difference between the cognitive-behavioural and control groups: $t(37) = 1.97$, $p = 0.056$, and there was no significant difference between the person-centred and cognitive-behavioural groups.

However, the data shows a large difference between males and females in the cognitive-behavioural group. For males only, there was a significant difference between the person-centred and cognitive behavioural groups: $t(12) = 2.89$, $p < 0.02$, but this was not significant for females. There was also a significant difference between the cognitive-behavioural and control groups for males: $t(10) = 2.92$, $p < 0.02$, but not for females.

To clarify the variables associated with empathy, multiple regression was performed. Using the total empathy scores as the dependent variable, the best fitting model had two significant variables in the equation – the course group, which when entered into the equation, accounted for 10.2% of the variance: $R^2 = 0.102$, $p < 0.03$; then femininity, which accounted for an additional 23.1%: $R^2 = 0.231$, $p < 0.001$. Thus the overall regression model was significant: $F(3, 66) = 10.99$, $p < 0.001$, explaining a total of 33.3% of the variance in the empathy scores ($R^2 = 0.333$). However, the results also show that femininity alone accounted for 29.2% of the variance: $F(1, 68) = 28.09$, $R^2 = 0.292$, $p < 0.001$, suggesting that much of the difference in empathy scores accounted for by the course group were shared with femininity.

Table 2. Means and standard deviations for femininity and masculinity.

		Femininity		Masculinity	
		Mean	SD	Mean	SD
Person-centred	Females	99.00	9.28	92.67	10.92
	Males	99.80	7.98	100.20	9.54
	Total	99.26	8.76	95.10	10.94
Cognitive-behavioural	Females	96.53	10.99	88.10	10.19
	Males	96.00	7.70	93.50	4.36
	Total	96.43	10.28	89.10	9.52
Control	Females	94.60	13.41	87.70	12.02
	Males	91.88	12.87	91.25	5.55
	Total	93.39	12.86	89.28	9.61
All groups	Females	97.21	10.74	90.00	10.93
	Males	96.23	10.21	95.73	8.37
	Overall total	96.90	10.51	91.80	10.48

The femininity and masculinity scores with regards to the course group were then analysed. The means and standard deviations are shown in Table 2 above.

The femininity and masculinity scores seem higher for the person-centred group than for the cognitive-behavioural and control groups, for males, females, and overall. However, in a 2 (gender) × 3 (course group) ANOVA for femininity scores, there were no evidence of main effects by gender, course group or the interaction between them.

It was predicted that the femininity scores for males in the person-centred group would be higher than for males in the other two groups. However, despite a trend in this direction the difference was not significant: $F(2,19) = 1.39$, n.s.

The results for masculinity were analysed in a similar way. In the 2 (gender) × 3 (course group) ANOVA performed for masculinity scores, there were marginally significant effects evident with the course group: $F(2,64) = 3.00$, $p = 0.057$, and gender: $F(1,64) = 3.98$, $p = 0.05$, but no interaction between them. Pairwise t-test comparisons showed a significant difference between the person-centred and cognitive-behavioural groups: $t(50) = 2.04$, $p < 0.05$, but not for any other comparisons. However, this would not remain significant with the Bonferroni correction applied.

The medians of the femininity (98.00) and masculinity (92.00) scores were used to calculate the number of feminine, masculine, androgynous and undifferentiated individuals within the sample in order to see whether there were differences in the number of androgynous individuals between course groups (Table 3).

The observed versus expected frequencies for each cell were calculated, and Pearson's chi-square statistic for goodness-of-fit was computed, testing the null hypothesis that the cell frequencies were equal. The person-centred group cell had a greater than expected frequency, and the chi-squared test was significant, thus indicating that the frequencies were not equal: $\chi^2\ (2) = 10.84$, $p < 0.01$.

The correlation between femininity and empathy scores (empathic concern and perspective taking subscales, and the total empathy score) was computed, to see

Table 3. Number of androgynous individuals in course groups.

Course group	Observed N (androgynous)	Total N (course group)	Percentage of total group
Person-centred	13	31	42.1
Cognitive-behavioural	4	21	18.1
Control	2	18	11.7

whether, as predicted, there was a significant positive correlation between the two variables for all groups. There were significant positive correlations with empathic concern: $r = 0.50$, $p < 0.001$, and perspective taking: $r = 0.41$, $p < 0.001$. The correlation for total empathy scores with femininity was: $r = 0.54$, $p < 0.001$.

Discussion

This study aims to understand the key characteristics of counsellors across cognitive-behavioural and person centred therapies, to highlight the importance of concordance across therapists within a subtype for the client.

In order to examine whether a trainees' choice of a counselling orientation was influenced by personality traits, this study addressed the question of whether individuals studying person-centred therapy, cognitive-behavioural therapy or other postgraduate social science courses (the control group) differed in their gender roles and empathy levels.

The first prediction we tested was whether students of person-centred counselling reported higher levels of empathy than those studying cognitive-behavioural therapy or the control group. When scores from both empathy scales were combined, it was found that participants in the person-centred group scored higher in empathy than those in the control group, regardless of gender. There was, however, no overall difference in empathy scores between men and women, which is congruent with previous findings that biological sex is not predictive of empathy (e.g. Eisenberg et al., 1988).

When the empathic concern and perspective taking subscales were examined individually, two distinct patterns emerged. Once again, individuals in the person-centred group scored higher for empathic concern than those in the cognitive-behavioural and control groups. This supports the first prediction, although it was not anticipated that the pattern of empathy scores would differ according to subscale. In addition, as noted previously, men and women in the person-centred group were comparable in terms of empathic concern, whereas women were slightly higher than men in the other two groups. Although this difference was not statistically significant, this suggests that men and women who choose to study person-centred counselling have equally high levels of empathic concern, whereas in other student groups, women tend to have slightly higher levels of this than men. However, this may still be lower than person-centred counselling students in general.

For the perspective-taking subscale, the pattern of results was more difficult to interpret – there was no difference between the person-centred and cognitive-behavioural groups overall, and the person-centred group was higher than the control group. For the cognitive-behavioural group, although scoring higher than

the control group, the difference was only marginally significant. By looking at the results, it can be seen that this was due to the men in the cognitive-behavioural group having much higher perspective-taking scores than the women. This would also explain the interaction between gender and course group.

When men and women were considered together, it can be concluded that both person-centred and cognitive-behavioural students have higher levels of perspective-taking than students of other social sciences, but that the two groups of counselling students are comparable. One conclusion that can be drawn, therefore, is that overall counselling students have greater perspective-taking abilities than other postgraduate students.

The current study is unable to distinguish whether this increase in perspective taking is due to the training, or the type of individual who applies for the training. Therefore, it is beyond the scope of this study to assess the effect of training itself. Nevertheless, an increase in this particular type of empathy over both groups suggests a higher ability to understand the client, and therefore determine the appropriate treatment.

The finding that person-centred counselling students report higher empathic concern can be explained in two ways. Firstly, potential students who see themselves as having more empathic concern or being better at perspective taking, may view themselves as better suited to person-centred counselling or cognitive-behavioural therapy (respectively). Alternatively, as suggested in Harton and Lyons (2003), the empathic concern may simply be a product of the counselling courses themselves. However, this is unlikely, as empathy is regarded as a stable trait (Davis, 1996). Furthermore, the association between femininity and empathy suggests that these students actually feel more empathy. It has previously been shown that empathy shown in trainees does not relate to supervisors' empathy (Payne & Gralinski, 1968). Thus, it is important for the consistency of therapy that trainees choose their counselling course carefully. It is also important for clients to understand fully the likely personality of their counsellor, to remove some of the daunting unknowns associated with visiting a counsellor for the first time. Using personality terminology to describe the type of treatment the client will receive may be a more understandable way of communicating what the counselling sessions are likely to entail.

The differences between the two groups of counselling students make theoretical sense in light of the values of each orientation. Empirical studies demonstrating a focus on empathy in humanistic theory (e.g. Shapiro, 1985) are congruent with the finding that in trainees of person-centred therapy, empathic concern is more pronounced. It also seems apt that these individuals embody this characteristic, which is central to the orientation's theory. By contrast, the lower observed scores for empathic concern in the cognitive-behavioural group appear congruent with the findings of Kubacki and Chase (1998) who revealed an emphasis on instrumental methods in cognitive-behavioural therapy. A focus on therapeutic methods as a "means to an end" does not intuitively seem to require such high levels of empathic concern, but more of an emphasis on other, more practical methods to achieve the goals of therapy.

However, the method of collecting individuals' empathy scores was self-report. As empathy is a positive trait, it is clear that individuals will want to portray an image of a highly empathic person, as well as truly believing they are very empathic. This is particularly relevant for trainee counsellors. However, this would suggest, if anything, a muted difference between groups, which is not the case. Nonetheless,

verification using reports from relatives or friends would help to gain a fuller picture of personalities and attributes of the participants.

This study additionally distinguishes between gender and femininity. This is crucial to avoid unjust stereotypes against males who become counsellors. Previous work has found that female psychology practitioners reported higher levels of empathic concern and perspective taking than male practitioners or all experimental psychologists (Hall et al., 2000). In addition, it was also established that the only factors linked to variations in empathy were femininity and course; thus none of the other measures (age, biological sex, highest previous qualification, or masculinity) were linked to the observed differences between individuals. Femininity was particularly strongly associated to empathy, independent of gender. This further disagrees with previous research (e.g. Hall et al., 2000) which found biological sex to be at least a factor in empathy differences. The finding here, then, is instead congruent with research such as that by Eisenberg et al. (1988), which revealed that femininity, but not gender, predicted the amount of helping in a non-emergency situation; a measure of empathy.

Concerning gender roles, it was predicted that males studying person-centred therapy would be more feminine, or androgynous, in their gender role identity. When femininity scores were examined, however, the difference in scores between groups was not statistically significant, although femininity was highest in the person-centred group. It is interesting that the overall pattern of femininity scores between the three student groups followed the same pattern as the total empathy scores – that is, the person-centred group had the highest score, followed by the cognitive-behavioural group and the control group scoring lowest. This may reflect the observation that empathy seems to be predicted by femininity – indeed, this has been suggested not only by empirical studies demonstrating this, but also by sociological and psychological writers on the topic of gender roles (e.g. Miller, 2010). Chodorow (1974), posited that in any society, the feminine personality identifies itself "in relation and connection to other people." This then suggests that a feminine gender role is itself fundamentally linked to empathy, as understanding and identifying with other people. By this argument, one would expect that the person-centred students' higher empathy is preceded by a more feminine gender role, for which a trend was observed.

In order to explore this further, it was asked whether higher empathy was associated only with a feminine gender role (i.e. high femininity, low masculinity) or whether androgynous individuals (high femininity and high masculinity) were similarly high in empathy. The latter was supported, which is congruent with the findings of Karniol et al. (1998) in adolescents. Thus it would appear an individual may endorse both masculine and feminine traits, and still embody the empathy associated with a feminine personality.

Considering the person-centred group scored higher in both masculinity and femininity overall, it is possible that rather than being more feminine as originally predicted, people who choose to study person-centred therapy may endorse both masculine and feminine traits. In support of this, there were many more individuals classed as androgynous in the person-centred group than in the other two groups, and more than would be expected by chance. One explanation for that might be that androgyny is associated with the humanistic concept of congruence, one of Roger's (1957) core conditions for person-centred therapy. This relates to the counsellor being self-aware, and being honest with regard to themselves and the client (Irving &

Dickson, 2006). This focus on self-awareness and "self-honesty" may mean that the person-centred counsellor is less influenced by stereotypical gender roles. Bem (1974) suggested that the sex-typed individual has internalised stereotypical ideas of gender-appropriate behaviour, as dictated by society, and thus may inhibit gender-inappropriate behaviours. An androgynous individual, by contrast, is more flexible in their traits and behaviour. Being congruent, by the above definition, seems to imply that one does not inhibit certain behaviours on the basis that they are stereotypical of the opposite gender.

This questionnaire, of course, fails to take into account the complex relationship between gender of the client, gender of the counsellor and femininity and masculinity. It has been shown that gender self-concept is a highly dynamic concept, and particularly changeable according to social interactions (Smith, Noll, & Bryant, 1999). Thus it is crucial that a contextual assessment, via video or observer report, of individuals' femininity and masculinity within a therapy session is carried out. This may accentuate the differences already appearing within this study.

The results of this study suggest that rather than assuming that therapists only differ on the basis of the therapeutic orientation they practice, they may also differ in their personal attributes. The indication that therapists of different orientations embody different types of empathy is particularly interesting, and could potentially be used to help identify which types of individuals are best suited to studying certain therapy orientations. Knowledge of therapist variation across orientations may also help clients to make more informed choices as to the type of therapy they wish to receive. Since therapy outcome has frequently been linked to the quality of therapeutic alliance (e.g. Roth & Parry, 1997), client knowledge of how the aims of therapy are likely to be implemented by the therapist may ultimately help maximise its effectiveness.

Notes on contributors

Dr Itai Ivtzan is a chartered psychologist and holds a position as a Positive Psychology lecturer in UEL (University East London) as part of the MAPP (Masters in Applied Positive Psychology) programme. His main areas of research are personal meaning, eudaimonic happiness, self-actualisation, positive therapy, spirituality and mindfulness.

Emily Redman was Dr Ivtzan's student and is fascinated by positive therapy, human potential, and growth.

Hannah E. Gardner was Dr Ivtzan's student and is fascinated by positive therapy, human potential, and growth.

References

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.

Bem, S.L. (1974). The measurement of psychological androgyny. *Journal of Consulting and Clinical Psychology, 42*, 155–162.

Casemore, R. (2011). *Person-centred counseling in a nutshell*. London: Sage.

Chodorow, N. (1974). Family structure and feminine personality. In M. Rosenberg & R. Turner (Eds.), *Women, culture, and society* (pp. 43–66). Stanford: Stanford University Press.

Corey, G.C. (2004). Designing an integrative approach to counselling practice. VISTAS online. Retrieved from http://counselingoutfitters.com/vistas/vistas04/29.pdf

Davis, M.H. (1980). A multidimensional approach to individual differences in empathy. *JSAS Catalog of Selected Documents in Psychology, 10*, 85.

Davis, M.H. (1996). *Empathy: A social psychological approach*. Boulder, CO: Westview.

Department of Health (1996). *A review of strategic policy on NHS psychotherapy services in England*. London: NHS Executive.

Eisenberg, N., Schaller, M., Miller, P.A., Fultz, J., Fabes, R.A., & Shell, R. (1988). Gender-related traits and helping in a nonemergency situation. *Sex Roles, 19*, 605–618.

Feltham, C. (2010). *Critical thinking in counseling and psychotherapy*. London: Sage.

Hall, J.A., Davis, M.H., & Connelly, M. (2000). Dispositional empathy in scientist and practitioner psychologists: Group differences and relationship to self-reported professional effectiveness. *Psychotherapy, 37*, 45–56.

Harton, H.C., & Lyons, P.C. (2003). Gender, empathy, and the choice of psychology major. *Teaching of Psychology, 30*, 19–24.

Helmreich, R.L., Spence, J.T., & Wilhelm, J.A. (1981). A psychometric analysis of the Personal Attributes Questionnaire. *Sex Roles, 7*, 1097–1108.

Holt, C.L., & Ellis, J.B. (1998). Assessing the current validity of the Bem Sex-Role Inventory. *Sex Roles, 39*, 929–941.

Howard, G.S., Nance, D.W., & Myers, P. (1986). Adaptive counseling and therapy: An in eclectic model. *Counseling Psychologist, 14*, 363–442.

Irving, P., & Dickson, D. (2006). A re-conceptualization of Rogers' core conditions: Implications for research, practice and training. *International Journal for the Advancement of Counseling, 28*, 183–194.

Karniol, R., Gabay, R., Ochion, Y., & Harari, Y. (1998). Is gender or gender-role orientation a better predictor of empathy in adolescence? *Sex Roles, 39*, 45–59.

Kubacki, S.R., & Chase, M. (1998). Comparing values and methods in psychodynamic and cognitive-behavioural therapy: Commonalities and differences. *Journal of Psychotherapy Integration, 8*(1), 1–25.

Miller, S.R. (2010). Attitudes toward individuals with disabilities: does empathy explain the difference in scores between men and women? *Annals of Behavioral Science and Medical Education, 16*, 3–6.

Murdock, N.L., Banta, J., Stromseth, K., Viene, D., & Brown, T.M. (2009). Joining the club: Factors relating to choice of theoretical orientation. *Counselling Psychology Quarterly, 11*, 63–77.

Payne, P.A., & Gralinski, D.M. (1968). Effects of supervisor style and empathy upon counselor learning. *Journal of Counseling Psychology, 15*, 517–521.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.

Roth, A.D., & Parry, G. (1997). The implications of psychotherapy research for clinical practice and service development: Lessons and limitations. *Journal of Mental Health, 6*, 367–380.

Shapiro, S.B. (1985). An empirical analysis of operating values in humanistic education. *Journal of Humanistic Psychology, 25*, 94–108.

Smith, C.J., Noll, J.A., & Bryant, J.B. (1999). The effects of social context on gender self-concept. *Sex Roles, 40*, 499–512.

Sumari, M., Mohamad, S.M.A.S., & Ping, C.L. (2009). Personality types and choice of counselling orientations among counselling students/trainees in Malaysian higher education institutions. *The International Journal of Research and Review, 3*(1), 1–9.

Truax, C.B., & Carkhuff, R.R. (2007). *Toward effective counseling and psychotherapy: Training and practice*. New York, NY: Aldine.