1987

# Therapist cognitive and affective responses as a function of therapist gender, client gender, and client anger and depression.

Shelley Lynn Murphy
*University of Massachusetts Amherst*

# THERAPIST COGNITIVE AND AFFECTIVE RESPONSES AS A FUNCTION OF THERAPIST GENDER, CLIENT GENDER, AND CLIENT ANGER AND DEPRESSION

A Master's Thesis

By

SHELLEY LYNN MURPHY

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

MASTER OF SCIENCE

September 1987

Department of Psychology

THERAPIST COGNITIVE AND AFFECTIVE
RESPONSES AS A FUNCTION OF THERAPIST GENDER,
CLIENT GENDER, AND CLIENT ANGER AND DEPRESSION

A Master's Thesis

By

Shelley Lynn Murphy

Approved as to style and content by:

Marian MacDonald, Chairperson of Committee

Richard Halgin, Member

Sally Freeman, Member

Seymour M. Berger, Chairperson
Psychology Department

ACKNOWLEDGEMENTS

I would like to begin with thanking the chairman of my committee, Marian Mac Donald, for her encouragement, advice, and teaching throughout the course of this project. I would also like to thank the other members of my committee, Richard Halgin and Sally Freeman, for their assistance and enthusiasm towards this project. The committee members were outstanding in sharing with me their insights into how gender might impact upon psychotherapy process and how this impact can best be examined and understood.

Much of the credit for this project goes to the therapist-trainees who participated as subjects. Without their willingness to share with me their candid reactions and observations this project would have contributed little to a greater understanding of gender and psychotherapy.

Finally, I am indepted to my family and friends for providing me with emotional support, ideas, and helpful feedback during all phases of this project. Special thanks to my parents Leon and Amy Smith, my brother Randy Smith, my sister-in-law-to-be Karen Kabnick, Dan Cerro for his statistical acumen, and friends Rachel Bush, Ami Ylda,Donna Starr, and members of my research team. Most importantly, thanks to my husband John Murphy for his enduring love, support, inspiration, assistance, and much more.

TABLE OF CONTENTS

APPENDICES

LIST OF TABLES

# C H A P T E R I

## INTRODUCTION

> Any assumption that there are no sex differences is as disastrous for research as the assumption that there are any given set of sex differences (Mead,1978 p.365).

### OVERVIEW

Within the last two decades there has been a growing trend in psychotherapy research to focus upon the therapist's role in the therapeutic relationship. It is widely recognized that before therapeutic processes and outcome can be fully understood, the direct and interactive impact of therapist variables such as gender, personality, and attitudes must be examined in relation to their influence upon clinical intervention (Orlinsky & Howard, 1976; Bergin & Lambert, 1978; Parloff, Waskow, & Wolfe, 1978; Strupp, 1978). Among these variables, gender has held preeminent significance. This role is not surprising, since as Gove and Tudor (1973) have observed about general social interaction: "sex acts as a master status, channeling one into particular roles and determining the quality of one's interactions with others" (p.2). Therapists, like people in general, are not impervious to the "master status" of gender. Recent research suggests that both therapist and client are influenced significantly by both therapist and

client gender (Jones & Zoppel, 1982; Orlinsky & Howard, 1976; Howard, Orlinsky & Hill, 1970; Kirshner, Hauser & Genack, 1978; Sherman, 1980; Abernethy, 1976; Stricker, 1977).

The concept of gender has often been misrepresented and misunderstood. It refers to the cultural expression and expectations of masculine or feminine characteristics and behavior determined by a given society and time (Kramarae, 1981). In this paper, gender shall refer to what Western society in recent times has prescribed to be essentially "feminine" or "masculine". This concept of gender is not to be confused with the concept of sex, which refers to the biological differences between females and males.

The study of the relationship between gender and therapy is a complex and delicate one. First, much of the impetus for this research has been drawn from the women's movement which charges that sexism and sex-role stereotyping pervades all social interactions, including those between therapists and their clients (Friedman, 1977; Miller, 1984; Carmen, Russo & Miller, 1984). Clinicians may unwittingly perpetuate sex-role conformity and sexism in their responses to clients. Furthermore, some feminists (Schlachet, 1984; Miller, 1984) argue that traditional theoretical orientations, primarily psychoanalysis, are sex biased because they are predicated on a male perspective which views male development and behavior as normative.

Because many clinicians have received at least some, if not all, of their training in these traditional orientations, some degree of sex bias may still influence clinical practice (Maracek & Johnson, 1980).

Secondly, it is not only gender-related attitudes and behaviors of therapists that shape therapeutic process: clients' gender related attitudes and behaviors, about both themselves and their therapists, shape the therapeutic process as well. Therefore, gender is a dynamic factor mutually impacting upon client and therapist interaction (Howard, Orlinsky & Hill, 1970; Kirshner et al.,1978; Mintz, Luborsky, & Auerbach, 1971).

Thirdly, gender also affects the therapeutic process through its channeling influence on the life experiences common to women and those commen to men. Because of our culture's deeply ingrained sex-role norms,(Maccoby & Jackson, 1974; Block, 1976), one might predict that the experiences of same-gender therapists and clients are more similar to one another than are those of opposite-gender therapists and clients. Some feminists (Chesler, 1972; Lerner, 1984; Klein, 1976) believe that because only women can truly understand and empathize with the life experiences of other women, women clients will be best helped by women therapists. Feminists are increasingly recommending women therapists for women clients (Carter, 1971; Rice & Rice, 1973; Chesler, 1972; Barrett, Berg,

Eaton, & Pomeroy, 1974) and there is a trend towards increased preference for woman therapists, (Moracek & Johnson, 1980). Despite the growing literature on the potential limitations of male therapists working with female clients, there is little discussion concerning female therapists' ability to understand and work effectively with male clients. A better understanding of the comparative effectiveness of male and female therapists working with opposite and same-sex clients is much needed on this controversial topic.

An understanding of how gender affects psychotherapy is essential to a thorough knowledge of therapy processes and of what determines successful therapeutic outcome. However, the task to achieve this understanding is a difficult and complex undertaking. The impact of gender in therapy is no doubt influenced by many other client and therapist variables such as client and therapist age, client and therapist values, client and therapist personality, and client symptomology. It is often difficult to tease out the effects of gender from these other variables. In addition, what we learn about the impact of gender in therapy will also be influenced by the point at which we examine the therapeutic process. The therapeutic process is an unfolding, dynamic phenomenon, and we cannot fall into the trap of believing that variables such as therapist and client gender will have uniform impact

throughout.

The Master's thesis arose from a long-standing interest in the relationship between gender issues and the therapeutic process. As a beginning therapist, I have been particularly interested in how gender interacts with therapist attitudes and behavior. In conducting and analyzing my own work, I often wonder to what extent my own "femaleness" influences my reactions to clients (and in turn,their reactions to me). Strupp's (1973) discussion of therapist attitudes keenly summarizes these feelings:

> Clearly, intensive research effort must be applied to the scrutiny of the therapist's attitudes, whether determined by the culture or his own personality. What the therapist perceives as on-going processes between himself and the patient, the manner in which her evaluates his perceptions, and the therapeutic actions he takes as a consequence- these are to important degree a function of his own personality and his culture (p.46-47).

This Master's thesis involves an empirical analogue study examining the interrelationship between gender and therapist attitudes and behavior. The major questions addressed are: First, do sex-role norms so influence therapists that their attitudes and interventions serve to reinforce client sex-role appropriate behavior and to punish sex-role inappropriate behavior? More specifically, do therapists tend to reinforce the expression of depressed feelings and punish the expression of angry feelings in their female clients but do the opposite for their male

clients? Second, do therapists view female clients as more psychologically maladjusted and view their distress as more related to intrapsychic factors, whereas male clients are viewed as less psychologically maladjusted and their distress more related to temporary, situational factors? Third, do male and female therapists respond to clients in different ways, ways which are related to therapist gender identity and which are held constant across variables such as client gender, symptomology, and personality?

The remainder of this introduction will present relevant empirical and theoretical literature to outline the potential influences of gender on therapist attitudes and behavior. The literature review will examine studies of sex-role stereotyping of mental health standards; sex bias in the therapeutic relationship; sex-role norms in relation to aggressive and depressive client symptomology; and clinician gender-related interpersonal behavior. Once these foundations are established, a brief overview of the study shall be presented along with an outline of the study's hypotheses.

## LITERATURE REVIEW

### SEX-ROLE STEREOTYPING OF MENTAL HEALTH STANDARDS

Pioneering empirical study of the relationship between sex bias, sex-role stereotyping, and clinical practice is

generally credited to the investigation by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel[1970]. Broverman and her colleagues asked 79 clinicians to describe the characteristics of a healthy adult man, healthy adult woman, and healthy adult person of unspecified sex using a sex-role Stereotype Questionnaire. This questionnaire consists of 122 bipolar items, each of which describes a particular personality trait. Findings indicated that male and female clinicians' concept of healthy men did not differ markedly from that of persons of unspecified sex. They were similarly assigned positive masculine characteristics and were equally as likely as women to be assigned positive feminine characteristics. However, healthy women were perceived as being significantly different from men and persons of unspecified sex. Healthy women were perceived as more submissive, less independent, less adventurous, more suggestible, less competitive, more excitable in minor crises, more conceited about appearance, less objective, and more illogical. A comparison of this constellation of traits with that for adult men suggests that clinicians may adhere to a a double standard of mental health. The authors conclude that:

> For a woman to be healthy, from an adjustment viewpoint she must adjust to and accept the behavioral norms of her sex eventhough these behaviors are generally less socially desirable and considered to be less healthy than the

> generalized competent mature adult... Acceptance of an adjustment notion of health, then, places women in a conflicting position of having to decide whether to exhibit those positive characteristics considered desirable for men and adults, and thus have their femininity questioned... or to behave in the prescribed second-class adult status... [p.6].

Broverman et al.'s [1970] essential findings were replicated by Neulinger, Stein, Schillinger, and Welkowitz [1970]. They asked 114 psychotherapists to rank descriptions of Murray's needs for "optimally integrated" males and females. Therapists ranked dominance and achievement higher for males and nurturance and succorance higher for females.

Fabricant and his colleagues [Fabricant, 1974; Fabricant, Landau, & Rollenhagen,1973] conducted a series of investigations where therapists were asked to rate adjectives as descriptive of the male or female role. Once again, male role traits were seen as positive and female role traits as "strongly negative". The authors believed they saw evidence of fewer prejudicial attitudes in their later studies compared to previous ones, suggesting more liberal attitudes over time.

The complex issue of sex-role stereotyping of mental health standards by therapists has also been examined in studies by Sherman, Koufacos, and Kenworthy, 1978; Brown & Kelligner, 1975; Aslin, 1977; Stricker, 1977; Maslin & Davis, 1975; Harris & Lucas, 1976; Cowan, 1976;

Billingsley, 1977; Delk & Ryan, 1975; Englehard, Jones, & Stiggins, 1976; and Davenport & Reims, 1978. In her critical review of the these studies, Sherman (1980) stresses that there has been a wide variation in results. This variation can be attributed to factors such as research design problems, the use of variables not clearly relevant to stereotyping- for example, confusing misogyny with stereotyping- and the likelihood that therapists may misrepresent their views in a liberal manner as to not appear sexist. However, despite the ambiguities within these results, Sherman concludes that overall, these results suggest that "therapists sex-role values are operating during therapy and counseling... (indicating that) there is sex-role stereotyping in mental health standards and that sex-role discrepant behavior are judged more maladjusted" (p.60). The same conclusion has been drawn by other researchers (e.g., Rice & Rice, 1973; Schlachet, 1984; Brody, 1984; Carmen, Rieker, & Mills, 1984; Collier, 1982; Lerner, 1984; Al-Issa, 1980; and Abernethy, 1976).

Research also suggests that of sex-role stereotyping of mental health standards may be most prevalent among male clinicians (Sherman, 1980; Brown & Hellinger, 1975; Collier, 1982; Sherman et al, 1978; Englehard et al.,1976). Brown and Hellinger surveyed 274 psychiatrists, psychiatric residents, psychologists, social workers, and psychiatric

nurses using a questionnaire. They reported that female therapists consistently held a more contemporary view of women than did male therapists. Sherman et al. asked 184 social workers, psychologists, and psychiatrists to answer the Therapists Information about Women Scale and the Therapists Attitudes toward Women Scale. Although data showed that attitudes were overall more liberal than stereotyped, female therapists were significantly better informed and more liberal in their attitudes than were male therapists.

The issue of male therapists having more sex-role stereotyped attitudes than female therapists has been viewed as especially problematic for male-therapist female-client dyads (Schlachet, 1984; Brody, 1984; Rice & Rice, 1973; Chesler, 1972; Abernethy, 1976). If male therapists perceive women in sex biased, sex-role stereotypical manner, how well can they understand a woman's innermost feelings and thereby encourage her to acquire more flexible, less restrictive ways of thinking and behaving (Schlachet,1984; Abernethy,1976)? Lerner (1984) warns that psychotherapy for women may entail a potential reenactment of male-female relationship paradigms as they exist in the culture at large. The therapeutic relationship is a hierarchical system, one based on a relationship between an authority and a person in need of help. Women have traditionally experienced unegalitarian

relationships with men an "natural" and have been trained to compliantly follow the "authoritarian 's" advice. Lerner suggests that:

> Cultural pressures on women to "please men" are so profound that the woman's desire to be attractive and admired by her therapist may override a more honest process of self-determination and self-determination. Women's attempt to fit themselves to definitions of femininity that are implicitly communicated by their therapist is often unconscious and subtle and may thus go unrecognized by both therapist and patient (p.277).

Although sex-role stereotyping by male therapists may be more prevalent among male therapists, female therapists are not immune to these attitudes (Broverman et al.,1970; Neulinger et al.,1970; Fabricant, 1974; Fabricant et al.,1973). Sex-role stereotyping by male and female therapists creates special problems for clinical work. One hypothesis is that sex-role stereotyping leads to female clients being perceived as more psychologically maladjusted than male clients and their distress more often viewed as stemming from underlying, intrapsychic factors (Friedman, 1977; Rice & Rice, 1973; APA Task Force, 1975; Bowman, 1982). Clinicians may adhere to this attitude because sex-role stereotypes of females portray them to be emotional, irrational, unreliable, and immature. Alternately, because sex-role stereotypes of males portray them to be sensible, rational, and reliable, they may be perceived as less maladjusted and their distress more often viewed as stemming from external, situational factors

(Al-Issa,1980). Consequently, clinicians may treat women's symptoms as an expression of individual psychopathology and fail to legitimize the situational and cultural limitations contributing to their problems (Lerner, 1984). On the other hand, clinicians may treat men's distress as a response to situational factors and fail to legitimize the internal, intrapsychic factors contributing to their problems.

A study by Bowman (1982) provides support for the hypothesis that women's problems are more commonly attributed to intrapsychic factors while those for men are more commonly attributed to situational factors. Bowman asked 61 male and female psychotherapists to formulate treatment plans for either a male or female client portrayed in case histories as active in work, sex, and interpersonal relationships. Case histories were identical except for client sex. Results indicated that male and female therapists did not significantly differ in their treatment plans. However, a main effect was found for sex of client. The female client's problem was more often perceived as conflict about sexual identity and dominance in marriage whereas that of the male client's was more often perceived as one of mutual anger between husband and wife. In regards to treatment, therapists more often considered developmental material pertinent to psychosocial development and a need to balance home and career roles as more salient for the female client than for the male

client. Bowman interpreted these results as therapist's perceptions of female distress as primarily rooted in internal conflicts whereas those for men are perceived as rooted in external conflict. In addition, activity in women is more often perceived as neurotic in that the conflict is conceptualized as unresolved issues concerning sexual identification.

The review of the preceding studies provides evidence of sex-role stereotyping of mental health standards by male and female therapists and that sex-role stereotyping may be more prevalent and severe among male therapists. Some authors hypothesize that given the lower status ascribed to women in our society, coupled with the hierarchical nature of therapeutic relationship, effects of sex-role stereotyping may be more detrimental to female clients than to male clients. However, both male and female clients suffer from the consequences of sex-role stereotyping and this issue behooves further investigation.

## Sex Bias, Sex-role Stereotypes and the Therapeutic Relationship

Another avenue researchers have taken in studying sex-bias and sex-role stereotyping in therapist attitudes and behavior is by investigating whether therapists reinforce in their clients sex-role appropriate behaviors and alternately punish sex-role reversals. Most of the

research on this topic has utilized analogue methodology where therapists are presented with a hypothetical client behaving in a sex-role appropriate or inappropriate manner. The therapist is asked to respond on a number of clinical dimensions, ex. treatment, diagnosis, personality. Evidence of sex bias and sex-role stereotyping is revealed when the therapist responds negatively or positively depending upon the client's sex.

In her review of 16 clinical analogue studies, Sherman (1980) found that nine (Abramowitz, Abramowitz, Jackson,& Gomes, 1973; Miller, 1974; Bowman, 1976; Schwartz & Abramowitz,1975; Gomes & Abramowitz, 1976; Abramowitz, Roback, Schwartz, Yasuna, Abramowitz, Gomes, 1976; Feinblatt & Gold,1976; Abramowitz, 1977; Abramowitz, Abramowitz, Weitz, & Tittler, 1976) clearly showed results consistent with bias and sex-role stereotyping while results from other studies (Libbey, 1975; Fischer, Dulaney, Fazio, Hudak, & Zivotofskyy, 1976; Goldberg, 1975; Oppedisano-Reich, 1976; Maxfield,1976; Johnson, 1978) were unclear and/or negative.

In studies by Miller (1974) and Bowman (1982), activity versus passivity in female and male clients was investigated. Miller asked 67 therapists to make clinical judgments concerning a written analogue of a very passive male or female client. Therapists rated the passive protocol as more maladjusted when it was labeled male than

when it was labeled female. In addition, passivity was suggested more frequently as a focus for therapy for the protocol when labeled male as opposed to female. As we recall from the previous discussion, Bowman's study found a bias against activity in women clients, but not against male clients, in her therapist sample. These studies suggest a double standard of mental health whereby men are reinforced for active behavior and punished for passive behavior whereas women are reinforced for passive behavior and punished for active behavior.

Abramowitz et al., (1973) conducted a study examining the role of political bias in clinical evaluation. Seventy-one professional therapists were given a simulated clinical protocol of a college student varying only in the student's sex and political orientation. Therapists were asked to rate the student's psychological adjustment. The only significant result was that the more conservative therapists attributed greater maladjustment to the left politically active female than to her male counterpart. This finding was interpreted as revealing bias against women who behave in a sex-role inappropriate way, namely, in an active, outspoken, and liberated manner. This finding is also important because it points to the possible interaction of political orientation and sex bias in clinical assessment.

A limited number of studies have examined sex-bias and

sex-role stereotypes in the attitudes and behavior of therapists who work with children and families. Feinblatt & Gold [1976] analyzed records of an outpatient child-guidance clinic. They discovered that children who demonstrated sex-role inappropriate behavior were more likely referred to psychiatric facilities than were children exhibiting sex-role appropriate behavior. Girls were more often referred for acting out and aggressive behaviors, while boys were more often referred for introverted, crying behavior. In two subsequent studies, [see Feinblatt & Gold] parents and graduate students read simulated case histories in which identical behavior problems were attributed to either a boy or to a girl. The child who exhibited behavior inappropriate to his/her sex-role was perceived as more severely disturbed and to have a poorer prognosis than the child who exhibited behavior appropriate to his/her sex-role. These data do not permit the generalization that such children will be institutionalized. However, they do suggest that sex-role stereotyping may well influence clinical judgments and interventions.

Abramowitz [1977] studied the relationship between clinician sex bias and the clinical judgments of parents. He found that mothers, more often than fathers, were blamed for their child's psychopathology and were perceived as more in need of individual treatment as opposed to family

therapy. Similar results were reported in a second study by Abramowitz, Abramowitz, Weitz, & Tittler [1976]. Their relatively liberal clinician sample attributed more maternal than paternal responsibility for the child's psychopathology as depicted in simulated case histories.

Despite the seemingly positive evidence of sex bias and sex-role stereotyping in the preceeding studies, evidence from other studies has been equivocal or negative [Abramowitz et al.,1976; Libbey 1975; Fischer et al.,1976; Oppedisano-Reich, 1976; Maxfield,1976]. Abramowitz et al. asked group therapists to assess identical protocols attributed to a male or female client. The only significant result involved female traditional therapists giving a better prognosis, and recommending less group therapy and more behaviorally-focused treatment to the female protocol than to the male protocol.

Libbey [1975] asked 60 psychotherapists to rate audiotape protocols of clients which were identical except for client sex. Findings revealed that therapists demonstrated greater positive empathy toward the female protocol rather than to the male protocol.

A doctoral dissertation by Maxfield [1976, cited by Stricker, 1977] asked 1000 members of the Division of Psychology of the APA to read vignettes balanced for gender, level of psychopathology, and stereotypically masculine and feminine characteristics and formulate a

diagnosis and treatment plan. Subjects also completed the Rosencrantz Questionnaire cited by Broverman et al. [1970]. and responses were received from 250 people. On the vignette task, therapists revealed no discrimination toward clients on the basis of gender, but they did discriminate toward clients on the basis of psychopathology. The questionnaire results indicated no systematic tendency to evaluate women as less healthy then men.

The literature suggests that the findings presented on sex bias and sex-role stereotyping by therapists are complex and contradictory. Nonetheless, there is substantial evidence suggesting that sex bias and sex-role stereotyping is operating in the clinical judgments and interventions of therapists in work both with adults and children. Our knowledge in this area is by no means complete, but we can assume that some therapists respond to clients in a manner which serves to reinforce sex-role appropriate behaviors and punishing sex-role inappropriate behaviors.

## Client Anger and Depression

Much of the research investigating bias and sex-role stereotyping in therapy has focused on clinical symptomatology of depression and anger/aggression. This has occurred because depression and anger/aggression conform to sex-role norms for females and males respectively [Gomes

& Abramowitz, 1976; Hammen & Peter, 1977, 1978; Stevens, 1974; Burtle, 1985). Depression is commonly associated with traditional feminine sex-role norms of dependency, helplessness, passivity, lack of self-esteem, and emotional expressiveness. Anger/aggression, on the other hand, is commonly associated with masculine sex-role norms of detachment, activity, volatility, dominance, and lack of emotion. Depression and anger/aggression have also been a focus of study because clinical surveys have demonstrated that women have high rates of depressive symptomatology whereas men have high rates of aggressive, acting-out symptomology (Dohrenwend & Dohrenwend, 1976; Weissman & Klerman, 1977).

Researchers have investigated the role therapists play in reinforcing the expression of anger/aggression in male clients and depression in female clients. Studies have focused on therapists' responses to hostile and friendly clients (Bohn, 1967; Russell & Snyder, 1963; Beery, 1970; Gamsky & Farwell, 1966); angry and depressed clients (Stengal,1976; Gomes & Abramowitz, 1976; Parsons & Parker, 1968; Haccoun & Laviguer, 1979; Johnson, 1977); aggressive and passive clients (Fisher et al, 1976); and depressed clients alone (Stein, Fox, & Luepnitz,1974; Stein, Del Gaudio & Ansley, 1976).

Strong support for the existence of sex-bias in the treatment of depressed clients has been discovered in

studies by Stein et al., [1974] and Stein et al., [1976]. Stein et al.[1974] asked therapists to rate hypothetical depressed patients depicted in case histories on a number of measures related to diagnosis, prognosis, and treatment recommendations. The identical hypothetical patient was rated as in need of medication significantly more often by those clinicians who were led to believe that the patient was a woman than by those clinicians who were led to believe that the patient was a man. Stein et al.[1974] interpreted these results as demonstrating differential attitudes towards women's and men's pathology that leads to differential treatment. However, it might be argued that therapists responded differently to male and female clients based on their knowledge that the two sexes express their pathology differently, i.e., female depression is more severe and hence more in need of medication.

To investigate the possibility that clinicians treat male and female depressives differently because of sex differences in the expression of pathology, Stein et al.[1976] conducted an archival study utilizing information gathered on a pool of 192 psychiatric outpatients. All of the subjects had received a diagnosis of neurotic depression. Dependent measures included the Terminator-Remainer Scale, the Hopkins Symptom Rating Scale, the Psychiatric Outpatient Mood Scale, the FIRO-B, and the Crowne-Marlowe Social Desirability Scale [see Stein

et al.,1976]. An analysis of the data revealed that the self-descriptions of men and women patients in areas of symptoms, moods, and interpersonal behaviors did not significantly differ. Nonetheless, female patients received significantly more therapy sessions than male patients and were more often treated with psychotropic and antidepressant medication. Male patients, on the other hand, were more often treated with minor tranquilizers- drugs that are less potent and less specifically mood-elevating than those prescribed for female patients. The authors interpreted these results as revealing sex bias in clinical judgment. Although female and male patients' symptomatology was similar, the female's depression was perceived as more severe and endogenous whereas male patient's depressive symptomatology was perceived as moderately severe and related to external, situational factors.

An ingenious study of possible sex-bias in psychotherapy was conducted by Haccoun & Lavigueur [1979]. They asked male and female therapists [varying in levels of experience] to conduct a therapy session with a female actor who portrayed either an angry or sad client. Therapy sessions were tape recorded and therapist behavior was rated on general impressions of clinical appraisal, etiology of distress, and treatment directives. Results demonstrated that therapists were significantly more likely

to judge angry female clients less favorably than depressed female clients. Angry female clients were perceived as less self-controlled, less likeable, less easy-going, and more inappropriate than were sad female clients. In addition, therapists intervened less with angry clients and were less supportive and directive in their interventions with them. However, experience level of therapist was positively correlated with tolerance of anger. These findings suggest that, at least with inexperienced therapists (less than 6 cases treated), bias may exist against females who respond with anger.

Another clever study of sex-bias in psychotherapy which employed actors as a stimulus was that by Gamsky and Farwell (1966). These authors utilized both male and female actors to portray hostile and friendly client-actors. Fifteen female and 15 male counseling students with minimal clinical experience interviewed all four clients. The interviews were tape recorded and rated by judges according to a modification of Bales' System of Interaction Process Analysis. Client's gender had a significant effect only in the hostile client condition. Hostile male clients elicited a significantly more non-directive pattern (e.g. agreement, reflection) from counselors than did female hostile clients. This finding is in contrast to that of Kaccoun & Lavigueur (1979) who found that angry female clients elicited more non-directive responses. However, it is

difficult to interpret these discrepant findings because the two studies used different independent and dependent variables. Nonetheless, both studies reveal the impact of client anger on therapists' attitudes and behavior.

Studies by Gomes & Abramowitz [1976] and Fisher et al.[1976] utilized the case history method to examine sex-bias in clinical judgement. Gomes & Abramowitz sent case histories to 640 APA members who evaluated a hypothetical patient's psychological well-being and provided information on their own sex-role traditionalism. Case histories differed in respect to patient gender and presenting problem which conformed to stereotypical masculine or feminine traits [including aggression for men and depression for women]. Results revealed no consistent evidence of sex-bias in any of the four variables: patient's sex and sex-role appropriateness and therapist sex and sex-role orientation. However, there was a trend favoring the female-identified rather than the male-identified stimulus patient. Surprisingly, the sex-role deviant female was perceived as especially emotionally mature. These findings are inconsistent with the hypothesis that females are judged more harshly than males. The authors attributed the positive female bias to either clinician's liberal attitudes which favor a competent female with masculine traits, or to clinician's perceiving the study's underlying intent which clinicians

to respond in an overly positive manner to the female patient.

Fisher et al.'s (1976) investigation of sex-bias and sex-role stereotyping in clinical judgments also provides data revealing a pro-female bias. 289 social workers were mailed a one-page case history describing either a passive male, passive female, aggressive male, or aggressive female. Dependent measures included 11 clinical judgments (ex. client's emotional maturity,prognosis, degree of disturbance). Data from 135 therapists were received. An analysis of these data indicated no main effect for therapist sex but the female protocols elicited a more favorable reaction than did the male protocols. Both the passive and aggressive female was rated more mature, intelligent, needing less home and family involvement, needing encouragement to be more emotionally expressive, and better suited to nondirective therapy than their male counterparts. Fisher et al. interpreted these ambiguous results as demonstrating that sex bias and sex-role stereotyping is absent from the social work practice. However, these authors failed to recognize that these results are difficult to interpret given their complexity and the study's failure to delineate how the aggressive and passivity dimensions were operationalized. Results from this study, as well as those from Gomes & Abramowitz's (1976) study, do not adequately refute allegations of

covert sex-related discrimination.

In an attempt to make the analogue investigation more representative of real-life clinical settings, researchers have employed audiotape and videotaped stimulus conditions (Parsons & Parker, 1968; Stengal, 1976; Johnson, 1977). Stengal asked 60 male and female graduate-student counselors to respond to one of two videotape situations. One group of counselors was presented with a videotape of a male client-actor making angry and sad statements and the other group of counselors was presented with a videotape of a female client-actor making angry and sad statements. The angry and sad statements were parallel to each other in content, with the only differences between them being tone of voice and non-verbal cues. Counselor responses were audiotaped and rated on levels of empathy, warmth, and genuineness. Counselor behavior did not significantly vary depending on sex of client, sex of counselor, nor client affect. However, Stengal questioned the validity of his findings because the dependent variables may not have been sensitive enough to tap sex-bias. Stengel also questioned "whether counselor's responses to statements changing in affect, as the statements did in this study, are the same as their responses to a sustained affect of one kind or another (e.g. anger or sadness)" (p.5819).

Johnson (1977) explored the relationship between client and therapist gender, angry versus depressed affect,

and sex-role stereotyping, by studying the responses of 40 experienced psychologists to videotaped client-actors. Five female and five male therapists viewed either an angry woman or man or a depressed woman or man. During four stops of the videotape, therapists expressed their immediate subjective responses to the clients. Responses were tape recorded and rated on dimensions of sympathy, identification, defensiveness, and anger. Therapists also rated themselves on dimensions of empathy, liking, comfort, and client attractiveness for counseling. Dependent measures revealed only two significant results: female therapists rated themselves as more empathic than did male therapists and female therapists were rated as angrier than were males therapists.

When Johnson's [1977] data were more closely examined, the author recognized trends in therapist responses which the global dependent measures did not identify. Female clinicians were somewhat more positive toward the depressed man than toward the depressed woman. Perhaps they were less tolerant with the woman because they could identify with her. In regards to the angry clients, female therapists generally disliked both but felt more negatively towards the male. A few of the therapists stated that the angry male made them feel physically threatened.

Male clinicians reacted to the depressed female with a mixture of annoyance and nurturance. The depressed male

elicited either a denial of feelings or a suspiciousness of his genuineness until the point where he wept. Since openly depressed feelings and crying is not socially sanctioned for men, these male therapist reactions may have been related to their discomfort and confusion. Male therapists' reactions to angry clients differed markedly from that of the female therapists. These men viewed female client's anger as "positive and energizing, and they enjoyed the prospect of helping her." (p.88). In contrast, the angry male client elicited primarily negative reactions. Unlike reactions to the angry female these therapists did not remark on the angry male client's spunk or spirit nor express an enthusiastic desire to work with him.

Results from the above literature are mixed but there is evidence suggesting that in some cases, therapists' sex bias and sex-role stereotyped attitudes and behavior may serve to reinforce the expression of anger in male clients, depression in female clients, and vice versa. However, there is some evidence that therapist sex bias and sex-role stereotyping may be lessening over time with the general liberalization of sex norms within the wider culture. Yet it is difficult to determine to what extent any liberalization of therapists' attitudes has occurred, and if it has been enough to ensure clinical intervention that is free from sex-bias.

## Potential Gender Differences in Therapist Attitudes & Behavior

Cultural prescriptions for masculinity and femininity influence the ways in which men and women perceive and relate to the world (Block, 1976; Miller, 1976; Gilligan, 82; Maccoby & Jacklin, 1974;). Current theories of personality (Chodorow, 1976; Block, 1976; Carlson, 1971; Miller, 1976) suggest that male attitudes and behavior are characterized by considerations of agency: power, self-assertion, independence, and prestige. In contrast, female attitudes and behavior are characterized by considerations of communion: cooperation, dependence, communication, interpersonal sensitivity, and closeness. An examination of sex differences in attitudes and behavior is a key element in understanding how gender impacts upon the therapeutic process and outcome.

Research has found evidence of sex differences in the conceptual and linguistic domains (Carlson, 1971; Walker, 1976; Thompson, Hatchett, Phillips, 1981; Lakoff, 1977). A study by Walker investigating social schemata provides evidence for an agency-communion dichotomy. Subjects learned a linear ordered vertical (influence) social structure in a paired-associate format. They were given either a horizontal (liking) schema or a vertical (dominance) schema for the task by providing them with liking, cooperative verbs (socialize, cooperate, exchange,

share) or dominance verbs (dominate, order, direct, lead). Among subjects given the horizontal (liking) schema, females persisted in perceiving the overall patterns of verb relationships as reciprocal while males found the patterns to be nonreciprocal, and expressing dominance. This study suggested that women attend more to affect and less to power or control in their conceptualization of interpersonal relations, while men do the opposite.

Differential patterns of language usage were investigated by Thompson et al.(1981) in his examination of sex differences in the judgments of interpersonal verbs. Male and female college student judged 71 sentences describing interpersonal relationships between two people (e.g., A "adores" B; A "likes" B). For each verb, subjects rated the degree to which it connoted affect (positive or negative) and interpersonal control. Data indicated an overall pattern in which females judged verbs to be more affectively polarized while males judged verbs to be more polarized on the control dimension. A similar pattern of affect and control was reported in a study by Carson (1971). Subjects were asked to describe themselves and a critical incident in their lives. Males were more likely to use adjectives involving achievement, success, risk, danger, and work. Women were more likely to use adjectives involving relationships, family, and inner psychological change. Both Thompson et al.'s and Carlson's work suggest

that the sexes may show subtle, if not substantial, differences in the meanings attached to interpersonal events.

The above findings suggest that there might be linguistically-induced miscommunication between the sexes in the therapeutic relationship. For instance, when a female client characterizes her behavior toward a male as "protecting" him with the intention of implying positive affect, she may be surprised by her male therapist's response to the control he perceives in her communication. Similarly, a male client's communication of feeling humiliated, intending to imply negative control, may be misconstrued by his female therapist as implying affect. Such potentials for miscommunication can have profound implications for therapeutic success, particularly because of the "expert" status afforded clinicians. Even when clients sense that they are being misunderstood, they may disregard their sense because their all-knowing therapist offers a different interpretation. It would be reasonable to expect that this problem might be most acute with female-client male-therapist dyads because of the submissive stance women often take with men (Burtle, 1985; Lerner, 1984).

Sex differences have also been found between the ways men and women interact. In mixed-sex groups, men have been reported to initiate more interactions than do women

(Strodtbeck, James & Hawkins, 1957; Heiss, 1962; Aries, 1976) and to emphasize task behavior while women emphasize social-emotional behavior (Heiss, 1962; Piliavan & Martin, 1978). In general, men have been found to be more likely to assert their status and establish dominance, while women have preferred to minimize status and establish affliative relationships (Frieze & Ramsey, 1976). With respect to nonverbal behavior, men have been found to assume more open, relaxed postures and other behaviors reflecting superior- subordinate interaction, particularly when relating to women (Mehrabian, 1969; Mehrabian & Friar, 1969).

Elizabeth Aries and Fern Johnson have conducted some of the most sophisticated and widely cited research on same-sex and cross-gender interpersonal behavior (Aries, 1976; Johnson & Aries,1983; Aries,1982; Johnson, Fine, Lutfiyya,& Ryan,1983). In her 1976 study, Aries observed the behavior of college students in mixed-sex and same-sex groups. Data indicated that while females dominated the mixed groups verbally, interaction styles and nonverbal postures remained sex-role stereotyped. Males engaged in a greater proportion of task behavior (i.e., giving opinions, suggestions, and information) than did females who engaged in behavior that was more reactive (i.e., stating agreements and disagreements). Males also exceeded females in displays of nonverbal behavior associated with

dominance. Therefore, even though females were verbally dominant, their assertions were impeded by an ineffectual nonverbal self-presentation.

Although traditional sex differences along instrumental and expressive lines may not be as pronounced as they were prior to the women's movement, research shows that they still exist. The therapeutic relationship is essentially an interpersonal one, as a consequence, researchers have begun to question how gender-related interpersonal styles might influence therapy. The preceding literature suggests that female clinicians can be expected to be more empathic, reactive, nurturant, affliative,and emotional, while male clinicians would be more active, controlling, task-oriented, and confrontational.

Research has examined the impact of therapist gender on same-sex pairing (Cartwright & Lerner, 1963; Hill, 1975; Orlinsky & Howard, 1976; Kirshner et al.,1978); counseling skills (Fisher et al.,1976; Haan & Livson, 1972; Werner & Block, 1975; Cowan et al.,1974; Fong & Border, 1985; Orlinsky & Howard, 1976; Billingsley, 1977; Johnson, 1978; Hill et al, 1977; Feinblatt & Gold, 1976); empathy (Abramowitz et al, 1976; Fong & Borders, 1985; Johnson, 1978; Kimberlin & Friesen, 1980; Carlozzi & Hurlbut, 1982; Hill, 1975; Hill et al.,1977) and authoritarian versus affiliative counseling styles (Buczek, 1981; Wright et

al.,1980; Hetherington & Allen, 1984; Green, 1980; Rice et al., 1974].

Studies that have reported few or no main effects for therapist gender include those by Fong & Borders [1985]; Feinblatt & Gold [1976]; Johnson [1978]; Kaschad [1978]; Werner & Block [1975]; and Fisher et al. [1976]. In his analysis of videotaped responses by beginning therapists, Fong and Borders found no significant differences by gender in counseling skills. Studies by Fisher et al. and Johnson also found no gender differences in counseling skills nor in therapists' clinical judgments. Johnson's female subjects self-reported more empathy for clients but they were not rated by judges as more empathic, but rather as angrier than male therapists. The female therapists appeared to have manifested this anger in their subjective reactions towards the angry male-stimulus, yet were able to temper it in their verbal responses. In their study of psychiatric referrals, Feinblatt & Gold's male and female therapist sample were equally likely to refer children when they behaved in a sex-role inappropriate manner.

Significant main effects for therapist gender have been reported in studies by Billingsley [1977]; Buczek [1981]; Hetherington & Allen [1984]; Jones & Zoppel [1982]; Greene [1980]; and Rice et al. [1974]. Billingsley looked for sex bias in treatment planning. She hypothesized that clinicians would prescribe "feminine" treatment goals for

females and "masculine" treatment goals for males. The data did not confirm her hypothesis but surprisingly, a main effect for therapist sex was found. Male therapists chose more feminine treatment goals, whereas female therapists chose more masculine goals. It is difficult to explain these results in light of the previous discussion on gender-related behaviors. Perhaps these therapists considered themselves to have atypical sex roles and therefore encouraged cross-sex behaviors in their clients.

Findings from other studies are more compatible with what has been suggested by the research on gender-related behaviors. In a counseling analogue study, Buczek [1981] asked therapists to listen to audiotapes of a simulated initial interview and to afterwards recall what they remembered. Although both male and female therapists recalled fewer facts of the female client, female therapists recalled and recognized more client information than did male therapists. These results suggest that female therapists are more empathic and attentive to the needs and concerns of their clients than are male therapists. However, these findings might also suggest that female therapists rely more on verbal and literal cues to encode information, whereas males rely on nonverbal and semantic cues.

Jones & Zoppel [1982] conducted two process and outcome studies of male and female clinicians and their

male and female clients. Results indicated,

> ...that women therapists rated themselves as more successful, particularly with female clients...and that clients regardless of gender, agreed that women therapists formed more effective therapist alliances than did male therapists" (p.259).

The authors also found that male therapists' adjective descriptions of their women clients were less socially desirable than female therapists' descriptions.

> ...Male therapists appear to assume a more judgmental or critical stance, using such adjectives as "affected", "awkward, and "conceited" to depict their women clients. Their descriptions are remarkable especially in terms of the absence of adjectives connoting interesting or appealing qualities. The more frequent use of adjectives such as "capable", "honest", "strong", and "intelligent" demonstrates that women therapists' characterizations of their female clients are far more sympathetic and capture more in the way of personality competencies and strengths (Jones & Zoppell, 1982, p.264).

Jones & Zoppel (1982) also asked clients to rate the quality of the therapeutic relationship with their therapist on the Therapeutic Alliance process scale. Clients of female therapists rated the therapeutic alliance as significantly stronger than did clients of male therapists. Based on these findings and those reported above, the authors speculated that "women therapists may assume a more accepting, tolerant stance in psychotherapy- that they display more 'unconditional positive regard'" (p.271).

Rice et al. (1974) examined the relationship between

therapist sex, theoretical orientation, and style of clinical intervention. Self-report questionnaires of rated in-therapy behaviors were analyzed for 86 therapists. Significant differences between male and female therapists emerged, with women therapists reporting themselves "more varying in their therapy behavior, less anonymous in therapy, and more judgmental" (p.413). Male therapists rated themselves as more consistent during the session, more anonymous, and more business-like. These findings were confirmed by the behavioral ratings of these therapists by their co-therapists.

Greene (1980) investigated therapist's affective reactions to the termination of psychotherapy as a function of therapist sex. Non-psychoanalytic female therapists experienced greater anxiety during termination and became more emotionally involved with their patients in terms of denying their feelings less, shifting the therapeutic relationship to a more equalitarian one, and being more available in the future than their male counterparts. The authors concluded :

> To the extent that these differences are in accord with sex-role prescriptions for more emotional expressiveness and availability by females, in general, and fewer restrictions on the expression of their dependency needs, in particular, the findings seem to provide further support for the notion of sex-role related countertransference phenomena (p.555).

Effects of therapist gender on therapy process and

outcome are most often found in higher order interactions. The most commonly found interaction has been that between therapist and client gender. Cartwright and Lerner (1963) found that experienced therapists achieved high empathy and improvement with same-sex clients while inexperienced therapists achieved high empathy and improvement with opposite-sex clients. Hill (1975) discovered that both inexperienced and experienced counselors were more empathic with same-sex clients. Similarly, in their study of clinicians' reactions to bogus case histories of passive and aggressive clients, Fisher et al. (1976) found that female and male therapists were more positive in their attitudes towards same-sex clients. Findings from these studies suggest that same-sex counseling dyads may be more satisfying and successful than cross-sex dyads, except perhaps for beginning therapists.

Wright, Meadow, Abramowitz, & Davidson (1980) investigated the interaction between therapist gender, therapist professional status, and psychiatric diagnosis. Diagnostic impressions of 200 outpatients were analyzed. Results indicated that female clinicians rendered significantly more situational diagnoses to female clients, whereas male clinicians rendered significantly more psychotic diagnoses. The authors interpreted these findings as representing female clinicians' protecting female patients from pejorative labeling effects. However, the

authors failed to recognize that perhaps women's diagnoses were reflective of their better understanding of how women as a class are adversely affected by life situations- namely, it's not all in their heads.

Study Design

This analogue study was designed to explore male and female therapists' responses to male and female "clients" who express anger and depression. The study was interested in assessing the extent to which therapist responses are affected by their gender when clients exhibit gender appropriate [anger in males, depression in females] and gender inappropriate [depression in males and anger in females] affect. Clients were portrayed by actors in videotape depictions. Subjects were asked to view two videotapes, an angry male client and depressed male client or an angry female client and depressed female client. They were then asked to report, verbally and on written questionnaires, their reactions to and perceptions of each client. They were also asked to answer a questionnaire concerning treatment recommendations. The study will be elaborated more fully in the following discussion on methodology. The construction of measures will also be described.

Hypotheses

It was hypothesized that the study would reveal sex-bias by male and female therapists in their ratings of clients who exhibited sex-role inappropriate behavior. The depressed male and angry female clients, therefore, would receive more negative evaluations than the angry male and depressed female clients on both the Therapist Feeling Towards Client and Therapist Perceptions of Client questionnaires. Similarly, the depressed male and angry female clients would receive more negative evaluations (e.g. poorer prognosis, rated as more disturbed, perceived as a less desirable client, etc.) on the Treatment Formulation questionnaire. The literature suggests that such biases against sex-role inappropriate client behavior exists in the attitudes and clinical judgments of therapists.

The literature also suggests that a double standard of mental health may exist whereby female clients, particularly sex-role inappropriate female clients, are evaluated more negatively than male clients. Subsequently, this study hypothesized that the female client, particularly the angry female client, would receive more negative evaluations on all three therapist-rated dependent measures than would the angry or depressed male client.

The literature on gender differences in male and female attitudes and behavior led to the formulation of

several hypotheses. In regards to treatment recommendations, it was hypothesized that female therapists would be more likely to recommend that intervention focus on situational factors for angry and depressed female clients. Male therapists, on the other hand, would be more likely to recommend that intervention focus on intrapsychic factors, early childhood experiences, intimacy issues, and interpersonal issues for only female clients. Male and female therapists would be equally likely to recommend that intervention focus on situational factors for male clients. In regards to what therapeutic intervention should involve, it was hypothesized that male therapists would be more likely to recommend intervention which is directive, uses confrontation, encourages self-reliance, and uses interpretation than will female therapists. Alternately, female therapists would be more likely to recommend intervention that encourages emotional expressiveness, provides empathy, and is supportive.

# CHAPTER II

# METHOD

## Subjects

Subjects included 32 (16 women, 16 men) graduate students enrolled in a counseling-related program (clinical psychology, counseling psychology, social work) in the New New England region. The majority of subjects held a B.A. or M.A. degree (34% and 44% respectively), while a minority (14%) held a Ph.D. in areas other than clinical psychology. All subjects had some formal academic training in psychotherapy technique or theory, and all had a minimum of four months and a maximum of four years of clinical experience. Independent *t*-tests (Table 1) revealed no significant differences between male and female therapist age, months practiced therapy, and number and type of cases treated. The mean age of subjects was 31.4. Information on subjects' marital status revealed that nearly equal numbers of subjects were either married, 43%, or single, 43%, while 13% were divorced or separated. In regard to theoretical orientation, therapists more often reported that they adhered to an eclectic, psychodynamic, or family systems model with an eclectic model being the most popular (43%). The mean number of months subjects had practiced psychotherapy since beginning graduate training

TABLE 1

Means, Standard Deviations and Group *t* Tests on Sex of Subject by Subject Personal Characteristics

| Variable | M | SD | t | 2-Tail p. |
|---|---|---|---|---|
| Subject Age | | | | |
| Male | 31.94 | 4.52 | .81 | .42 |
| Female | 30.88 | 5.86 | | |
| Months Practiced | | | | |
| Male | 24.63 | 14.91 | .09 | .93 |
| Female | 24.31 | 11.77 | | |
| Cases Treated | | | | |
| Male | 28.28 | 31.96 | -.18 | .86 |
| Female | 29.69 | 31.1 | | |
| Males Treated | | | | |
| Male | 9.63 | 17.1 | .58 | .56 |
| Female | 7.63 | 9.33 | | |
| Females Treated | | | | |
| Male | 18.19 | 20.65 | -.53 | .60 |
| Female | 21.19 | 24.76 | | |
| Couples & Families Treated | | | | |
| Male | 11.56 | 11.71 | 1.16 | .25 |
| Female | 8.06 | 12.36 | | |
| Individuals Treated | | | | |
| Male | 13.38 | 18.69 | -.83 | .41 |
| Female | 17.5 | 21.07 | | |

Note. For each male and female group, n = 16.

TABLE 2

Descriptive Statistics on Subject Characteristics for Male Subjects (N = 16)

| VARIABLE | Freq. | % | Mode | Range |
|---|---|---|---|---|
| Subject Age | | | 36.0 | 24-38 |
| 23-25 | 3 | 18.8 | | |
| 26-28 | 1 | 6.3 | | |
| 29-31 | 3 | 18.8 | | |
| 32-34 | 3 | 18.8 | | |
| 35-37 | 6 | 37.5 | | |
| Over 37 | 0 | 0. | | |
| Marital Status | | | | |
| Married | 9 | 56.3 | | |
| Single | 4 | 25 | | |
| Divorced/Separated | 3 | 18.6 | | |
| Highest Degree | | | | |
| B.A. | 4 | 25 | | |
| M.A. | 8 | 50 | | |
| Ph.D. | 4 | 25 | | |
| Theoretical Orientation | | | | |
| Behavioral | 1 | 6.3 | | |
| Psychodynamic | 2 | 12.5 | | |
| Eclectic | 9 | 56.3 | | |
| Interpersonal | 1 | 6.3 | | |
| Family Systems | 2 | 12.5 | | |
| Existential | 1 | 6.3 | | |
| Months Practiced Therapy | | | 24.0 | |
| 5-48 | | | | |
| 4-12 | 5 | 31.3 | | |
| 13-18 | 1 | 6.3 | | |
| 19-24 | 4 | 25 | | |
| 25-30 | 1 | 6.3 | | |
| 31-36 | 0 | 0 | | |
| 37-42 | 2 | 12.5 | | |
| 43-48 | 3 | 18.8 | | |
| Total Cases Treated | | | 6.0 | 3-97 |
| 1-5 | 3 | 18.8 | | |
| 6-10 | 5 | 31.3 | | |
| 11-20 | 0 | 0.0 | | |
| 21-30 | 4 | 25 | | |

Table 2 Continued

| Variable | Freq. | % | Mode | Range |
|---|---|---|---|---|
| **Total Cases Treated (Continued)** | | | | |
| 31-40 | 1 | 6.3 | | |
| 41-50 | 0 | 0. | | |
| Over 50 | 3 | 18.8 | | |
| **Males Treated** | | | 0.0 | 0-70 |
| 0 | 3 | 18.0 | | |
| 1-5 | 7 | 43.8 | | |
| 6-10 | 2 | 12.5 | | |
| 11-15 | 1 | 6.2 | | |
| 16-20 | 2 | 12.5 | | |
| 21-25 | 0 | 0.0 | | |
| 26-30 | 0 | 0.0 | | |
| Over 30 | 1 | 6.3 | | |
| **Females Treated** | | | 3.0 | 3-70 |
| 0 | 0 | 0.0 | | |
| 1-5 | 7 | 43.8 | | |
| 6-10 | 2 | 12.5 | | |
| 11-15 | 1 | 6.2 | | |
| 16-20 | 0 | 0.0 | | |
| 21-25 | 2 | 12.5 | | |
| 26-30 | 0 | 0.0 | | |
| Over 30 | 4 | 25 | | |
| **Couples & Families Treated** | | | 1.0 | 0-35 |
| 0 | 1 | 6.3 | | |
| 1-5 | 6 | 37.5 | | |
| 6-10 | 3 | 18.8 | | |
| 11-15 | 1 | 6.3 | | |
| 15-20 | 1 | 6.3 | | |
| 21-25 | 1 | 6.3 | | |
| 26-30 | 2 | 12.5 | | |
| Over 30 | 1 | 6.3 | | |
| **Individuals Treated** | | | 1.0 | 1-65 |
| 1-5 | 7 | 43.8 | | |
| 6-10 | 4 | 25 | | |
| 11-15 | 2 | 12.5 | | |
| 16-20 | 0 | 0.0 | | |
| 21-25 | 0 | 0.0 | | |
| 26-30 | 1 | 6.3 | | |
| 31-35 | 0 | 0.0 | | |
| Over 35 | 2 | 12.5 | | |

TABLE 3

Descriptive Statistics on Subject Characteristics for Female Subjects (N = 16)

| Variable | Freq. | % | Mode | Range |
|---|---|---|---|---|
| Subject Age | | | 27.00 | 23-43 |
| 23-25 | 2 | 12.5 | | |
| 26-28 | 7 | 43.8 | | |
| 29-31 | 0 | 0.0 | | |
| 32-34 | 3 | 18.8 | | |
| 35-37 | 1 | 6.3 | | |
| Over 38 | 3 | 18.8 | | |
| Marital Status | | | | |
| Married | 5 | 31.3 | | |
| Single | 10 | 62.5 | | |
| Divorced/Separated | 1 | 6.3 | | |
| Degree Obtained | | | | |
| B.A. | 7 | 43.8 | | |
| M.A. | 8 | 50. | | |
| Ph.D. | 1 | 6.3 | | |
| Theoretical Orientation | | | | |
| Behavioral | 0 | 0.0 | | |
| Psychodynamic | 3 | 18.8 | | |
| Eclectic | 10 | 62.6 | | |
| Interpersonal | 1 | 6.3 | | |
| Family Systems | 2 | 12.5 | | |
| Existential | 0 | | | |
| Months Practiced Therapy | | | 24.0 | 4-48 |
| 4-12 | 2 | 12.5 | | |
| 13-18 | 4 | 25 | | |
| 19-24 | 5 | 31.2 | | |
| 25-30 | 2 | 12.5 | | |
| 31-36 | 1 | 6.3 | | |
| 37-42 | 0 | | | |
| 43-48 | 2 | 12.5 | | |
| Total Cases Treated | | | 2.0 | 2-100 |
| 1-5 | 4 | 25 | | |
| 6-10 | 2 | 12.5 | | |
| 11-20 | 3 | 18.8 | | |
| 21-30 | 1 | 6.3 | | |

Table 3 Continued

| Variable | Freq. | % | Mode | Range |
|---|---|---|---|---|
| Total Cases Treated (Continued) | | | | |
| 31-40 | 2 | 12.5 | | |
| 41-50 | 2 | 12.5 | | |
| Over 50 | 2 | 12.5 | | |
| Males Treated | | | 0 | 0-30 |
| 0 | 4 | 25 | | |
| 1-5 | 5 | 31.2 | | |
| 6-10 | 4 | 25 | | |
| 11-15 | 0 | | | |
| 16-20 | 1 | 6.3 | | |
| 21-25 | 1 | 6.3 | | |
| 26-30 | 1 | 6.3 | | |
| Over 30 | 0 | | | |
| Females Treated | | | 4.0 | 2-80 |
| 0 | 0 | 0.0 | | |
| 1-5 | 5 | 31.2 | | |
| 6-10 | 4 | 25 | | |
| 11-15 | 1 | 6.3 | | |
| 16-20 | 1 | 6.3 | | |
| 21-25 | 1 | 6.3 | | |
| 26-30 | 1 | 6.3 | | |
| Over 30 | 3 | 18.8 | | |
| Couples & Families Treated | | | 0.0 | 0-50 |
| 0 | 4 | 25 | | |
| 1-5 | 6 | 37.5 | | |
| 6-10 | 3 | 18.8 | | |
| 11-15 | 1 | 6.3 | | |
| 16-20 | 1 | 6.3 | | |
| 21-25 | 0 | | | |
| 26-30 | 0 | | | |
| Over 30 | 1 | 6.3 | | |
| Individuals Treated | | | 2.0 | 2-80 |
| 1-5 | 5 | 31.2 | | |
| 6-10 | 5 | 31.2 | | |
| 11-15 | 1 | 6.3 | | |
| 16-20 | 1 | 6.3 | | |
| 21-25 | 0 | | | |
| 26-30 | 1 | 6.3 | | |
| Over 35 | 3 | 18.8 | | |

was 24. The mean number of total cases treated by subjects was 30. Summaries of interval and nominal descriptive statistics of male and female subjects are presented in Tables 2 and 3 respectively.

Recruitment of subjects was conducted by the experimenter through personal contact. Students enrolled in the clinical psychology and counseling psychology programs at the University of Massachusetts were asked for their participation by the experimenter in person or by telephone. Students enrolled at the Smith College School of Social Work and at Antioch College were contacted with the assistance of the Director of Research Training at each college. Each Director was sent a copy of the experimenter's master's thesis proposal and a statement of intention. The Directors then authorized their students' participation and sent the experimenter a list of students' addresses and telephone numbers. Prospective students from these two colleges were contacted by phone; however, only students from Antioch College agreed to participate.

Whether students were recruited in person or by telephone, a standardized recruitment procedure was used (see Appendix A for telephone protocol). The experimenter first introduced herself and stated that she was a third year doctoral student in clinical psychology at the University of Massachusetts at Amherst. The study was described as a Master's thesis project examining

therapists' reactions to clients presenting different problems. Subjects were informed that they would view videotaped depictions of clients in a simulated therapy setting and would be asked to report their responses along certain cognitive and affective dimensions. Students were given the option to participate in the study either at their personal offices or at the experimenter's laboratory at the University of Massachusetts. However, only two subjects opted to participate at their offices. Students were assured that data from their participation would be kept strictly confidential and were informed that results from the study would be made available to them upon their request. They were also informed that no foreseeable risks were involved in their participation. The benefits from participation were explained as an opportunity to examine, in a controlled setting, the ways in which they respond to clients with different presenting problems. For students who agreed to participate, a one hour appointment was scheduled. On the day before the scheduled appointment, the experimenter called each subject to remind him/her of the appointment.

## Stimulus Materials:

Stimulus materials consisted of two videotape vignettes depicting presenting problems often encountered

at university counseling centers and training clinics. One videotape vignette depicted an angry, assertive client who was upset over a recent separation from a girl/boyfriend. The other videotape vignette depicted a depressed, passive client who was sad over a recent separation from a girl/boyfriend. Each vignette was portrayed by a male and female actor. The angry male and female client-actors used identical scripts as did the the depressed male and female client-actors (see Appendix B for scripts).

The client-actors were professional actors who had performed in stage productions in the Western Massachusetts region. Each actor was paid twenty-five dollars for his/her services. Two females and two males each made an angry and depressed videotape vignette yielding a total of eight vignettes: two angry male, two angry female, two depressed male, and two depressed female. The scripts for both angry and depressed clients contained an equal number of feeling words (N = 17). The angry script was slightly longer (262 words compared against 228 words) because the client's speech was faster, with less frequent pauses than was the depressed client's speech. The overall length of the videotapes for the angry client was two minutes, fifteen seconds while that for the depressed client was three minutes, fifteen seconds.

Actors were videotaped full face as to appear to be talking directly to the therapist. The two male actors were

ages 28 and 34 and the two female actors were ages 24 and 32. All were of average weight and physical attractiveness. For the taping, the actors were well groomed and dressed in similar casual, neat attire. One of the female actors wore a V-neck dress while the other three wore an oxford shirt and polyester pants. The tapes were made in black in white as to heighten the "projective" quality of the tape, hence, the color of the actor's attire was unimportant.

Validity checks of the depressed and angry stimulus conditions were conducted by three licensed clinical psychologists naive to the study's purpose. All three psychologists agreed that the videotapes had face validity concerning the intensity and clarity of the actors' portrayal of anger and depression. They also rated the technical quality of the videotapes from good to excellent.

## Dependent measures

Personal Data Sheet: The personal data sheet [see Appendix C] was used to obtain general background information about each subject. This measure included questions concerning the subject's gender, marital status, highest degree obtained, theoretical orientation, and amount of clinical experience. To determine if the study's underlying intention was transparent, the last question asked what the subject thought the study intended to

investigate. Three subjects listed "gender" as one of several possible variables under investigation but no one listed "gender" or "therapist sex-role stereotypes" as the sole or primary variable. The majority of subjects expressed surprise upon learning the true purpose of the study.

Therapist Feelings Toward Client: This was a self-report set of semantic differential scales comprised of a list of 25 bipolar adjectives anchored with a 7-point rating scale (see Appendix D). Subjects were asked to rate each adjective pair by indicating which response option best represented how the subject felt toward the client. The first 23 items were derived from Johnson (1977) who had found them to be frequently reported therapist feelings toward angry and depressed clients in her counseling analogue study. The last two items were derived from Howard and Orlinsky's (1970) and Hill's (1975) studies which both found them to be commonly expressed feelings of therapists toward clients. The favorable and unfavorable ends of each item were reversed in random order to control for acquiescence and positional response biases. However, for purposes of the data analysis, the favorable and unfavorable ends of each item were coded in a similar direction for clarity in interpreting results.

Therapist Perceptions of Client: This is a set of self-report semantic-differential scales containing a list

of 32 bipolar adjectives anchored with a 7-point rating scale (see Appendix E). Subjects were asked to rate each scale with respect to his/her perception of the client's personality traits. Items were selected for this scale on the basis of past research documenting their sensitivity to therapist perceptions of clients related to therapist biases: (1) gender differences, (2) sex bias, and (3) sex-role stereotyping. Items 1 through 11 were derived from Johnson (1977) who had reported them to be frequently reported therapist perceptions of angry and depressed clients. Items 12 through 13 were selected from a list of traits that Broverman et al. (1970) had found to significantly discriminate between what clinicians perceived as characteristic of a healthy female adult and a healthy male adult. Items 14 through 17 were selected from Kout's (1985) 19 item Clinical Judgement Scale which measures clinical impressions along a global dimension of pessimism- optimism for clinical prognosis. Items 18 through 20 were selected from a list of 37 adjective descriptions of male and female patients that Jones & Zoppel (1982) found to significantly differ among male and female therapists. Item 21 was selected from a list of ten adjective descriptions of therapist perceptions of their clients in Kaccoun & Lavigueur's (1979) study. Finally, items 22 through 32 were derived from the experimenter's own speculations. The favorable and unfavorable ends of

each item were reversed, in random order, to control for acquiescence and positional response biases. Again, for purposes of data analysis, the favorable and unfavorable ends of each item were coded in a similar direction for clarity of results.

Treatment Formulation: This was an 18 item questionnaire regarding various treatment formulation dimensions (see Appendix F). Items 1 through 15 were 7-point rating scales on which subjects marked how much they would incorporate that treatment formulation dimension into his/her treatment plan (1=not at all, 7=all of the time). Items 1 through 4 concerned the extent to which the therapeutic intervention should focus on early childhood experiences (Haccoun & Lavigueur, 1979; Bowman, 1982), interpersonal/intimacy issues (Bowman, 1982), intrapsychic factors (Bowman, 1982, Stein et al.,1976, Haccoun & Lavigueur, 1979), and situational factors (Stein et al.,1976, Haccoun & Lavigueur, 1979). Items 5 through 11 concerned the extent to which the therapeutic intervention should involve interpretation (Haccoun & Lavigueur, 1979), provide empathy (Haccoun & Lavigueur, 1979), encourage self-reliance (Fisher et al.,1976), encourage emotional expressiveness (Fisher et al.,1976), be supportive, be directive (Fisher, 1976, Haccoun & Lavigueur, 1979), and item 11 was an open-ended question for additional treatment formulation suggestions. Items 12 through 15 asked for clinical

judgments of the client's motivation for therapy (Parsons & Parker, 1968, Houts, 1985, Haccoun & Lavigueur, 1979), the client's prognosis (Houts, 1985, Fisher et al., 1976, Gomes & Abramowitz, 1976, Hill et al.,1977, Billingsley, 1977), the client's degree of psychological disturbance (Fisher et al.,1976, Billingsley, 1977, Helms, 1978), and how much the therapist would like to treat the client (Hill, 1975, Parsons & Parker, 1968, Fisher et al.,1976). Items 16 and 17 were open-ended questions asking how many times per week the client should be treated and over how many weeks. Item 18 was a forced choice question asking the therapist who was more responsible for the relationship breaking-up, the client or his/her lover?

## Procedure

Subjects were tested individually by the experimenter at her research laboratory (N = 30) or at their offices (N = 2). First, they were greeted and asked to fill out an informed consent form (see Appendix G). When the study did not take place in the laboratory, the experimenter took this time to set up the videotape machine. The subject was then handed a manual containing the standard instructions, client intake forms, subject self-rated questionnaires, and subject personal data sheet. The experimenter read the instructions to each subject (see Exhibit 1). The

Exhibit 1

## INSTRUCTIONS TO SUBJECTS

Today you will participate in a study examining therapists' responses to clients with different presenting problems. The study utilizes videotaped depictions of hypothetical clients who have been modeled after actual clients. You are to take the role of the therapist. First, you will be given an intake form which you may read over for a few minutes, and prepare yourself as if you were going to conduct an initial interview with the client. When you feel prepared, push the PAUSE button of the remote control device to turn on the videotape. You will view the client describing his/her problem. After a few minutes when the videotape stops, push the PAUSE button again. I will then ask you to describe your immediate feelings towards and perceptions of the client. This is not a request for a clinical description but for your immediate SUBJECTIVE, PERSONAL REACTIONS. These verbal responses will be tape recorded. When you have finished responding, you will fill out a few questionnaires. This exact procedure will be repeated with your viewing a second client.

After each videotape:

1. Describe as fully as possible how you are FEELING toward the client right now.

2. Describe as fully as possible how you PERCEIVE the client right now.

3. What do you feel he/she wants from you?

4. How might you verbally respond to the client?

instructions stated that two videotaped vignettes would be presented and that subjects would be asked to describe both verbally, and on a written questionnaire their feelings toward and perceptions of the client. Subjects were informed that their verbal responses were tape recorded.

Each subject received two intake forms and viewed two videotapes. Half of the male and half of the female subjects viewed an angry male and a depressed male; the other half viewed an angry female and a depressed female. Subjects were randomly assigned to each client pair based on a table of random permutations. Order of client within pairs was counterbalanced to control for order effects.

After the general procedure was explained, the subject was asked to turn to the one-page intake form in the manual [see Appendix H] which outlined salient information about the first client's background and presenting problem. The subject was told that he/she was to read the intake form, prepare him/herself for meeting the client as they would do before an actual session, and when they felt ready, to turn on the videotape machine. The subject was instructed to view the videotape as if he/she were actually conducting therapy with the client. The researcher sat behind the subject so as to be out of his/her view. After the first vignette [approximately two to three minutes later], the subject stopped the videotape machine and was asked to respond to the questions presented in Exhibit 1.

When the subject finished responding, he/she was asked to fill-out the first three self-rated questionnaires in the manual: the Therapist Feelings Toward Client, the Therapist Perception of Client, and the Treatment Formulation. When the subject's questionnaires were completed, he/she was instructed by the manual to read the intake form on the following page and when ready, to start the videotape. After the second tape was completed, the procedure was then repeated with the subject viewing the second vignette. At the end of the procedure, the subject was asked to complete the Personal Data Sheet. The session was completed with the experimenter thanking the subject for his/her participation and giving him/her a debriefing form [see Appendix I]. Subjects were also asked not to divulge information about the study to friends or colleagues.

# CHAPTER III

## RESULTS

Because each subject-therapist viewed two videotapes, initial analysis explored whether therapist responses to each videotape were confounded by order in which the videotape was viewed and the client-actor who played the depressed/angry role. More specifically, were therapists' responses influenced by the fact that half of the subjects viewed the depressed tape first and the angry tape second, while the other half viewed the angry tape first and the depressed tape second? Also, were therapists' responses influenced by the particular male or female actor in each tape? To test whether therapist responses were independent of order and actor variables, a Five-Way Analysis of Variance [order x actor x therapist gender x client gender x affect] was conducted on the Perceptions of Client and Feelings Toward Client Scales. No significant main or interaction effects were found for order and actor. Therefore, data were collapsed across these two variables, yielding a total of 64 [32 male & 32 female] therapist response sets for data analysis.

### Factor Analysis on Perceptions of Client Items

A factor analysis was conducted on the 32 perceptions

of client items. The codings of all negative items were reversed so that factors would load unidirectionally. Items were analyzed using a principle components analysis with a varimax rotation. Four orthogonal factors emerged with eigenvalues greater than 1.00. Only the first factor was retained for analysis because it had an eigenvalue of 10.24 while the other factors had eigenvalues ranging from 1.22 to 3.57. This demonstrated that the first factor accounted for 33% of the total variability and 53.5% of the communal variability. Therefore, the first factor best represented the observed interrelations of the data while the other factors did not. The complete varimax rotated matrix appears as Table 9 in Appendix J, with the items chosen for the first factor underlined.

Table 4 presents the perceptions of client items that marked the first factor along with their accompanying factor loadings and corrected item-total correlation coefficients. Two criteria were used in selecting items as markers in the first factor. First, only those items were selected which had a positive loading of .40 or above. Second, a Cronbach's alpha was calculated on the remaining items and those items serving to lower this alpha were deleted. The Cronbach's alpha on the final selection of items was .94, indicating that the factor as selected and defined reliably represented an underlying pattern of therapists' perceptions of clients.

Table 4

Means, Standard Deviations and Item-Total Correlations For Perceptions of Client Scale Items (based on N=64)

| Variable | Factor Loading | M | SD | Corrected Item-Total Correlation |
|---|---|---|---|---|
| accepting-rejecting | .88 | 4.47 | 1.58 | .86 |
| even-tempered-volatile | .81 | 4.68 | 1.62 | .77 |
| calming-abrasive* | .81 | 4.68 | 1.38 | .79 |
| passive-aggressive* | .79 | 4.28 | 1.61 | .74 |
| cooperative-uncooperative | .78 | 3.77 | 1.49 | .74 |
| submissive-domineering* | .76 | 4.02 | 1.52 | .71 |
| unselfish-selfish* | .75 | 4.34 | 1.43 | .73 |
| genuine-deceptive | .66 | 3 .13 | 1.66 | .65 |
| emotionally mature-emotionally immature | .65 | 4.60 | 1.36 | .62 |
| undramatic-dramatic* | .65 | 5.03 | 1.46 | .63 |
| unassuming-demanding* | .63 | 5.22 | 1.66 | .61 |
| rational-irrational | .62 | 3.85 | 1.33 | .58 |
| likeable-unlikable | .61 | 3.42 | 1.54 | .58 |

Table 4 Continued

| Variable | Factor Loading | M | SD | Corrected Item-Total Correlation |
|---|---|---|---|---|
| reliable-unreliable | .60 | 3.56 | 1.22 | .57 |
| not manipulative-manipulative* | .58 | 4.55 | 1.26 | .57 |
| insightful-uninsightful | .51 | 3.83 | 1.39 | .49 |
| self-disclosing-secretive* | .51 | 3.64 | 1.38 | .49 |
| emotionally stable-emotionally unstable | .47 | 4.67 | 1.25 | .45 |

Note. Cronbach's alpha = .935
The first variable represents the positive pole of the Perceptions of Client Scale while the second variable represents the negataive pole.
* The original codings of these items were reversed for the purposes of this analysis, so that ratings on all perceptions of client would have a uniform directionality.

This factor consisted of 18 items drawn from the Perceptions of Client Scale. The three loading items with the highest loading (.81 +) were: accepting-rejecting, even-tempered- volatile, calming-abrasive. Others items marking the factor were: passive-aggressive, cooperative-uncooperative, submissive- domineering, unselfish-selfish, genuine-deceptive, emotionally mature- emotionally immature, undramatic-dramatic, unassuming- demanding, rational-irrational, likeable-unlikeable, not manipulative-manipulative, insightful-uninsightful, self-disclosing- secretive, and emotionally stable-emotionally unstable. This factor represents the dimension of therapists perceiving the client as generally receptive to therapy versus rejecting of therapy.

Factor Analysis on Feelings Toward Client Items

A factor analysis was conducted on the 25 feelings toward client statements. The factor analysis and the criteria used in the selection of factor items were identical to those employed in the Perceptions of Client Scale. Items were analyzed using a principle components analysis with a varimax rotation procedure. Four orthogonal factors emerged with eigenvalues greater than 1.00. Only the first factor was retained for analysis because it had an eigenvalue of 9.46 while the other factors had

eigenvalues ranging from 1.01 to 2.49. This demonstrated that the first factor accounted for 37.9% of the total variability and 59.2% of the communal variability. Thus, the first factor represented the best observed interrelations of the data while the other factors did not. The complete varimax rotated matrix appears as Table 10 in Appendix K, with the items chosen for the first factor underlined.

Table 5 presents the feelings toward client statements that marked the first factor along with their accompanying factor loadings and corrected item-total correlation coefficients. The Cronbach's alpha for the first factor was .93, indicating that the factor as selected and defined reliably represented an underlying pattern of therapists' feelings toward clients.

The first factor consisted of 14 of the items drawn from the Feelings Toward Client scale. The four highest loading items (.81+) were: unperturbed-angry, tolerant-intolerant, empathic-unempathic, and sympathetic-unsympathetic. This factor also included: relaxed-tense, masterful-frustrated, comfortable- uncomfortable, supportive-unsupportive, unprovoked- provoked, pleased-annoyed,accepting-critical,clear-headed-perplexed, caring-uncaring, and hopeful-pessimistic. This factor represents the dimension of therapists feeling supportive versus unsupportive of the client.

Table 5

Means, Standard Deviations and Item-Total Correlations For Feelings Toward Client Scale Items (based on N=64)

| Variable | Factor Loading | M | SD | Corrected Item-Total Correlation |
|---|---|---|---|---|
| unperturbed-angry | .84 | 3.13 | 1.56 | .83 |
| tolerant-intolerant | .82 | 2.91 | 1.37 | .78 |
| empathic-unempathic | .81 | 2.59 | 1.22 | .78 |
| sympathetic-unsympathetic | .81 | 2.67 | 1.25 | .75 |
| comfortable-uncomfortable | .76 | 3.38 | 1.60 | .73 |
| caring-uncaring | .75 | 2.41 | .90 | .69 |
| supportive-unsupportive | .71 | 2.84 | 1.28 | .67 |
| unprovoked-provoked | .70 | 3.73 | 1.65 | .72 |
| pleased-annoyed | .69 | 4.25 | .99 | .67 |
| accepting-critical* | .64 | 3.42 | 1.56 | .61 |
| relaxed-tense* | .60 | 4.05 | 1.52 | .57 |
| hopeful-pessimistic* | .59 | 2.98 | 1.32 | .54 |
| masterful-frustrated | .58 | 3.36 | 1.55 | .55 |

Table 5 Continued

| Variable | Factor Loading | M | SD | Corrected Item-Total Correlation |
|---|---|---|---|---|
| clear-headed-perplexed* | .55 | 3.09 | 1.51 | .52 |

Note: Cronbach's alpha = .926
The first item represents the positive pole of the Feelings Toward Client scale while the second item represents the negative pole.
* The original codings of these items were reversed for the purposes of this analysis, so that ratings on all items would have a uniform directionality.

## Analysis of Variance

On each of the Perceptions of Client and Feelings Toward Client Scales, factor scores were calculated by creating an additive index of subject ratings on factor markers. These factor scores, and subjects' scores on each of the 17 treatment variables, were submitted to 2 x 2 x 2 (therapist gender x client gender x affect) ANOVAS. For significant interaction effects, post hoc comparisons between means were made. The Newman-Keuls test was used for all pair-wise comparisons between means, and the Scheffe test was used for general comparisons among means.

For analyses that found significant main or interaction effects, ANOVA statistics are presented in Table 6. Cell means for significant main effects are presented in Table 7 while cell means for significant interaction effects are presented in Table 8. For analyses that revealed no significant main or interaction effects, ANOVA statistics and cell means are presented in Appendix L, Table 10 and Appendix M, Table 11 respectively. Results of the Newman-Keuls test and Sheffe test are presented in Table 8.

Main Effects:

The results demonstrated that therapist gender influenced certain therapist recommendations for treatment.

Table 6

Three Way ANOVAs on Dependent Variables

Perception of Client

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender (A) | 1 | 1064.39 | 6.89 |
| Affect (B) | 1 | 9240.02 | 59.80** |
| Therapist Gender (C) | 1 | 31.64 | .21 |
| A x B | 1 | 3.52 | .02 |
| A x C | 1 | 1691.27 | 10.95** |
| B x C | 1 | .016 | .00 |
| A x B x C | 1 | .016 | .00 |
| Error | 56 | 154.51 | |

Therapy should focus on interpersonal/intimacy issues.

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender (A) | 1 | 0 | 0 |
| Affect (B) | 1 | .25 | .35 |
| Therapist Gender (C) | 1 | .06 | .09 |
| A x B | 1 | .06 | .09 |
| A x C | 1 | 6.25 | 8.81** |
| B x C | 1 | 0 | 0 |
| A x B x C | 1 | .06 | .09 |
| Error | 56 | .71 | |

Therapy should be directive.

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender (A) | 1 | 6.89 | 4.52* |
| Affect (B) | 1 | .14 | .09 |
| Therapist Gender (C) | 1 | .77 | .50 |
| A x B | 1 | .02 | .01 |
| A x C | 1 | 8.27 | 5.42* |
| B x C | 1 | .14 | .09 |
| A x B x C | 1 | .02 | .01 |
| Error | 56 | 1.53 | |

Table 6 Continued

Degree of psychological disturbance.

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender (A) | 1 | 1.56 | 2.87 |
| Affect (B) | 1 | .06 | .12 |
| Therapist Gender (C) | 1 | 1.0 | 1.84 |
| A x B | 1 | .06 | .12 |
| A x C | 1 | 2.25 | 4.13* |
| B x C | 1 | .25 | .50 |
| A x B x C | 1 | .25 | .50 |
| Error | 56 | .55 | |

Degree client will profit from therapy

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender (A) | 1 | 1.0 | 2.84 |
| Affect (B) | 1 | 1.56 | 4.43* |
| Therapist Gender (C) | 1 | .25 | .71 |
| A x B | 1 | .56 | 1.60 |
| A x C | 1 | .25 | .71 |
| B x C | 1 | .56 | 1.60 |
| A x B x C | 1 | .06 | .18 |
| Error | 56 | .35 | |

Client's motivation for therapy

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender (A) | 1 | 1.27 | 1.65 |
| Affect (B) | 1 | 4.52 | 5.90* |
| Therapist Gender (C) | 1 | .14 | .18 |
| A x B | 1 | .14 | .18 |
| A x C | 1 | .14 | .18 |
| B x C | 1 | .02 | .02 |
| A x B x C | 1 | .14 | .18 |
| Error | 56 | .77 | |

Table 6 Continued

Degree therapist wants to treat client

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender (A) | 1 | 2.25 | 3.54 |
| Affect (B) | 1 | .02 | .07 |
| Therapist Gender(C) | 1 | 3.06 | 4.87* |
| A x B | 1 | 1.0 | 1.59 |
| A x C | 1 | .56 | .89 |
| B x C | 1 | .06 | .10 |
| A x B x C | 1 | .56 | .89 |
| Error | 56 | .63 | |

Times per week client should be seen.

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender(A) | 1 | .39 | 1.44 |
| Affect (B) | 1 | .02 | .07** |
| Therapist Gender (C) | 1 | 2.65 | 9.81 |
| A x B | 1 | .22 | .22 |
| A x C | 1 | .24 | .89 |
| B x C | 1 | .05 | .19 |
| A x B x C | 1 | .21 | .78 |
| Error | 56 | 15.12 | |

Number of weeks client should be seen.

| Variable | DF | MS | F |
|---|---|---|---|
| Client Gender (A) | 1 | 112.89 | .06 |
| A ffect (B) | 1 | 92.64 | .05 |
| Therapist Gender (C) | 1 | 8765.64 | 4.77* |
| A x B | 1 | 9.77 | .01 |
| A x C | 1 | 968.77 | .53 |
| B x C | 1 | 87.89 | .05 |
| A x B x C | 1 | 405.02 | .22 |
| Error | 56 | 1840.24 | |

* $p < .05$
** $p < .01$

Table 7

Cell Means of Significant Main Effects

| | Client Gender | | Affect | | Therapist Gender | |
|---|---|---|---|---|---|---|
| | Male | Female | Anger | Depr. | Male | Female |
| Perceptions of Client | 4.44 | 3.98 | 4.88 | 3.54 | | |
| Therapy should be directive | 3.80 | 3.10 | | | | |
| Degree client will profit from therapy | | | 3.60 | 3.90 | | |
| Client's motivation for therapy | | | 3.13 | 3.66 | | |
| Degree therapist wants to treat client | | | | | 3.80 | 3.40 |
| Times per/week client should be seen | | | | | 1.49 | 1.08 |
| Number of weeks client should be seen | | | | | 51.80 | 28.40 |

Table 8

Cell Means and
Post Hoc Mean Comparisons of
Significant Interaction Effects[a 1]

| Variable | Male therapist Male client | Male therapist Female client | Female therapist Male client | Female therapist Female client |
|---|---|---|---|---|
| Perceptions of Client | 4.76[a 1] | 3.74[b 2] | 4.11[a 1] | 4.23[a 1] |
| Therapy should focus on Interpersonal/Intimacy Issues | 5.69[a 1] | 5.06[a 2] | 5.00[a 2] | 5.63[a 1] |
| Therapy should be directive | 3.50[a 1] | 3.56[ab 1] | 4.00[a 1] | 2.63[b 2] |
| Degree of psychological disturbance | 3.19[a 1] | 3.13[a 1] | 2.56[b 2] | 3.25[a 1] |

[a] Means that do not share any common subscripts were found to be significantly different from eachother on Newman-Keuls comparisons at $p < .05$.

[1] The average of the means that share common numerical subscripts were found to be significantly different from the average of the means that share a different common numerical subscript.

Male therapists reported a greater desire to treat clients than did female therapists [3.80 vs. 3.40], F [1,56] = 4.87, p < .03. Male therapists also recommended that clients be seen in therapy more times per week [1.49 vs. 1.08], F [1,56] = 9.81, p < .005 and for more weeks [51.80 vs 28.40], F [1,56] = 4.77, p < .03 than did female therapists.

Significant main effects were revealed for client affect. Angry clients were perceived more negatively than were depressed clients [4.88 vs. 3.54], F [1,56] = 59.80, p < .001. Angry clients were also judged as profiting less from therapy [3.60 vs. 3.90], F [1,56] = 4.43, p < .04 and as less motivated for therapy [3.13 vs. 3.66], F [1,56] = 5.90, p < .02 than depressed clients.

Significant main effects for client gender were found on two dependent variables. The perceptions of client mean score for female clients was less than mean score for male clients [3.98 vs. 4.44], F [1,56] = 6.89, p < .01. This indicated that female clients were perceived more positively than were male clients. This main effect is better understood given the significant interaction effect discussed below. Female clients were also rated as less in need of direction in therapy than were male clients [3.10 vs. 3.80], F [1,56] = 4.52, p < .04. Several treatment variables approached significance. There were trends toward therapists preferring to treat female clients over male

clients [3.81 vs. 3.44], $p < .06$ and perceiving female clients as as profiting more from therapy [3.88 vs. 3.44], $p < .10$] than male clients.

Interaction Effects:

Only therapist gender by client gender significant interactions emerged. Therapists' evaluations of the degree of the client's psychological disturbance revealed a significant interaction, $F [1,56] = 4.13$, $p < .05$. Newman-Keuls tests demonstrated that male therapists rated male and female clients comparably. Female therapists, however, rated male clients as significantly less disturbed than female clients. This rating was also significantly lower than that by male therapists of both genders. In addition, Scheffe mean comparisons found that female therapists' mean rating of male clients was less than the average mean rating of the other three therapist/client dyads combined. This finding may account for the trend towards a significant main effect for male clients being perceived as less psychologically disturbed than female clients. In summary, male therapists judged male and female clients comparably, but female therapists' judged male clients as significantly less disturbed compared to the judgments of the other three therapist/client dyads.

On the Therapist Perceptions of Client Scale, a significant interaction was revealed, $F [1,56] = 10.95$, $p < .002$. Low ratings on this scale indicated more positive

perceptions of clients (toward the receptivity to therapy end) whereas high ratings indicated more negative perceptions of clients (toward the rejection of therapy end). Newman-Keuls tests found that whereas female therapists mean rating for male and female clients was similar, male therapists' mean rating was significantly lower than the mean ratings of the other three therapist/client dyads. This low mean rating may account for the main effect of more positive perceptions of female clients than of male clients. Sheffe comparisons found that male therapists' mean rating was significantly lower than the average mean ratings for the other three therapist/client dyads combined. This pattern suggests that female therapists perceived male and female clients similarly, but male therapists had more positive perceptions of female clients compared to the perceptions reported by the other three therapist/client dyads.

On judgments concerning the degree to which therapy should focus on interpersonal/intimacy issues, a significant therapist gender by client gender effect emerged, $F(1,56) = 8.81$, $p < .01$. Newman-Keuls tests revealed no significant pair-wise differences between means. However, Scheffe tests found that male and female therapists' ratings of same-gender clients were higher than ratings of opposite-gender clients ($p < .05$). This result indicates that for same-gender clients, therapists believed

that therapy should have focused more on interpersonal/ intimacy issues.

Finally, when therapists were asked to what degree therapy should be directive, a significant therapist gender by client gender interaction emerged, $F(1,56) = 5.42$, $p < .02$. Male therapists rated male and female clients comparably. However, Newman-Keuls tests found that female therapists rated female clients as needing significantly less direction than male clients; this rating was significantly lower than that given by male therapists to male clients. These differences help explain the main effect of female clients rated less in need of direction in therapy than male clients. Scheffe tests revealed that female therapists' mean rating of female clients was significantly lower than the average mean rating of the other three therapist/client dyads combined. In summary, male therapists judged male and female clients comparably,but female therapists' judged female clients as needing significantly less direction compared to the judgments of the other therapist/client dyads.

# CHAPTER IV

## DISCUSSION

The primary hypothesis of this study was that there would be clinical bias found in therapist cognitive and affective reactions as a function of therapists of both genders, client gender, and client affect. It was hypothesized that therapists would give more negative evaluations to clients who exhibited sex-role inappropriate behaviors [i.e., depression for men, anger for women] than they would to clients who exhibited sex-role appropriate behaviors [i.e., anger for men, depression for women]. It was also hypothesized that therapists' clinical judgments would reflect a double standard of mental health, whereby angry female clients would be evaluated more negatively than would angry or depressed male clients. Lastly, it was hypothesized that therapists' clinical judgments would reflect particular gender-related attitudes and behaviors.

Results of the study failed to confirm all of the original hypotheses. However, several consistent effects of therapist gender, client gender, and client affect were found and could be regarded as sources of clinical bias. These effects were not predicted but they have important implications for psychotherapy process and outcome. These biases were primarily evident for therapists' perceptions of clients [namely, perceptions of client's receptivity to

therapy) and therapists' clinical judgments.

Male and female therapists differed from one another on three clinical judgment items. In contrast to female therapists, male therapists expressed a greater desire to treat clients and recommended that clients be seen in therapy more times per week and over a longer period of time. These findings are difficult to interpret because related findings have not been reported in the literature. On one level, it can be surmised that male therapists had a greater desire to treat clients than did female therapists, and this desire translated into their prescribing a more intensive treatment plan.

On another level, these findings might be related to cultural prescriptions for masculinity and femininity that influence how therapists perceive and relate to clients. The literature presented in the introduction outlined current theories of gender and personality. These theories suggest that male attitudes and behavior may be characterized by considerations of agency: self-assertion, dominance, control, and independence. In contrast, female attitudes and behavior may be characterized by considerations of communion: cooperation, dependence, submissiveness, and closeness. Perhaps the male therapists' greater desire to treat clients and their treatment prescriptions were representative of a more authoritarian, controlling masculine style. An informal analysis of

therapist verbal responses supports this notion. For example, themes of clients being "saved" or "rescued" theme emerged in the verbal responses of male therapists but not in those of female therapists'. Commenting on his perceptions of a depressed male client, a male therapist stated:

> I think it seems like he wants to be pursued if that makes any sense to you, and to be rescued.

Another male therapist who viewed a depressed male client said:

> He might be the kind of person who wants you to save him but I'm not certain about that.

After viewing a depressed female client, a male therapist replied:

> That look, I kind of go "bong" when she had that look I found myself backing up a little bit and wondering what that request, "Can you help me?", meant. The way she delivered it alerted me to something about my feelings for her. Sort of with her I had this struggle thinking "Oh, poor thing" and then not wanting to get drawn into that I could rescue her.

Themes around clients being "saved" or "rescued" emerged in male therapists' responses to clients of both genders. This finding might point to male therapists attempting to assert their superiority, status, or control over clients. However, we cannot assume that male therapists were any more authoritarian or controlling than were the female therapists. Perhaps our female therapist sample had similar inclinations or fantasies around clients being saved or rescued, but they chose not to verbalize them, or they did, but not in ways that were recognized as such.

The study found that therapists' perceptions and clinical judgments of clients were strongly influenced by client affect. On the Perceptions Scale, therapists perceived angry clients more negatively than depressed clients. Therefore, angry clients were judged to be less receptive to therapy and more rejecting of therapy. Therapists also judged angry clients as less able to profit from and be motivated for therapy. These findings corroborate those reported in earlier studies on angry and sad clients (Haccoun & Lavigueur, 1979); hostile versus friendly clients (Heller, Myers, & Kline, 1963; Parsons & Parker, 1968) and explosive versus restrictive clients (Billingsley, 1977). In Haccoun & Lavigueur's study, therapists perceived female clients as less able to profit from therapy, less motivated for therapy, less self-controlled, responding more inappropriately to their problem, less easy to relate to, and less likeable than depressed clients.

Therapists' negative perceptions of angry clients contribute to negative countertransferential feelings (Haccoun & Lavigueur, 1979). Earlier studies revealed that therapists felt less friendly (Heller et al, 1963), more anxious (Russell & Snyder, 1963; Parsons & Parker, 1968), more withdrawn (Haccoun & Lavigueur, 1979), and less supportive and tolerant (Haccoun & Lavigueur, 1979) of angry, hostile clients. In this study, differences in

therapists' feelings toward angry and depressed clients did not emerge on the Feelings Scale. Therefore, we cannot say with certainty if therapists felt more or less negatively toward angry clients than toward depressed clients. However, an informal analysis of therapists' verbal responses revealed that the majority of therapists expressed negative feelings toward angry clients, and these feelings stemmed from their negative perceptions of them. Angry clients were often described as emotionally immature, volatile, defensive, manipulative, and challenging. Therapists, in turn, often felt withdrawn, defensive, cautious, manipulated, and angry [among other negative feelings].

After viewing an angry male client, one female therapist stated that she felt:

> Very annoyed. Very angry. Feeling like how will I help him, why don't you just quit. I don't want to have to deal with you. Annoyed at his sort of chauvinistic attitude.

A male therapist commented that he felt sadistic after viewing an angry male client:

> In a word, sadistic. I don't like him and I think he's more dramatic than the other person, he had a traumatic presentation. I found myself angry at him but not simply angry but entertaining fantasies of attacking him which I didn't feel the first time... I didn't feel particularly empathic.

After viewing an angry female, this female therapist responded:

> I think she's upset but she doesn't act genuinely

> like the other one. She presents in an immature way. I was not as sympathetic towards her as I was towards the other, especially when she said "I think I behave like a child." I thought, she probably did. I think she would be more controlling than the other one, more manipulative..I wouldn't mind her as a client but I would like the other one better.

Another female therapist who viewed an angry female client responded:

> Annoyed. I don't feel very empathic. She brings out sort of feelings of edginess in me and annoyance. I feel sympathetic towards her anger but feel that I can understand how she feels but she does not bring out feelings of sadness or pulling in. If anything, she makes me back away.

Research has demonstrated that the experience level of therapists increases tolerance of anger in clients (Haccoun & Lavigueur, 1979). Because therapists in this sample were trainees, their reactions may have been more negative and defensive than reactions by experienced therapists. Nonetheless, the findings have important implications for psychotherapy training. Evidence suggests that expression of anger is associated with improved functioning in psychiatric patients (e.g. Moos, Shelton, & Petty, 1973). Thus, we hope all therapists, experienced and inexperienced, will learn to tolerate and encourage clients' expressions of this potentially beneficial affect.

One important finding was that three of the eight female therapists who viewed an angry male client expressed difficulty tolerating him because they felt fearful and/or frightened of physical harm. None of the male therapists

voiced this concern. This finding also emerged in Johnson's (1977) analogue study of therapist's responses to angry and depressed clients. The following quotes exemplify the fear women in the study experienced:

> He made me feel very uneasy, untrusting. He felt very angry and very hostile so he just made me feel very afraid of him. I didn't feel real sympathy.
>
> I feel somewhat annoyed, a tiny bit frightened actually. Just sort of want to wade him out until he's done talking about her because, I don't know, it seems sort of, I can't respond to his anger, I have to wait till he does something else. Or I can't only to that, to the rage right now. I'd respond to him with a great deal of caution. If this were real, I'd be afraid he might attack me.

Female therapists' fear of angry male clients in this study has important implications for psychotherapy process. It is reasonable to expect that if they were threatened by hypothetical clients portrayed on a television screen, they would be even more threatened by hostile clients in an actual clinical setting. In this study it was impossible to ascertain how female therapists would respond to threat they reported experiencing from hostile male clients. For instance, would they find ways to deflect threatening gestures or would they ignore them? How often do women therapists fear angry, acting out male clients, and how does experience affect the therapeutic relationship? Also, to what extent are female therapists' fears an accurate assessment of potential danger or an over-reaction to perceived threat? These and related questions must be

researched further.

On therapists' evaluations of clients' degree of psychological disturbance, male therapists rated male and female clients comparably, but female therapists rated male clients as less psychologically disturbed. Only female therapists, therefore, adhered to the predicted double standard of mental health, whereby male clients are perceived as less psychologically maladjusted than are female clients [Broverman et al., 1970; Fabricant, 1974; Fabricant et al., 1973].

This finding suggests that only female therapists in our sample had a pro-male bias in their clinical assessments of mental health. One explanation for this finding is that female therapists still adhere to traditional, stereotypical views of male and female mental health, whereas male therapists do not. On the other hand, perhaps female therapists perceived male clients as less maladjusted based on their clinical experiences with angry and depressed clients. A more thorough investigation is needed to determine the extent to which this single instance of pro-male bias can be generalized to other clinical judgments by female therapists.

In contrast to the pro-male bias cited above, the data also revealed tentative evidence suggesting a pro-female bias on two therapist clinical judgment items. Trends emerged toward therapists perceiving female clients as more

desirable to treat and as profiting more from therapy than male clients. These findings are consistent with earlier studies where therapists perceived female clients as demonstrating greater improvement in therapy (Mintz et al.,1971), and having characteristics consonant with therapy success (Fisher et al., 1976; Gomes & Abramowitz, 1976; Gamsky & Farwell, 1966).

A pro-female bias also emerged on the Perceptions of Client Scale, but this bias was found only for male therapists. Female therapists' ratings of male and female clients were comparable, but male therapists' ratings of female clients were significantly higher than those of the other three therapist/client pairs. Male therapists, therefore, judged female clients higher on dimensions of receptivity to therapy. Pro-female biases in therapists' perceptions of clients have been reported in earlier studies. Female clients have been perceived as more emotionally mature (Fisher et al,.1976; Gomes & Abramowitz, 1976; Gamsky & Farwell, 1966), more intelligent (Fisher et al.,1976), and having more favorable personality traits (Gamsky & Farwell, 1966) than male clients. Yet the pro-female biases reported in these studies were for both male and female clinicians in contrast to this study where the bias emerged only for male therapists.

The obvious explanation for why male therapists rated female clients so positively is that they think more highly

of female clients than male clients based on clinical experience. Consequently, the literature has falsely accused male therapists of misogyny and sexism when in fact their perceptions of female clients are skewed in women's favor. On the other hand, these results may have stemmed from male therapists consciously, or unconsciously, trying not to appear sexist (especially since the experimenter was female) so they overcompensated to rate female clients positively.

There is convincing evidence that in actual clinical work, male therapists perceive female clients more negatively then these results would suggest. Jones and Zoppell (1982) conducted two naturalistic studies on psychotherapy process and outcome. They discovered that male therapists perceived female clients more negatively than did female therapists. This effect was demonstrated by male therapists assuming a more judgmental or critical stance in describing female clients while female therapists assumed a more sympathetic, caring stance. It is difficult to ascertain why Jones and Zoppell's findings contrasted so strongly with the present one but regardless of the reason, the issue of how therapists' perceptions of clients affect the therapeutic relationship has important implications for therapeutic success. This issue requires more extensive investigation.

When therapists viewed same-gender clients, as opposed

to opposite-gender clients, they recommended more strongly that therapy focus on interpersonal and intimacy issues. This particular finding has not been reported in the research literature. However, as was stated in the introduction, numerous studies revealed that same-sex and opposite-sex therapist/client dyads affect therapy process differently. Same-sex therapist/client dyads have been associated with higher therapist empathy (Cartwright & Lerner, 1963, Hill, 1975), greater client improvement (Cartwright & Lerner, 1963; Jones & Zoppell, 1982), and greater client satisfaction (Fisher et al.,1976) than opposite-sex therapist/ client dyads. These findings are often attributed to the greater therapist-client identification that occurs when therapist and client are of the same gender.

We can surmise that therapists' recommendations that there be a greater focus on interpersonal and intimacy issues for same-sex clients proceded from their more intensive identification with them. When first learning psychotherapy skills, therapist- trainees are probably better able to identify with persons whose experiences are similar to their own (Hill, 1975). They may recognize that for themselves, issues involving interpersonal relationships and intimacy are salient to their own psychological growth and well-being. This recognition, in turn, may have been projected onto the hypothetical client

as salient to his/her psychological development.

Finally, this study revealed that female therapists judged female clients as significantly less in need of direction in therapy than male clients. Male therapists, on the other hand, judged male and female clients similarly. Earlier studies found that male and female therapists recommended that therapy for female clients be less directive [Fisher et al., 1976; Parker, 1967]. It is difficult to ascertain why in this study the effect emerged only for female therapists. One explanation is that their clinical experience informed them that angry and depressed female clients show greater improvement with a less directive approach. It is also possible that female therapists experienced a less directive approach as more beneficial to their own emotional development, hence, this approach was recommended for female clients.

A surprising finding of this study was the absence of significant effects on the Feelings Toward Client Scale. One interpretation is that there were truly no significant differences in therapists' feelings toward clients regardless of client gender or expressed affect. On the other hand, perhaps there were significant differences but the Feelings Scale failed to capture them. Given that feelings are representative of internal experience, they may have been too elusive for the structured, fixed-choice format of the Feelings Scale to measure. An informal

analysis of therapists' free verbal responses revealed a rich array of therapist feelings, and in fact, these free response data were used to inform the significant effects presented above.

## Limitations

Analogue research has become an increasingly popular method in examining psychotherapy process in recent years (Kazdin, 1978). The value of analogue research is its allowing for analytic and controlled investigations to address issues that are often prohibitive or difficult to assess in real-life clinical situations. For instance, this study was able to control the conditions of experimentation and thereby minimize the sources of variance that might obscure an effect of therapist and client gender on clinical judgments. However, because this was a controlled, analogue study, it has inherent limitations that must be considered in the final analysis.

The major limitation of this study concerns its external validity, that is, the extent to which the contrived analogue situation departed from the real-world clinical endeavor to which the study's inferences apply. We must question to what degree the videotape depictions of

client-actors were able to capture therapists' countertransferential feelings and attitudes given that there was no interaction and no relationship between therapist and client. We can surmise that the same intensity of emotional reaction, identification with client, and inhibition of therapist affect (e.g. anger, attraction) may not be activated by the kind of vicarious participation required in the analogue situation.

The laboratory setting utilized in this study had several limitations. Although it closely resembled a therapy office, its departure from realism may have affected therapist's behavior in significant ways. For example, the experimenter's presence in the room may have influenced therapists' verbal and written responses. Perhaps her presence contributed to therapists feeling more anxious, less comfortable, and wanting to respond in more socially desirable ways than might have been the case had she not been present, or if a male experimenter had been present instead. Also, the fact that the experimenter was a woman might have influenced therapists' responses, e.g. her presence may have inhibited or fostered therapist sex-bias.

A major limitation of the study was the lack of validation for the videotape's depiction of sex-role appropriate and sex-role inappropriate behavior. The study revealed no main or interaction effects for client

affect. Perhaps no significant effects were found because 1.) the actors failed to accurately portray anger and depression; 2.) the actors accurately portrayed anger and depression but the affect was so dramatic and strong that therapists responded more to the affect than to its subtle dimensions of sex-role appropriateness versus sex-role inappropriateness; or 3.) theorists have mistakenly assumed that people perceive anger as sex-role inappropriate behavior for females and depression as sex-role inappropriate behavior for males.

It is also important to consider that anger and depression are vague and complicated emotions. Persons often disagree as to what behaviors constitute anger and depression. This was clearly borne out when the study's actors rehearsed their angry and depressed vignettes. Each actor had a different interpretation of how an angry and depressed person would behave although their scripts were identical. Interestingly, the female actors expressed more comfort acting depressed while the male actors expressed more comfort acting angry. In addition, therapists often associated angry affect with underlying depression depressed affect with underlying anger. The vagueness and complexity of anger and depression, and the difficulties the actors demonstrated in portraying them, may be a partial explanation for why this study found no significant results for client affect.

The study's absence of significant findings for client affect might also be attributed to the limitations of the study's dependent measures. All three rating scales were paper-and-pencil inventories which are restricted in their ability to measure therapist behavior. The insensitivity of these inventories may have failed to measure not only significant effects for client affect but for other independent variables as well. For instance, a surprising finding of this study was the absence of significant effects on the Feelings Toward Client Scale. One interpretation is that there were truly no significant differences in therapists' feelings toward clients regardless of client gender or expressed affect. On the other hand, perhaps there were significant differences but the Feelings Scale failed to capture them. Given that feelings are representative of internal experience, they may have been too elusive for the structured, fixed-choice format of the Feelings Scale to measure. An informal analysis of therapists' free verbal responses revealed a rich array of therapist feelings, and in fact, these free response data were used to inform the significant effects presented in the Discussion.

Given the preceding discussion of the the study's limitations, it is significant that any main and interaction effects were found. This implies that for certain variables female and male therapists, despite their

individual differences, responded in ways characteristic of their gender and related to the client's gender. These results are difficult to interpret, their meanings are complicated and have far-reaching implications. However, they are valuable indicators of the possible function of therapist gender, client gender, and client affect on the psychotherapy process. They are also a valuable means to gain preliminary information to be verified in subsequent studies.

## REFERENCES


Abernathy, V. (1976). Cultural perspectives on the impact of women's changing roles in psychiatry. American Journal of Psychiatry, 133, 657-661.

Abramowitz, C.V. (1977). Blaming the mother: An experimental investigation of sex-role bias in countertransference. Psychology of Women Quarterly, 2, 25-34.

Abramowitz, S.I. & Abramowitz, C.V., Jackson, C. & Gomes, B. (1973). The politics of clinical judgement: What nonliberal examiners infer about women who do not stifle themselves. Journal of Consulting and Clinical Psychology, 41, 385-391.

Abramowitz, C., Abramowitz, S., Weitz, L., & Tittler, B. (1976). Sex-related effects on clinician's attributions of parental responsibility for child psychopathology. Journal of Abnormal Child Psychology, 4, 129-138.

Abramowitz, S.I., Roback, H.B., Schwartz, J.M., Yasuna, A., Abramowitz, C.V., & Gomes, B. (1976). Sex bias in psychotherapy: A failure to confirm. American Journal Psychiatry, 133, 706-709.

Abramowitz, S., Abramowitz, C., Weitz, C. (1976). Are men soft on empathy? Two studies in feminine understanding. Journal of Clinical Psychology, 32, 434-437.

Al-Issa,I. (1980). The Psychopathology of Women, Englewood Cliffs, N.J.: Prentice-Hall.

American Psychological Association. (1975). Report of the Task force on Sex Bias and Sex-role Stereotyping in Psychotherapeutic Practice. American Psychologist, 1169-1175.

Aries,E. (1976). Interaction patterns and themes of male, female, and mixed groups. Small Group Behavior, 7, 7-18.

Aries, E. (1982). Verbal and nonverbal behavior in single-sex and mixed-sex groups: Are traditional sex roles changing? Psychological Reports, 51, 127-134.

Aslin, A.L. (1977). Feminist and community mental health center psychotherapists' expectations of mental health for women. Sex Roles: A Journal of Research, 3, 537-544.

Barrett, C.J., Berg, P.I., Eaton, E.M. & Pomeroy, E.L. (1974) Implications of women's liberation and the future of psychotherapy. Psychotherapy Theory, Research, & Practice, 11, 11-15.

Bergin, A.E. & Lambert, M.J. (1978). The evaluation of therapeutic outcomes. In Handbook of Psychotherapy and Behavior Change. Second edition. S.L. Garfield and A.E. Bergin (Eds.).New York: John Wiley.

Berry,J. (1970). Therapists responses as a function of level of therapist experiences and attitude of the

patient. Journal of Consulting and Clinical Psychology, 34, 239-249.

Billingsley, D. (1977). Sex bias in psychotherapy: An examination of the effects of client sex, client psychopathology, and therapist sex on treatment planning. Journal of Consulting and Clinical Psychology, 45, 250-256.

Block, J.H. (1976). Conceptions of sex-role: Some cross-cultural and longitudinal perspectives. In A.G. Kaplan & J.P. Beam (Eds.), Beyond sex-role stereotypes: Readings toward a psychology of androgyny, (pp.64-78). Boston: Little, Brown and Company.

Bohn, M.J. (1967). Therapist response to hostility and dependency as a function of training. Journal of Consulting Psychology, 31, 195-1987.

Bowman, P.R. (1982). A decade of feminist influence on psychotherapy. Psychology of Women Quarterly, 4, (3), 331-344.

Brody, C.M. (1984). Women therapists working with women: New theory and process of feminist therapy, New York: Springer Publishing Co.

Broverman, I.K., Broverman, D.M., Clarkson, F.E., Rosenkrantz, P.S., & Vogel, S.R. (1970). Sex-role stereotypes and clinical judgments of mental health. Journal of Consulting and Clinical Psychology, 34, 1-7.

Brown, C. & Hellinger, M. (1975). Therapist attitudes toward women. Social Work, 20, 266-270.

Buczek, T. (1981). Sex biases in counseling: Counselor retention of the concerns of a female and male client. Journal of Counseling Psychology, 1,13-21.

Burtle, V. (1985). Therapeutic Anger in Women. in L. Rosewater & L. Walkers (Eds.), Handbook of Feminist therapy: Women's Issues in Psychotherapy. New York: Springer Publishing Company.

Carlozzi, A. & Hurlburt, J. (1982). Empathy, expressiveness, and instrumentality. The Humanist Educator, 20,154-160.

Carlson, R. (1971). Sex diferences in ego functioning: Exploratory studies of agency and communion. Journal of Consulting and Clinical Psychology, 37, 267-277.

Carmen, E., Rieker, R. & Mills, T. (1984). Victims of violence and psychiatric illness. in P. Rieker & E. Carmen's (Eds) The Gender Gap in Psychotherapy: Social Realities and Psychological Processes, New York: Plenum Press.

Cartwright, R. & Lerner, B. (1963). Empathy, need to change and improvement with psychotherapy. Journal of Consulting Psychology, 27, 138-144.

Carmen, E., Russo, N., & Miller, J. (1984). Inequality and women's mental health: an overview. In P. Rieker & E. Carmen (Eds.) The gender gap in psychotherapy: Social

realities and psychological processes, New York: Plenum Press.

Carter, C.A. [1971]. Advantages of being a woman therapist. Psychotherapy: Theory, Research, & Practice, 8, 297-300.

Chesler,P. [1972]. Women and madness. New York: Doubleday.

Chodorow, N. [1978]. The reproduction of mothering: Psychoanalysis and the sociology of gender. Berkeley: University of California Press.

Collier,H. [1982]. Counseling Woman. New York: The Free Press.

Cowan, G. [1976]. Therapist judgments of clients' sex-role problems. Psychology of Women Quarterly, 1, 115-124.

Cowan, M.L., Weiner, E.A. & Weiner, B.J. [1974]. Therapist perceptions of clients and client self-report. Journal of Clinical Psychology, 30, 277-230.

Davenport, J. & Reims, N. [1978].Theoretical orientation and attitudes towards women. Social Work, 23, 306-309.

Delk, J.L. & Ryan, T.T. [1975]. Sex role stereotyping and A-B therapist status: Who is more chauvinistic? Journal of Consulting and Clinical Psychology, 43, 589.

Dohrenwend, B. & Dohrenwend, B. [1976]. Sex Differences and Psychiatric Disorders. American Journal of Sociology,

81 (6), 1447-1453.

Engelhard, P.A., Jones, K.O.,& Stiggins, R.J. (1976). Trends in counselor attitude about women's roles. Journal of Counseling Psychology, 23, 365-372.

Fabrikant, B. (1974). The psychotherapist and the female patient: Perceptions and change. In V. Franks & V. Burtle (Eds), Women in Therapy. New York: Brunner/Mazel.

Fabrikant, B., Landau, D. & Rollenhagen, J. (1973). Perceived female sex-role attributes and psychotherapists' sex-role expectations for female patients. New Jersey Psychologist, 23, 13-16.

Feinblatt, J.A. & Gold, A.R. (1976). Sex roles and the psychiatric referral process. Sex Roles: A Journal of Research, 2, 109-122.

Fischer, J., Dulaney, D.D., Fazio, R.T., Hudak, M.T.,& Zivotofsky, E. (1976). Are social workers sexists? Social Work, 21, 428-433.

Fong, M.L. & Borders, L.D. (1985). Effects of sex-role orientation and gender on counseling skills training. Journal of Counseling Psychology, 1, 104-110.

Friedman, H. (1977). Special problems of women in psychotherapy. American Journal of Psychotherapy, 31 (3), 405-416.

Frieze, L. & Ramsey, S.J. (1976). Nonverbal maintenance of traditional sex roles. Journal of Social Issues,

32, 133-141.

Gamsky, N.R. & Farwell, G.K. (1966). Counselor-verbal behavior as a function of client hostility. Journal of Counseling Psychology, 13, 184-190.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge: Harvard University Press.

Goldberg, B. (1980). Mental health practice as social control: Practitioners' choices of therapy goals as a function of sex of client, situations, and other practitioner opinions. Cited in Sherman,J. Therapist attitudes and sex-role stereotyping in A. Brodsky & R. Hare-Mustin (Eds), Women and Psychotherapy: an Assessment of Research and Practice, New York: Guilford Press.

Gomes, B. & Abramowitz, S.I. (1976). Sex-related patient and therapist effects on clinical judgment. Sex-Roles: A Journal of Research, 2, 1-13.

Gove, W.R. & Tudor, J.F. (1973). Adult sex roles and mental illness. American Journal of Sociology, 78, 50-73.

Greene, L. (1980). On terminating psychotherapy: More evidence of sex-role related countertransference. Psychology of Women Quarterly, 4(4), 548-557.

Haan, N. & Livson, N. (1973). Sex differences in the eyes of expert personality assessors: Blind spots? Journal of Personality Assessment, 37, 486-492.

Haccoun, D.M. & Laviguer, H. (1979). Effects of clinical experience and client emotion on therapists' responses. Journal of Consulting and Clinical Psychology, 47 (2), 416-418.

Hammen, C.L & Peters, S.D. (1977). Differential responses to male and female depressive reactions. Journal of Consulting and Clinical Psychology, 45, 994-1001.

Harris, L.H., & Lucas, M.E. (1976). Sex-role stereotyping. Social Work, 21, 390-395.

Heiss, J.S. (1962). Degree of intimacy and male-female interaction. Sociometry, 25, 197-208.

Hetherington, L. & Allen, G. (1984). Sex relational communication patterns in counseling. Journal of Counseling Psychology, 3, 31, 287-294.

Hill, C. (1975). Sex of client and sex and experience level of counselor. Journal of Counseling Psychology, 22, 6-11.

Hill, C.E., Tanney, M.F., Leonard, M.M. & Reiss J.A. (1977). Counselor reactions to female clients: Type of problem, age of client, and sex of counselor. Journal of Counseling Psychology, 24, 60-65.

Howard, K., Orlinsky, D., & Hill, J. (1969). The therapist's feelings in the psychotherapeutic process. Journal of Clinical Psychology, 25, 83-93.

Johnson, M. (1977). Influence of counselor gender and of client gender and affect on counselor response.

(Doctoral dissertation, University of Pennsylvania, 1977) Dissertations International, (University Microfilms No. 77-30,210.

Johnson, F. & Aries, E. (1983). Conversational patterns among same-sex pairs of late-adolescent close friends. Journal of Genetic Psychology, 142, 225-238.

Johnson, F., Fine, M., Lutfiyya, M. & Ryan, M. (1983). Working women's perceptions of communication. Unpublished manuscript for the Speech Communication Association Annual Meeting, Nov.

Jones, E. & Zoppel, C. (1982). Impact of client and therapist gender on psychotherapy process and outcome. Journal of Counsulting and Clinical Psychology, 50 (2), 259-272.

Kaschad, E. (1978). Therapist and client: Two views of the process and outcome of psychotherapy. Professional Psychology, 9, 232-239.

Kazdin, A. (1978). Evaluating the generality of findings in analog therapy research. Journal of Consulting and Clinical Psychology, 4, 673-686.

Kimberlin, C. & Friesen, D. (1980). Sex and conceptual level empathic responses to ambivalent affect. Counselor Education and Supervision, 19, 252-257.

Kirshner, L., Hauser, S., & Genack, A. (1979). Effects of gender on short-term psychotherapy. Psychotherapy: Theory, Research, and Practice, 15, 158-167.

Lakoff, R. [1977]. Women's Language. Language and Style, 10 [4], 222-247.

Lerner, H.E. [1984]. Special issues for women in psychotherapy. in P. Rieker & E. Carmen [Eds.], The gender gap in psychotherapy: Social realities and psychological processes New York: Plenum Press.

Libbey, M.D. [1975]. Sex-stereotyping in psychotherapist responses in an analogue therapy situation [Doctoral dissertation, Columbia University, 1975]. Dissertations Abstracts International, 36, 1441B.

Maccoby, E. & Jackson, C. [1974]. The psychology of sex differences. Stanford, Ca: Stanford University Press.

Marecek, J. & Johnson, M. [1980]. Gender and the process of therapy. In A. Brodsky and R. Hare-Mustin [Eds.], Women and psychotherapy: An assessment of research and practice, [pp.67-93]. New York: Guilford Press.

Maslin, A., & Davis, J.L. [1975]. Sex-role stereotyping as a factor in mental health standards among counselors-in- training. Journal of Counseling Psychology, 22, 87-91.

Maxfield, R.B. [1976]. Sex-role stereotypes of psychotherapists [Doctoral dissertation, Adelphi University, 1976]. Dissertations Abstracts International, 37, 1914B. [Univesity Microfilms No.76-22,816].

Mehrabian, A. [1969]. Significance of posture and position

in the communication of attitude and status relationships. Psychological Bulletin, 71, 359-372.

Mehrabian, A. & Friar, J.T. (1969). Encoding of attitude by a seated communicator via posture and position cues. Journal of Consulting and Clinical Psychology, 33, 330-336.

Miller, J. (1984). The effects of inequality on psychology. In P. Rieker & E. Carmen (Eds.), The gender gap in psychotherapy: Social realities and psychological processes, New York: Plenum Press.

Miller, D. (1980). The influence of the patient's sex on clinical judgment. Smith college studies in social work, 1974, 4, 89-100 Cited in Sherman,J. Therapist attitudes and sex-role stereotyping in A.Brodsky & R. Hare-Mustin (Eds.), Women and Psychotherapy: An assessment of research and practice, New York: Guilford Press.

Miller, J. (1976). Toward a new psychology of women. Boston, MA: Beacon Press.

Mintz, J., Luborsky, L.& Auerbach, H. (1971). Dimensions of psychotherapy: A factor-analytic study of ratings of psychotherapy sessions. Journal of Consulting and Clinical Psychology, 36 (1), 106-120.

Moos, R., Shelton, R., & Petty, G. (1973). Perceived ward climate and treatment outcome. Abnormal Psychology, 82, 291.

Neulinger, J., Stein, M.I., Schillinger, M. & Welkowitz, J. (1970). Perceptions of the optimally intergrated person as a function of therapists' characteristics Perceptual and Motor Skills, 30, 375-484.

Oppedisano-Reich, M.T. (1976). The effect of a patient's social class, race and sex on mental health professionals' diagnoses, prognoses and recommendations for treatment (Doctoral disertation, Adelphi University, 1976). Dissertations Abstracts International, 37, 3157B-3158B. (University Microfilms No. 76-29,259).

Orlinsky, D.E.,& Howard, K.I. (1976). The effects of sex of therapist on the therapeutic experiences of women. Psychotherapy: Theory, Research and Practice, 31, 82-88.

Parker, G. (1967). Some concomitants of therapist dominance in the psychotherapy interview. Journal of Consulting Psychology, 31, 313-318.

Parloff, M., Waskow, I. & Wolfe, B. (1978). Research on therapist variables in relation to process and outcome. In Handbook of psychotherapy and behavior change. Second Edition, S.L. Garfield and A.E. Bergin (Eds.), pp.233-282. New York: John Wiley and Sons, Inc.

Parsons, L.B. & Parker, B.V. (1968). Personal attitudes, clinical appraisals, and verbal behavior of trained and untrained therapists. Journal of Consulting and

Clinical Psychology, 32, 64-71.

Piliavin, J.A. & Martin, R.R. (1978). The effects of the sex composition of groups on style of social interaction. Sex Roles, 4, 281-296.

Rice, D.G., Gurman, A.S.,& Razin, A.M. (1974). Therapist sex, style, and theoretical orientation. Journal of Nervous and Mental Disease, 159, 413-420.

Rice, J. & Rice, D. (1973). Implications of womens's liberation for psychotherapy. American Journal of Psychiatry, 130 (2), 191-196.

Russell, P. & Snyder, W. (1963). Counselor anxiety in relation to amount of clinical experience and quality of affect demonstrated by clients. Journal of Consulting Psychology, 27, 358-363.

Schlachet, B. (1984). Female role socialization: The analyst and the analysis. In C.M. Brody's (Ed.) Women Therapists working with Women.

Sherman, S. (1980). Therapist attitudes and sex-role stereotyping. In A.M. Brodsky & R.T. Hare-Mustin (Eds.) Women and Psychotherapy: An assessment of research and practice. New York: Guiford Press.

Sherman, J.A., Koufacos, C. & Kenworth, J.A. (1978). Therapists: Their attitudes and information about women. Psychology of Women Quarterly, 2, 299-313.

Stein, L., Fox, M. & Luepnitz, D. (1976). Therapists judgements of prognosis, severity of disturbance, and

treatment needs as a function of patients'sex. Cited in L. Stein, A. Del Gaudio & M. Ansley, A comparison of female and male neurotic depressives.Journal of Clinical Psychology, 32, (1), 19-21.

Stein, L.S., Del Gaudio, A.C. & Ansley, M.Y. (1976). A comparison of female and male neurotic depressives. Journal of Clinical Psychology, 32, 19-21.

Stengel, J. (1976). Counselor response as a function of client's sex, counselor's sex, and client's presenting affect (Doctoral dissertation, Boston University School of Education, 1976). Dissertations Abstracts International, 36, 5819B. (University Microfilms No. 76-11, 831).

Stevens, B. (1974). The Sexually Oppressed Male. Psychotherapy: Theory, Research and Practice, 11, (1), 16-21.

Stodtbeck, F.L., James, R. & Hawkins, C. (1957). Social status in jury deliberations. American Sociological Review, 22, 713-719.

Stricker, G. (1977).Implications of research for psychotherapeutic treatment of women. American Psychologist, 32, 14-22.

Strupp, H.H. (1978). Psychotherapy research and practice: an overview. In S.L. Garfield & A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change, Second edition (pp.233-282). New York: John Wiley & Sons, Inc.

Strupp, H. (1973). Psychotherapy: clinical, research and theoretical issues. New York: Jason Aronson.

Thompson, E.G., Hatchett, P., Phillips, J. (1981). Sex differences in the judgment of interpersonal verbs. Psychology of Women Quarterly, 5 (4), 523-531.

Walker, C.J. (1976). The employment of vertical and horizontal social schemata in the learning of a social structure. Journal of Personality and Social Psychology, 33, 132-141.

Weissman, M. & Klerman, G.L. (1977). Sex differences and the epidemiology of depression. Archives of General Psychiatry, 34, 98-111.

Werner, P.D. & Block, J. (1975). Sex differences in the eyes of expert personality assessors: Unwarranted conclusions. Journal of Personality Assessment, 39, 110-113.

Wright, C.T., Meadow, A., Abramowitz, S.I. & Davidson, C.V. (1980). Psychiatric diagnosis as a function of assessor profession and sex. Psychology of Women Quarterly, 5, (2), 240-241.

# APPENDICES

Appendix A

## Telephone Protocol to Recruit Subjects

Hello. My name is Shelley Murphy and I was referred to you by _____. I am currently a third year graduate student in clinical psychology at U-Mass, Amherst. As my master's thesis, I am conducting a psychotherapy process study examining therapist trainee's perceptions of clients with different presenting problems. I understand that you are a graduate student in the _____ program at _____. I'd like to know if you'd be interested in participating in my study as a subject?

- If the person states that she/he is not interested, I will thank them for their time.
- If the person states that she/he is interested:

I'm glad that you're interested. But before I tell you more about the study, I need to inform you that the criteria for participation is that subjects have at least 4 months but not more than 4 years of clinical experience.

- If the person meets this criteria,

The study involves your watching videotaped depictions of hypothetical clients with different presenting problems. You will be asked to give verbal and written responses describing your subjective, personal reactions to these clients. The study will take approximately 1 hour of your time and can be conducted either in my office at U-Mass or if you should so choose, in your office. Your participation involves no foreseeable risks. The benefit in participating in this study is the chance to examine for yourself, in a controlled, "neutral" setting, how you subjectively respond to clients with different presenting problems. Are you still interested in participating?

- If the person is still interested, an appointment shall be made. I will also give my home and office phone numbers so the subject can contact me if necessary. All subjects will be thanked for their time and consideration.

Appendix B

## Script for Angry Client

I don't know why I'm here. I guess things haven't been going too well. It all started with my girlfriend/boyfriend. I'm upset. I feel like I'm gonna explode. We've been going out for a year and, I don't know, things started to fall apart, um..., maybe two months ago. We agreed to break up. It was a hard decision for me, and I don't know about her/him.

I'm beginning to realize what a selfish bitch/bastard she/he is. It's like she/he never really cared about me. Like, whenever we went out we went where she/he wanted to go and did whatever she/he wanted to do. Whenever I made a suggestion, it would just go in one ear and out the other. I can't remember her/him ever listening to me or taking my needs into account. When I tried to tell her/him how that made me feel, all she/he say is "stop acting like a 2 yr. old". She's/he's the 2 yr. old!

Last week she/he stopped by my apartment, unannounced, and wanted a couple of her/his records back. I thought they were presents. She/he said "no", they weren't presents, she/he just loaned them to me. Loaned them? Can you imagine it? What a manipulator! What does she/he think, I was born yesterday? Well, I'll tell you, that's the last time I'm going to be manipulated by another woman/man. Well, to hell with them all.

I don't know why I bothered to come here anyway. You'll probably side with my girlfriend/boyfriend and think I'm acting like a child. Besides, what can a shrink do for me?

## Script for Depressed Client

There's so much to say...I don't know where to begin. Um...I guess I could start with saying I've been really down lately. I seem to be spending a lot of my time sleeping. It's really hard for me to get out of bed in the morning. There just seems to be nothing to look forward to. (Bows head, silence).

Um,...things started to get bad about two months ago, when my girlfriend/boyfriend and I split up. I guess it's true that our relationship wasn't going anywhere, but now that I think about it, I feel so guilty that it didn't work out. (Pause).

Things got really bad last week when I bumped into her/him at the mall. I asked her/him how she'd/he'd been doing, and she/he seemed really happy. After she/he walked away, I realized that she/he hadn't asked me anything about how I was. Maybe she/he never did really care about me. When we were together, she/he almost never asked me how I was or what I wanted. Whenever I would tell her/him that I needed something from the relationship, she'd/he'd say "you're just too demanding." Maybe I am too demanding, maybe I'm too demanding to ever be in a good relationship with any woman/man.

I guess I'm really feeling hopeless. I came here because I've been feeling like I need help. I'm hoping you can give me some suggestions. Can you help me?

Appendix C

## PERSONAL DATA FORM

1. Your sex: [1]Male_____ [2] Female_____

2. Age:_____

3. Marital status: [1] Married _____ [2] Single _____
[3] Divorced/Separated _____
[4] Widowed_____

4. Highest academic degree: [1] Bachelor's _____
[2] Master's _____ [3] Doctorate _____

5. Theoretical Orientation: [Please select only ONE]

[1] Behavioral_____

[2] Psychodynamic_____

[3] Cognitive/Rational Emotive_____

[4] Eclectic_____

[5] Interpersonal_____

[6] Family Systems_____

[7] Client Centered_____

[8] Other [Please specify]_____

6. How long have you practiced psychotherapy? [Include supervised training] _____years_____months

7. Approximate # cases treated: _____

of these cases, # couples & families_____,
# individuals _____

of individual cases, # males _____, # females _____

8. What did you think this study was attempting to investigate?

Appendix D

## FEELINGS TOWARD CLIENT

Indicate how you FELT toward the client by placing a check mark in the appropriate space.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. Tense | Extremely tense | Moderately tense | Slightly tense | Neither tense nor relaxed | Slightly relaxed | Moderately relaxed | Extremely relaxed | Relaxed |
| 2. Masterful | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | Frustrated |
| 3. Concerned | | | | | | | | Unconcerned |
| 4. Unempathic | | | | | | | | Empathic |
| 5. Energized | | | | | | | | Drained |
| 6. Comfortable | | | | | | | | Uncomfortable |
| 7. Angry | | | | | | | | Unperturbed |
| 8. Sad | | | | | | | | Happy |
| 9. Involved | | | | | | | | Detached |
| 10. Vulnerable | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | Secure |

## FEELINGS TOWARD CLIENT

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 11. Unsupportive | : | : | : | : | : | : | : | Supportive |
| | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | |
| 12. Provoked | : | : | : | : | : | : | : | Unprovoked |
| 13. Pleased | : | : | : | : | : | : | : | Annoyed |
| 14. Critical | : | : | : | : | : | : | : | Accepting |
| 15. Trusting | : | : | : | : | : | : | : | Suspicious |
| 16. Perplexed | : | : | : | : | : | : | : | Clear-headed |
| 17. Identified with client | : | : | : | : | : | : | : | Unidentified with client |
| 18. Sympathetic | : | : | : | : | : | : | : | Unsympathetic |
| 19. Intolerant | : | : | : | : | : | : | : | Tolerant |
| 20. Challenging to work with | : | : | : | : | : | : | : | Unchallenging to work with |
| 21. Caring | : | : | : | : | : | : | : | Uncaring |
| 22. Pessimistic | : | : | : | : | : | : | : | Hopeful |
| | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | |

## FEELINGS TOWARD CLIENT

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 23. Objective | : | : | : | : | : | : | : | Subjective |
| | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | |
| 24. Apprehensive | : | : | : | : | : | : | : | Certain |
| 25. Uninsightful | : | : | : | : | : | : | : | Insightful |
| | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | |

Appendix E

PERCEPTIONS OF CLIENT

Indicate how you PERCEIVE this client by placing a check mark in the appropriate space.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. Content | Extremely Content | Moderately Content | Slightly Content | Neither Content nor Needy | Slightly Needy | Moderately Needy | Extremely Needy | Needy |
| 2. Unattractive | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | Attractive |
| 3. Demanding | | | | | | | | Unassuming |
| 4. Genuine | | | | | | | | Deceptive |
| 5. Dramatic | | | | | | | | Undramatic |
| 6. Decisive Thinker | | | | | | | | Wishy Washy |
| 7. Manipulative | | | | | | | | Not Manipulative |
| 8. Selfish | | | | | | | | Unselfish |
| 9. Even-tempered | | | | | | | | Volatile |
| 10. Likeable | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | Unlikeable |

## PERCEPTIONS OF CLIENT

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 11. Abrasive | : | : | : | : | : | : | : | Calming |
| | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | |
| 12. Domineering | : | : | : | : | : | : | : | Submissive |
| 13. Unswayable | : | : | : | : | : | : | : | Suggestible |
| 14. Intelligent | : | : | : | : | : | : | : | Unintelligent |
| 15. Cooperative | : | : | : | : | : | : | : | Uncooperative |
| 16. Secretive | : | : | : | : | : | : | : | Self-disclosing |
| 17. Insightful | : | : | : | : | : | : | : | Uninsightful |
| 18. Emotionally Mature | : | : | : | : | : | : | : | Emotionally Immature |
| 19. Cowardly | : | : | : | : | : | : | : | Brave |
| 20. Inhibited | : | : | : | : | : | : | : | Uninhibited |
| 21. Masculine | : | : | : | : | : | : | : | Feminine |
| 22. Dependent | : | : | : | : | : | : | : | Independent |
| | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | |

## PERCEPTIONS OF CLIENT

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 23. Elated | : | : | : | : | : | : | : | Depressed |
| | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | |
| 24. Having No Awareness of Inner Resources | : | : | : | : | : | : | : | Having Awareness of Inner Resources |
| 25. Angry | : | : | : | : | : | : | : | Unperturbed |
| 26. Accepting | : | : | : | : | : | : | : | Rejecting |
| 27. Reliable | : | : | : | : | : | : | : | Unreliable |
| 28. Abandonment Issues | : | : | : | : | : | : | : | Has no Abandonment Issues |
| 29. Rational | : | : | : | : | : | : | : | Irrational |
| 30. Incompetent | : | : | : | : | : | : | : | Competent |
| 31. Aggressive | : | : | : | : | : | : | : | Passive |
| 32. Emotionally Stable | : | : | : | : | : | : | : | Emotionally Unstable |
| | Extremely | Moderately | Slightly | Neither/Nor | Slightly | Moderately | Extremely | |

Appendix F

## TREATMENT

Indicate what treatment recommendations you would make for this client by circling the appropriate number.

Therapy should focus on:

| | Not at all | | | Some of the time | | Much of the time | All of the time |
|---|---|---|---|---|---|---|---|
| 1. Early Childhood Experiences | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Interpersonal/ Intimacy Issues | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. Intrapsychic Factors | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. Situational (Factors related to client's immediate situation/environment) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Therapy should:

| | Not at all | | | Some of the time | | Much of the time | All of the time |
|---|---|---|---|---|---|---|---|
| 5. Involve Interpretation | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. Provide empathy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Encourage Self-reliance | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Encourage Emotional Expressiveness | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Be supportive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. Be directive | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

11. Other: (please specify)

_____

_____

## TREATMENT

Please answer the following questions by circling the appropriate number.

12. How psychologically disturbed in this client?

1 Not at all

2 Very little

3 To some extent

4 A fair amount

5 A great deal

13. How much will this client profit from therapy?

1 Not at all

2 Very little

3 To some extent

4 A fair amount

5 A great deal

14. How motivated in this client for therapy?

1 Not at all

2 Very little

3 To some extent

4 A fair amount

5 A great deal

15. How much would you like to treat this client?

    1 Not at all

    2 Very little

    3 To some extent

    4 A fair amount

    5 A great deal

16. How many times per week should this client be seen in therapy? _____

17. Over how many weeks do you feel this client will need to be seen? _____

18. Who do you think was more responsible for the relationship breaking up, the client or the lover? (What immediately comes to mind?)

    _____

Appendix G

## INFORMED CONSENT

I voluntarily agree to participate in this study which examines therapist attitudes and behaviors towards clients with different presenting problems. Specifically, I will be asked to view two videotapes of hypothetical clients and asked to verbally respond as to what my subjective reactions are; answer various questionnaires concerning my feelings, perceptions, and treatment recommendations for each client; and fill out a personal data sheet. I understand that the study is for research purposes only; it will not benefit me personally but may contribute to knowledge; my answers are strictly confidential and will not be made known to anyone but to the experimenter and her research associates but may be published without name in case study or group statistical form; and there are no known or foreseeable risks in participating in this study. I further understand that I am free to discontinue participation at any time, without penalty. Any questions that I have about the procedure, or about any other matter, will be answered by the experimenter.

Signature_____

Print Name_____

Date_____

Appendix H

INTAKE FORM FOR ANGRY CLIENT

Date of Intake: July 15, 1986

Referred by: Self

Current living situation: Lives alone in an apartment.

Current employment or school situation: Employed full-time as a data processor with the Comstock Corp. in the New England region. Has been employed there for 2 yrs.

Last mental health intervention: none.

Initial Formulation: Mr./Ms. D. is a 28 year old man/woman who has recently separated from his/her girl/boyfriend of one year. They agreed to end their relationship about 8 weeks ago. Mr. D. feels ambivalently towards his/her girl/boyfriend and has occasional contact with him/her. Mr./Ms. D. is upset over the break-up and describes his/her moods as "rollercoaster highs and lows" where he/she is often overcome with anger and feels agitated. Concerning Mr./Ms. D.'s clinical history, he/she has no history of depression, mania, medication, suicide, or past mental health interventions. He/she doesn't drink nor engage in drugs.

INTAKE FORM FOR DEPRESSED CLIENT

Date of Intake: July 15, 1986

Referred by: Self-referred.

Current living situation: Lives alone.

Current employment or school situation: For the past two

years, she has held a professional position in the marketing at Data-Co Corp.

Last mental health intervention: Mr./Ms. L. has never has any previous contact with a mental health organization, therapist, etc.

Initial Formulation: Mr./Ms. L. is a 28 year old man/woman who is feeling upset over having separated from a girl/boyfriend a last few months ago. They have been going out for approximately a year. Since the break-up, he/she has occasionally spoken with her/him on the phone and has seen her/him a few times. Mr./Ms. L doesn't want to reunite with her/him, but he/she is uncertain of how he/she feels. Mr./Ms. L mentioned that he/she has been generally feeling tearful, hopeless, and unmotivated. Within the last few weeks, he/she has experienced some difficulty with eating and falling asleep. Mr./Ms. A. does not drink, take drugs, nor have any history of mental health intervention, depression, mania, suicide, or medication.

Appendix I

## WRITTEN FEEDBACK

This study seeks to investigate the relationship between gender and therapist cognitive and affective responses. Research suggests that sexism and sex-role stereotypes are so pervasive that they effect all social interactions, including those between therapists and their clients. Therapists may unknowingly perpetuate sex-role conformity and sexism in their clients. For instance, it has been suggested that therapists may reinforce sex-role appropriate behaviors in their clients while punishing sex-role inappropriate behaviors. This issue is examined by this study in having therapist trainees, such as yourself, view and respond to clients behaving in sex-role appropriate (anger in male clients, depression in female clients) and in sex-role inappropriate (depression in males, anger in females) ways. It is hypothesized that the sex-role appropriate clients will be responded to more favorably than will sex-role inappropriate clients. In addition, because sex-role stereotypes depict females as being less psychologically healthy than males, it is hypothesized that female clients will receive less positive clinical evaluations than will male clients. For example, female clients may be percieved as less likeable, less intelligent, and more psychologically disturbed than will their male counterparts.

Research also suggests that sex-role norms may differently shape the perceptions and behaviors of males and females. Therefore, it is hypothesized that the male and female therapists in this study will respond to clients in sex-role determined ways.

Thank you for your time and effort in this study. Should you have any further questions, or wish to find out the study's results when it is completed, please contact Shelley Murphy at 203-529-5896 or Professor Marian MacDonald at 617-545-0396.

Appendix J

Table 9

Perceptions of Client
Factor Loadings of 32 Adjectives on One Factor after Varimax Rotation
(N = 64)

| Adjective | Factor 1 |
|---|---|
| content-needy | .00612 |
| attactive-unattractive* | .45072 |
| unassuming-demanding* | .63460 |
| genuine-deceptive | .65824 |
| undramatic-dramatic* | .65042 |
| decisive thinker-wishy-washy | -.26317 |
| not manipulative-manipulative* | .58471 |
| unselfish-selfish* | .75485 |
| even-tempered -volative | .81293 |
| likeable-unlikeable | .61388 |
| calming-abrasive* | .81233 |
| submissive-domineering* | .76189 |
| unswayable-suggestible | -.61363 |
| intelligent-unintelligent | .26818 |
| cooperative-uncooperative | .77748 |
| self-disclosing-secretive* | .50933 |
| insightful-uninsightful | .51103 |
| emotionally mature-emotionally immature | .64570 |
| brave-cowardly* | .18832 |
| uninhibited-inhibited* | -.13049 |
| masculine-feminine | -.40994 |
| independent-dependent* | .10113 |
| elated-depressed | -.42047 |
| having awareness of inner resources-having no awaerness of inner resources* | .29937 |
| unperturbed-angry* | .68466 |
| accepting-rejecting | .87800 |
| reliable-unreliable | .60201 |
| no abandonment issues-abandonment issues* | .15205 |
| rational-irrational | .62144 |
| competent-incompetent* | .40913 |
| passive-aggressive | .79323 |
| emotionally stable-emotionally unstable | .46888 |

Appendix K

Table 10

Feelings Toward Client
Factor Loadings of 25 Adjectives on One Factor after Varimax Rotation

(N = 64)

| Adjective | Factor 1 |
|---|---|
| relaxed-tense* | .59996 |
| masterful-frustrated | .57515 |
| concerned-unconcerned | .32974 |
| empathic-unempathic* | .81078 |
| energized-drained | .42051 |
| comfortable-uncomfortable | .75960 |
| unperturbed-angry* | .83824 |
| happy-sad* | -.28061 |
| involved-detached | .46134 |
| secure-vulnerable* | .49679 |
| supportive-unsupportive* | .70880 |
| unprovoked-provoked* | .70132 |
| pleased-annoyed | .69409 |
| accepting-critical* | .63767 |
| trusting-suspicious | .46534 |
| clear-headed- perplexed* | .55037 |
| unidentified with client-identified with client* | -.58242 |
| sympathetic-unsympathetic | .80627 |
| tolerant-intolerant* | .81781 |
| challenging to work with-unchallenging to work with | -.38447 |
| caring-uncaring | .75201 |
| hopeful-pessimistic* | .58809 |
| objective-subjective | .30568 |
| certain-apprehensive* | .52848 |
| insightful-uninsightful* | .42539 |

APPENDIX L

Table 11

Three Way Analysis of Variance on Treatment Variables [2 X 2 X 2 based on N=64]

Feelings Toward Client

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Gender [A] | 1 | 351.56 | 1.73 | .19 |
| Affect [B] | 1 | 430.56 | 2.11 | .15 |
| Subject Gender [C] | 1 | .063 | .00 | .99 |
| A x B | 1 | 36.00 | .18 | .68 |
| A x C | 1 | 42.25 | .21 | .65 |
| B x C | 1 | .25 | .001 | .97 |
| A x B x C | 1 | .56 | .96 | |
| Error | 56 | 203.19 | | |

1. Therapy should focus on early-childhood experiences.

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Sex [A] | 1 | .02 | .01 | .91 |
| Affect [B] | 1 | .02 | .01 | .91 |
| Subject Sex [C] | 1 | 4.52 | 3.51 | .07 |
| A X B | 1 | .39 | .30 | .58 |
| A X C | 1 | 1.89 | 1.47 | .23 |
| B X C | 1 | 4.52 | 3.51 | .07 |
| A X B X C | 1 | .14 | .11 | .74 |
| Error | 56 | 1.64 | | |

3. Therapy should focus on intrapsychic factors.

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Sex [A] | 1 | .56 | .29 | .59 |
| Affect [B] | 1 | 5.06 | 2.63 | .11 |
| Subject Sex [C] | 1 | .25 | .13 | .72 |
| A X B | 1 | .06 | .03 | .86 |
| A X C | 1 | 1 | .52 | .47 |
| B X C | 1 | 0 | 0 | 1.0 |
| A X B X C | 1 | 0 | 0 | 1.0 |
| Error | 56 | 1.92 | | |

Table 11 Continued

4. Therapy should focus on situational factors.

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Sex (A) | 1 | 2.64 | 1.13 | .29 |
| Affect (B) | 1 | .02 | .01 | .94 |
| Subject Sex (C) | 1 | 1.89 | .81 | .37 |
| A X B | 1 | .39 | .17 | .68 |
| A X C | 1 | .77 | .33 | .57 |
| B X C | 1 | .14 | .06 | .81 |
| A X B X C | 1 | 4.52 | 1.93 | .17 |
| Error | 56 | 2.34 | | |

5. Therapy should involve interpretation.

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Sex (A) | 1 | 1.27 | .99 | .33 |
| Affect (B) | 1 | .39 | .30 | .58 |
| Subject Sex (C) | 1 | .39 | .30 | .58 |
| A X B | 1 | 2.64 | 2.06 | .16 |
| A X C | 1 | .02 | .02 | .91 |
| B X C | 1 | .39 | .30 | .58 |
| A X B X C | 1 | .14 | .11 | .74 |
| Error | 56 | 1.28 | | |

6. Therapy should provide empathy.

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Sex (A) | 1 | .14 | .08 | .78 |
| Affect (B) | 1 | .14 | .08 | .78 |
| Subject Sex (C) | 1 | .02 | .01 | .92 |
| A X B | 1 | .39 | .23 | .64 |
| A X C | 1 | .14 | .08 | .78 |
| B X C | 1 | .02 | .01 | .92 |
| A X B X C | 1 | .14 | .08 | .78 |
| Error | 56 | 1.71 | | |

Table 11 Continued

7.Therapy should encourage self-reliance.

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Sex (A) | 1 | 2.25 | 1.04 | .31 |
| Affect (B) | 1 | 6.25 | 2.89 | .10 |
| Subject Sex (C) | 1 | .25 | .12 | .74 |
| A X B | 1 | 3.06 | 1.42 | .24 |
| A X C | 1 | 1.56 | .73 | .40 |
| B X C | 1 | .06 | .03 | .87 |
| A X B X C | 1 | .25 | .12 | .74 |
| Error | 56 | 2.12 | | |

8. Therapy should encourage emotional expressiveness.

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Sex (A) | 1 | .14 | .07 | .8 |
| Affect (B) | 1 | 6.89 | 3.17 | .08 |
| Subject Sex (C) | 1 | 1.89 | .87 | .36 |
| A X B | 1 | 1.27 | .58 | .45 |
| A X C | 1 | 1.89 | .87 | .36 |
| B X C | 1 | .02 | .01 | .93 |
| A X B X C | 1 | .14 | .07 | .80 |
| Error | 56 | 2.18 | | |

9. Therapy should be supportive.

| Variable | DF | MS | F | Sign. |
|---|---|---|---|---|
| Client Sex (A) | 1 | .39 | .22 | .64 |
| Affect (B) | 1 | .39 | .22 | .64 |
| Subject Sex (C | 1 | 1.89 | 1.07 | .31 |
| A X B | 1 | .02 | .01 | .93 |
| A X C | 1 | .02 | .01 | .93 |
| B X C | 1 | 1.27 | .71 | .40 |
| A X B X C | 1 | .02 | .01 | .93 |
| Error | 56 | 1.78 | | |

Appendix M

Table 12

Cell Means for Three Way Analysis of Variance (2 x 2 x 2) on Dependent Variables

| THERAPIST GENDER | Male | | | | Female | | | |
|---|---|---|---|---|---|---|---|---|
| CLIENT GENDER | Male | | Female | | Male | | Female | |
| AFFECT | Angry | Depressed | Angry | Depressed | Angry | Depressed | Angry | Depressed |
| Therapy should: | | | | | | | | |
| Encourage Emotional Expressiveness | 4.5 | 4.75 | 3.88 | 4.88 | 4.38 | 4.88 | 4.63 | 5.59 |
| Be supportive | 5.75 | 5.38 | 5.63 | 5.13 | 5.13 | 5.25 | 5.00 | 5.13 |
| Be directive | 3.38 | 3.63 | 3.50 | 3.63 | 4.00 | 4.00 | 2.63 | 2.63 |
| Treatment: | | | | | | | | |
| How psychologically disturbed is this client? | 3.13 | 3.25 | 3.00 | 3.25 | 2.50 | 2.63 | 3.38 | 3.13 |
| How much will client profit from therapy? | 3.38 | 4.13 | 3.75 | 4.00 | 3.38 | 3.63 | 3.88 | 3.88 |
| How motivated is client for therapy? | 3.00 | 3.50 | 3.38 | 3.88 | 2.88 | 3.63 | 3.25 | 3.63 |
| How much would you like to treat client? | 3.50 | 4.00 | 4.13 | 3.75 | 3.00 | 3.25 | 3.63 | 3.75 |
| Times per week client should be seen in therapy? | 1.69 | 1.56 | 1.38 | 1.31 | 1.00 | 1.19 | 1.13 | 1.00 |
| Over how many weeks client should be seen? | 54.63 | 54.12 | 53.75 | 44.75 | 26.12 | 20.25 | 30.75 | 36.50 |

Table 12

Cell Means for Three Way Analysis of Variance (2 x 2 x 2) on Dependent Variables

| THERAPIST GENDER | Male | | | | Female | | | |
|---|---|---|---|---|---|---|---|---|
| CLIENT GENDER | Male | | Female | | Male | | Female | |
| AFFECT | Angry | Depressed | Angry | Depressed | Angry | Depressed | Angry | Depressed |
| Feelings toward Client | 3.55 | 3.07 | 3.23 | 2.95 | 3.67 | 3.19 | 3.10 | 2.86 |
| Perceptions of Client | 5.52 | 4.10 | 4.42 | 3.06 | 4.76 | 3.46 | 4.91 | 3.55 |
| Therapy should focus on: | | | | | | | | |
| Early Childhood Experiences | 3.63 | 3.38 | 3.50 | 2.75 | 3.38 | 4.00 | 3.75 | 4.25 |
| Interpersonal/ Intimacy Issues | 5.75 | 5.63 | 5.13 | 5.00 | 5.00 | 5.00 | 5.75 | 5.50 |
| Intrapsychic Factors | 4.25 | 4.75 | 3.75 | 4.38 | 3.88 | 4.38 | 3.88 | 4.50 |
| Situational Factors | 5.25 | 4.50 | 4.38 | 5.00 | 4.50 | 5.00 | 4.25 | 4.00 |
| Therapy should: | | | | | | | | |
| Involve Interpretation | 3.63 | 4.13 | 3.88 | 3.38 | 3.75 | 4.38 | 3.75 | 3.75 |
| Provide Empathy | 4.88 | 5.25 | 5.13 | 5.00 | 4.88 | 5.00 | 5.13 | 5.13 |
| Encourage Self-reliance | 4.38 | 4.38 | 4.50 | 5.63 | 4.63 | 5.00 | 4.38 | 5.38 |