Psychotherapists' Responses to Anger Manifested by Female Clients

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PSYCHOTHERAPISTS' RESPONSES TO ANGER MANIFESTED BY FEMALE CLIENTS

by

Lisa L. Morshead

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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and Counseling Psychology

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PSYCHOTHERAPISTS' RESPONSES TO ANGER MANIFESTED BY FEMALE CLIENTS

Lisa L. Morshead, Ed.D.
Western Michigan University, 1988

The responses of therapists to anger directed at them by female clients was the topic under investigation. Sixty-nine professional therapists were engaged as subjects, with each therapist reading two fictitious transcripts depicting the first portion of a therapy session. The two transcripts portrayed an angry client and a non-angry client, with client sex varied in each condition for a total of four transcripts. Each subject read both an angry and nonangry transcript of either two male or two female clients. Subjects were then asked to rate the client on competence, and interpersonal functioning, along with providing diagnostic impressions. A four factor repeated measures analysis of variance was conducted, with client sex, therapist sex, and therapist level of training as between-subjects factors, and anger versus nonanger as a within-subjects factor. It was hypothesized that the angry female client would be rated more negatively on competence and interpersonal functioning than the angry male client, and that the angry female client would be perceived as having a greater degree of
internally-generated psychopathology when compared with the angry male client.

None of the proposed hypotheses was supported. Results indicated that the female clients were rated as more competent and as functioning better interpersonally than the male clients. In addition, the angry clients were rated as less competent, functioning less well interpersonally, and as having a more internally-generated type of psychopathology than the nonangry clients. These findings suggest that nonangry female clients may be the most favored client group. It was also found that female therapists judged the angry clients as functioning less well interpersonally than the male therapists did, and the doctoral level therapists perceived the angry clients as less likely to have an externally-generated form of psychopathology when compared with the master's level therapists.

Overall, the present results suggest that client sex, therapist sex, and therapist level of training are not factors which contribute to sex bias by therapists against angry female clients on judgments of competence, interpersonal functioning, and diagnostic appraisals.
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Psychotherapists' responses to anger manifested by female clients

Morshead, Lisa Laura, Ed.D.
Western Michigan University, 1988

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Lisa L. Morshead
# TABLE OF CONTENTS

**ACKNOWLEDGEMENTS** .................................. ii

**LIST OF TABLES** ........................................ v

**CHAPTER**

I. **INTRODUCTION** ..................................... 1

   The Problem........................................... 1

   The Purpose.......................................... 2

II. **REVIEW OF THE LITERATURE** ....................... 4

   Theoretical Work on Women and Anger ............. 4

   Summary of Theoretical Work....................... 16

   Empirical Work on Sex-Role Stereotyping ......... 17

   Implications for Therapy......................... 28

   Hypotheses........................................... 35

III. **METHOD** .......................................... 37

   Subjects............................................. 37

   Design................................................. 38

   Independent Variables............................. 38

   Dependent Variables............................... 43

   Procedure........................................... 58

   Analyses.............................................. 59

IV. **RESULTS** ......................................... 60

   Introduction........................................ 60

   Summary of Results................................ 76

iii

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<table>
<thead>
<tr>
<th>List of Tables</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Factor Analysis of Personality Judgement Questionnaire</td>
<td>48</td>
</tr>
<tr>
<td>2. Factor Analysis of Diagnostic Questionnaire for Angry Vignette</td>
<td>53</td>
</tr>
<tr>
<td>3. Factor Analysis of Diagnostic Scale Items for Nonangry Vignette</td>
<td>54</td>
</tr>
<tr>
<td>4. Reliabilities for all Scales</td>
<td>55</td>
</tr>
<tr>
<td>5. Descriptive Statistics for Competence Scale for Angry and Nonangry Vignettes</td>
<td>62</td>
</tr>
<tr>
<td>6. Results of Analysis of Variance on Competence Scale</td>
<td>63</td>
</tr>
<tr>
<td>7. Descriptive Statistics for Interpersonal Functioning Scale for Angry and Nonangry Vignettes</td>
<td>65</td>
</tr>
<tr>
<td>8. Results of Analysis of Variance on Interpersonal Functioning Scale</td>
<td>66</td>
</tr>
<tr>
<td>9. Descriptive Statistics for Diagnostic Scale 1 for Angry and Nonangry Vignette</td>
<td>70</td>
</tr>
<tr>
<td>10. Results of Analysis of Variance on Diagnostic Scale 1</td>
<td>71</td>
</tr>
<tr>
<td>11. Descriptive Statistics for Diagnostic Scale 2 for Angry and Nonangry Vignettes</td>
<td>74</td>
</tr>
<tr>
<td>12. Results of Analysis of Variance on Diagnostic Scale 2</td>
<td>75</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

The Problem

In the body of research on sex-role stereotyping, very little work has been done investigating therapists' responses to anger directed at them by female clients. The studies available on perception of client anger, have generally failed to devote significant attention to client and therapist gender. In the area of sex-role stereotyping, researchers have investigated reactions of therapists to activity and assertiveness in male versus female clients (Bowman, 1982; Fischer, Dulaney, Fazio, Hudak, & Zivotofsky, 1976; Kelly, Kern, Kirkley, & Patterson, 1980; Lao, Upchurch, Corwin, & Grossnickle, 1975), and have obtained results which suggest bias against women. However, only one study was found in which the investigator attempted to examine the effects of anger directed at the therapist by male and female clients (Johnson, 1978).

This has been determined to be an area of importance for several reasons: First, part of what occurs in the therapy process is the development of a relationship between the client and therapist. As in any relationship which endures, conflict and disagreement are inevitable
and must be worked through. If the client is discouraged by the therapist from expressing anger or irritation, perhaps very unintentionally, the message conveyed is that the therapist must not be upset, or must be pacified. This is often a replication of the type of situation which may have contributed to the client's current difficulties. Second, negative reactions to client anger by the therapist may communicate a double meaning to the client. On the one hand therapists may encourage certain clients to become more aware of negative feelings they may have or to take risks in asserting themselves for the purpose of getting their needs met. However if the clients attempt this with the therapist and the response is negative or possibly punitive, the underlying message is very different from what has been verbalized.

The Purpose

The purpose of the present study was to investigate therapists' responses to anger in both male and female clients. Two fictitious transcripts of the initial portion of a therapy session were constructed, one portraying an angry client and the other a nonangry client. Client gender was varied for both scripts, thus giving a total of four different transcripts. Sixty-nine professional therapists served as subjects and rated the clients on competence, interpersonal functioning, and severity of
psychopathology. A 4-factor design was employed with anger, client sex, therapist sex, and therapist level of training as the four factors. The anger/nonanger dimension was a within-subjects variable.

It was expected that anger displayed by a female client would be met with negative personality judgments when compared with anger expressed by her male counterpart. The specific questions to be answered included whether or not the angry female client would be judged as less competent, functioning less well interpersonally, and as having a greater degree of psychopathology than the angry male client.
CHAPTER II

REVIEW OF THE LITERATURE

Theoretical Work on Women and Anger

There is a theoretical base of literature which suggests that women have difficulty in allowing themselves to feel and express anger. This repression and inhibition of anger seems to be due in large part to the negative consequences which frequently follow female anger. In the following section, theoretical material which is aimed at explaining why women have difficulty with anger will be reviewed, along with material which examines why people have difficulty in confronting feminine anger.

A number of contemporary writers have addressed the issue of why women have difficulty with allowing themselves to feel and express anger (Bernardez-Bonesatti, 1978; Lerner, 1980; J. B. Miller, 1983, 1985a, 1985b). Lerner (1980) and Bernardez-Bonesatti (1978) believe that this difficulty with anger is connected to the importance placed on the maintenance of relational ties by women. When a person is angry at another person, he or she has separated themself from the target of anger. For women this experience of separation can be frightening, for it signifies that the stability of relational ties is no
longer certain. This fear of separation often results in the woman crying, apologizing, and performing other behaviors which indicate relinquishment from her position of anger, in an attempt to pull back the object from which she is separated.

Lerner (1980) and Bernardez-Bonesatti (1978) hold that the root of these separation difficulties can be traced to the mother-daughter relationship. For girls, a sense of self is developed in the context of a close interpersonal relationship. The girl experiences continuity in development and also a longer preoedipal period due to the fact that in most instances the mother is the primary caretaker. The girl must separate from a parent of the same sex and then return to incorporate her qualities and be like her. Boys learn to separate from a parent of the opposite sex and in a sense receive "permission" to be not like her. Girls do not have the same early experiences as boys do of actively differentiating self from the primary caretaker, and as a result they tend to be more interpersonally oriented. Subsequently women may perceive the threatening of relational ties as an "unconscious fear of object loss" (Lerner, 1980, p. 141). Lerner postulates that these differences in early psychological development between boys and girls account for women having greater difficulty than men with separation, and consequently anger.
Westkott (1986) holds that in addition to creating difficulty with expression of anger, the emphasis placed on affiliation by women may also serve to generate and sustain feelings of anger. She points out that the caretaking and nurturing functions carried by women, may bring with them increased dependency and repressed feelings of anger. Westkott notes that historically, the idea that women should create a warm, nurturing home environment, can be viewed as a result of men working outside the home in competitive situations. Women were expected to create and represent the opposite of the hostile, aggressive, and immoral outside world. With this image of women as serving and nurturing, came the idea that men were entitled to care by females. In such situations, the daughters also became engaged in the momentous task of taking care of the father and younger children. Thus the girl learned early to deny her own needs. The daughter in observing her mother's discomfort and unhappiness elects to sacrifice her own needs and wishes and join her mother in suffering. This is done in an effort to prevent further misery on the part of the mother should the mother notice her daughter's happiness and consequently feel even worse. This action on the part of the daughter of giving up her needs results in fear and anger. She is afraid that she cannot do it well enough and will therefore be responsible for more unhappiness on the part of her mother and possibly
abandonment. She is also angry at sacrificing her own wants but must repress the anger because it is incompatible with the feminine image. The anger then becomes turned against the self. This combination of attempting to serve and please others along with anger turned against the self results in a characterological split, which Westkott (1986) describes as:

On the one hand the turning backward of anger creates self-contempt, a feeling of being unworthy, a sense of self that deserves abuse or devaluation. On the other hand, the attempt to find safety through compliantly submitting to the demands of powerful adults creates a persona that attempts to hide and compensate for the underlying self-hatred. . . . Thus, the under-nurtured nurturer believes that she herself is unworthy but that her redemption lies in unconditional attention to others. (p. 218)

Westkott (1986) also discusses the implications of living under such conditions, where the woman experiences self-hatred yet strives to conform to the image of the feminine ideal. The important thing to note here, is that the image of the ideal comes from the outside, it is external. The woman must rely on feedback from others in order to determine if she indeed has a self, and what is it comprised of.

Following this line of reasoning, if a person is totally dependent upon other people for a sense of identity, to upset or anger them by becoming angry, can result in the feeling that one is no longer worthwhile. A sense of self which is derived and maintained exclusively
through the responses of others, is necessarily very fragile, and feelings of self-worth will waiver based on the giving and retraction of praise from others.

There are also theorists who believe that both men and women hold unconscious fears of women's anger (Bernardez-Bonesatti, 1978; Lerner, 1974). This belief is thought to be a result of the early mother-infant relationship where the mother was viewed as all-powerful, and if angry enough could destroy the infant. Following this line of reasoning, the way in which society treats women can be viewed as an attempt to control or ward off expressions of female power. Lerner (1974) believes that men and women unconsciously envy and fear the power of women, and that these feelings lead to the defensive reaction of devaluation of women. The pressure put on women to be passive and submissive can be viewed as an attempt to retain the nurturant qualities of the good mother, while stamping out the destructive aspects of the bad mother. Therefore, the nearly universal desire to control women may be connected to early experiences in relatedness with the mother where the child felt threatened and was afraid he/she might be destroyed. Lerner (1986) believes that devaluation of women and sex-role stereotyping can be seen as defensive reactions to the power once possessed by the mother. The goal of such oppressive efforts is that of bringing about a "reversal of an early matriarchy" (p.
Lerner (1980) also developed the idea that expressions of autonomy, such as anger may be viewed by the daughter as actions of betrayal against her mother. Mother and daughter share an unconscious understanding that the daughter will not separate. This necessitates the daughter giving up her independence in order to maintain the relationship with her mother: an arrangement which is reinforced by the fact that the daughter is unconsciously afraid of the magnitude of her power since it is largely unknown to her, and may view her mother as weak and unable to tolerate the experience of the daughter's attempts at separation.

J. B. Miller (1982) discusses the reasons why women shun positions of power and authority. She believes that women equate power with selfishness, and this image of self as selfish is incompatible with the nurturing role of which many women take part. Miller also believes that women equate power with destructiveness, and consequently fear they will destroy or damage others with expressions of power. This notion relates back to the ideas of Bernardez-Bonesatti (1978), Lerner (1974), and Westkott (1986) about the extreme amount of power imputed to the mother. The fundamental issue here seems to be that women believe they will be abandoned if they display anger or any other behavior reflecting power, and this dissolution
of relational ties for many women may be experienced as a loss of part of self. J. B. Miller (1982) also states that the only acceptable display of power for women occurs when they use their power to empower someone else, to make another person strong, and women often do not recognize this as a manifestation of their power, and ignore this important source of strength they possess.

In addition, J. B. Miller (1976, 1983) holds that our society is able to function as it does because there is an underclass comprised of women which functions to perform all the tasks the dominant class deems necessary but which they themselves do not want to carry out. Thus the powerlessness carried by women is of functional significance. Women can't behave otherwise because the viability of our social structure is dependent upon them remaining in subservient positions. J. B. Miller (1983) suggests that the members of the dominant class have not been socialized to take care of one another, and that "Not only does everyone want to believe that women will do this, everyone wants to believe that women want to do it and want to do it more than anything else" (p. 4). J. B. Miller contends that our culture's fear and intolerance of women's anger stems from the belief that if women get angry and pull out of relationships, there will be no one to care for the members of our society and it will subsequently fall apart. Thus much time and energy is devoted to
discouraging expressions of anger by women. Anger in females is apt to be met with negative responses which eventually become internalized by the woman herself (J. B. Miller, 1985a).

Anger can also be viewed as an attempt to act in one's own self-interest, and women have traditionally been discouraged from acting in ways which reflect pursuit of their own interests. In discussing differences between women and men with regard to achievement, Horner (1972) notes that women avoid achievement in traditionally masculine areas because they fear the consequences will be negative. Subsequently, they choose to conform to the traditional female role but not without psychological cost. They experience feelings of hostility, frustration, and anger, but these cannot be expressed because they also do not fit with the female role they've elected to follow.

Both Horner (1972) and Hoffman (1975) discuss the idea that women have difficulty with achievement, yet these authors seem to adhere to the traditional "masculine" definition of achievement whereby it refers to the attainment of money, status, and power. Hoffman notes that women have been socialized to achieve in a relational sense but she also seems to convey that this form of achievement is less worthy than achievement as we traditionally know it. She refers to feminine socialization as resulting in "infantile fears of abandonment" (p. 136).
J. B. Miller (1976) has addressed such issues, and claims that achievement in a relational sense needs to be valued. There are difficulties with this however, because our society has a distorted conception of the characteristics which necessarily accompany this role of caregiver. It is believed that in order to effectively care and nurture, one can never behave in an angry, impatient, or self-centered manner. Instead one must possess total selflessness, and act only in the interest of others. This includes not upsetting or hurt others by displaying any emotion which might be interpreted as anger. Likewise, if one wishes to achieve in the traditional or masculine sense, he or she must become the counterpart to the individual achieving in the relational sense. They must act aggressively, competitively, and indicate that they have little interest in building relationships, as this is construed as a sign of weakness. Society cannot tolerate the idea that at various times, one may be dependent, angry, selfish, nurturing, and aggressive. This is a strong message, and one which indicates to caretakers that their angry and aggressive feelings are destructive to others, and therefore wrong.

Two distinct modes of expressing angry feelings have been noted (Symonds, 1976) and labeled as vertical aggression and horizontal aggression. Vertical aggression is thought to be used predominantly by men and involves clear
and direct action on the part of the angry person which induces fear and subsequent compliance on the part of the target. Horizontal aggression is thought to typify expression of anger in women, and involves reactions of hurt and suffering on the part of the angry person in an attempt to induce guilt and compliance or behavior change in the target. The expression of anger here is indirect and is manifested in the form of hurt or suffering on the part of the angry woman. This mode of expressing anger allows at least some release of the angry feelings, although in an indirect fashion, and also creates the illusion that interpersonal relationships, and consequently self, are not damaged.

**Blame and Attribution in Relation to Anger**

When women express anger overtly they tend to experience guilt and blame themselves for factors responsible in bringing about the anger episode (Lerner, 1977; J. B. Miller, 1985a, 1985b). Chodorow & Contratto (1982) have attempted to trace the origin of blame placed on women by society. They postulate that an infant or young child comes to relate pleasurable events and stimuli and painful events and stimuli to the primary caretaker. Because a young child does not yet have the capacity to integrate contradictory emotions, this process results in blame and idealization of the parent holding this position, which in
our society has most often been the woman. Chodorow and Contratto write:

Blame and idealization of mothers have become our cultural ideology. This ideology, however, gains meaning from and is partially produced by infantile fantasies that are themselves the outcome of being mothered exclusively by one woman. If mothers have exclusive responsibility for infants who are totally dependent, then to the infant they are the source of all good and evil. Times of closeness, oneness, and joy are the quintessence of perfect understanding; times of distress, frustration, discomfort, and too great separation are entirely the mother's fault. . . . This creates the quality of rage we find in 'blame the mother' literature. (p. 65)

Overall, women have accepted and internalized this blame attributed to them for failures in pleasing and satisfying other people. The tendency for women to quickly accept blame fits in with the concept developed by Westkott (1986) that women turn their anger inward and it becomes manifested in the form of self-hate, while at the same time they hold up an idealized image of the feminine with which to compare themselves. The self-hate component leads women to believe that everything which goes wrong in relationships is their fault, and it also results in further feelings of anger being used as confirmation of the woman's inner badness.

How then does this acceptance of blame by women relate to anger? When a woman becomes angry she is aware that she may have generated some hurt or discomfort in another person and quickly accepts the responsibility for the other person's comfort and happiness. In accepting
this responsibility she ascribes the cause of the unpleas­
ant event (anger) to herself and then apologizes for
disrupting the well-being of the person with whom she was
angry.

The attribution literature (Wegner & Valacher, 1977)
has found that when a person violates the expectations
held for his/her role, or behaves in a way which is viewed
as violating the situational demands, an internal attribu­
tion is ascribed to explain the cause of the behavior. An
external attribution is usually made to explain behavior
that is consonant with the demands of the role or situ­
atation. Following this line of reasoning, women who ex­
press anger, a behavior not consistent with notions of how
women should behave will evoke internal attributions on
the part of observers to explain the behavior.

Internal attributions imply greater personal respon­
sibility, thus making it easier to blame the individual
and hold him or her personally accountable for the beha­
vior. Examples of this include references to angry women
as "castrating," "narcissistic," or "bitchy." Therefore
the punishment for displaying anger is that of losing
one's sex role identify (e.g., angry women are not femi­
nine). In addition, such labels, once applied, tend to be
difficult to refute for they imply that the problem is
internal and therefore "fixed." Further behavior on the
part of the labeled individual is usually explained as
being characteristic of the "syndrome" she or he displays and serves to reinforce the label which has been applied.

Summary of Theoretical Work

Based on the theoretical concepts discussed here, it seems reasonable to postulate that anger expressed by women is likely to be met with negative responses. These responses function to halt expression of the angry feelings, and induce behavior which arouses less conflict for the target of the woman's anger. Two issues were raised in the introduction of this section: Why women have difficulty with feelings of anger, and why people respond negatively to female anger. Clearly, these are interrelated issues in that behavior which is responded to negatively, will be more difficult to perform. Women have difficulty with anger because angry responses are met with negative responses, which over time become internalized, resulting in both internal and external prohibitions against female anger. One can speculate that negative responses to female anger stem from fear and anger aroused by the primary caretaker in early object-relations, and also fear that if women refuse to partake in the role of caregiver, our social structure cannot continue to exist in its present form.
Empirical Work on Sex-Role Stereotyping

Over the course of the last decade there have been a number of studies published having to do with therapist attitudes and sex-role stereotyping (Davidson & Abramowitz, 1980; Sherman, 1980; Smith, 1980; Stricker, 1977; Zeldow, 1978). Overall the results of these studies are mixed, some supporting the notion that stereotyping occurs and others refuting this. Selected portions of this body of literature are regarded as relevant to the present study and will be reviewed here. A number of studies seem to suggest that therapists hold views of the average woman as naturally passive, submissive, and nonaggressive. Other researchers have carried this notion one step further and attempted to demonstrate that when women act in ways which are not consonant with the traditional image of females as passive, nonangry, nonassertive, and apathetic about performing behaviors in their own self-interest, they encounter negative consequences.

Therapists' General Views on Women

Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) seem to be the starting point for research in the area of sex-role stereotyping. Seventy-nine clinicians were engaged as subjects, and asked to use the Broverman Stereotype Questionnaire in describing characteristics which would be displayed by a healthy,
competent, and mature adult person, adult man, and adult women. It was found that the descriptions of the healthy adult and adult male were not different. The adult woman however, was depicted as more submissive, less independent, less aggressive, more easily influenced, less competitive, more excitable in minor crises, and as having hurt feelings more easily than a man.

D. Miller (1974) revealed similar findings in a study which demonstrated that clinicians judged a profile of an overly passive person as being more healthy when the client was presented as a female than as a male. Several other researchers (Aslin, 1977; Maslin & Davis, 1975) attempted to replicate the Broverman results using the Sex-Role Stereotype Questionnaire (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968), and found that only male therapists held different standards of mental health for men and women.

Delk and Ryan (1977) obtained similar results in a study which employed 240 psychotherapists, medical/nursing students and psychiatric outpatients as subjects. Using an adaptation of the Sex-Role Stereotype Questionnaire (Rosenkrantz et al., 1968) these researchers found that within all three groups males stereotyped significantly more than females. Using social workers as subjects, Brown and Hellinger (1975) found that female therapists held more contemporary attitudes toward women than male
therapists, particularly in the areas of child care and sexuality. On one item which stated that women could better be described as "oppressed" rather than "neurotic," psychiatrists and residents (assumed to be male) answered in the direction confirming stereotypic views significantly more than psychiatric nurses. In a recent review of the literature (Page, 1987) the author concluded that the results of the Broverman et al. (1970) study are still supported by current research.

In an attempt to examine therapist's perceptions of the "optimally integrated person" Neulinger, Schillinger, Stein and Welkowitz (1970) had male and female therapists rank order 20 descriptions, each of which corresponded to one of Murray's manifest needs, for a male and female client. It was found that female therapists ranked abasement and deference as being less characteristic of female clients than male therapists did, and they ranked sex as being more characteristic of female clients than the male therapists did. Also the more experienced therapists ranked aggression higher in the hierarchy of needs for females than did therapists with less experience. Thus it was found that sex of therapist and experience level of therapist were determining factors in evidencing sex bias, with female therapists and more experienced clinicians stereotyping less than male therapists and less experienced therapists. Hippie (cited in Helwig, 1976) however,
found that high school counselors and college freshmen perceived the "ideal woman" as possessing a balance of career- and home-oriented interests, leaning slightly toward the career direction. Thus these results do not support the hypothesis that clinicians sex-role stereotype. In a more recent study, Werner and LaRussa (1985) concluded that sex-role stereotypes have for the most part persisted over the last 20 years. The authors replicated a study conducted by Sherriffs and McKee (1957) several decades later. They asked 100 college students to indicate on two identical check lists which descriptors were generally true of males and which descriptors were generally true of females. Although it was found that females were viewed more favorably in the recent study, men were still described by raters of both sexes as more forceful, independent, stubborn, and reckless than women. Women were described as more mannerly, giving, emotional, and submissive than men.

Therapists' Views on Women Behaving in a Nontraditional Manner

Much of the research in the area of sex-role stereotyping has attempted to gain information on clinicians' perceptions of and responses to male and female clients. Orlinsky and Howard (1980) have stated that the most valuable research in the area of stereotyping in psychotherapy will likely come from an examination of how client
sex interacts with other variables (e.g., assertiveness, type of psychopathology, sexual orientation, achievement, career goals), as opposed to employing client sex as the sole variable. In the following section, literature which examines the interaction of client sex with other variables will be reviewed.

S. I. Abramowitz et al. (1975) demonstrated that females expressing a desire to go to medical school were determined by nonliberal examiners (judged on the basis of scores on the traditional moralism factor of the New Left Scale by Gold, Friedman, & Christie, 1971), to be less well adjusted psychologically than male students intending to study medicine. S. I. Abramowitz, Abramowitz, Jackson, and Gomes (1973) found that profiles which depicted a politically left-oriented and active person were assigned a greater degree of maladjustment by counselors judged to hold nonliberal social and political views when the client was presented as a female than as a male. In addition, Thomas and Stewart (1971) found that counselors of both sexes rated female clients expressing a desire to major in engineering as more in need of counseling than female clients intending to pursue home economics.

Several studies have been conducted for the purpose of determining how assertive behavior in women is perceived. Kelly et al. (1980) found that an assertive female model was met with responses indicating devaluation
on the part of both male and female subjects. It was also found that the female assertive models as opposed to the male assertive models, were rated lower on a likability factor, which was comprised of things such as degree to which the person was judged to be pleasant, kind, warm, thoughtful. The authors concluded that assertive behavior in women is apt to be met with negative consequences.

An experiment utilizing videotaped vignettes and three levels of assertiveness—low, medium, and high (Lao et al., 1975), found that highly assertive females were perceived as having lower intelligence, while highly assertive males were rated as having high intelligence. In addition, high assertiveness in women resulted in the woman being viewed as much less likeable than the high assertiveness males. The results of this study and the previous study lend support to the theoretical notions of J. B. Miller (1985a), Bernardez (1985), and Lerner (1980), that women do not express anger because of strong social sanctions which are displayed when this occurs.

In a 1984 study, Gerber found that internal attributions were used in explaining the behavior of an achieving female, and a combination of internal and external attributions were used in explaining the behavior of an achieving male. This is consistent with what has been postulated by attribution theorists (Jones, Davis, & Gergen, 1961; Wegner & Vallacher, 1977) that when persons perform
behaviors which are not consistent with what is socially expected, these behaviors are presumed to be internally caused. Gerber employed confederates to pose as a "dating couple" with one member of the couple described as an achiever. It was found that in ratings made by men, when the woman was described as the achiever they attributed lower masculinity and lower self-esteem to the man than when the female partner was described as a failure. This again, seems to provide support for the idea that if females deviate from traditional behavior the consequences will be negative.

A study conducted by Feinblatt and Gold (1976) in an outpatient child psychiatric clinic, found that more girls were referred than boys for defiance and verbal aggression, and more boys than girls were referred for being passive and emotional. There is also some empirical evidence to support the position held by Chodorow and Contratto (1982) that mothers are held accountable more so than are fathers for difficulties experienced by their children. In several studies (C. V. Abramowitz, 1977; C. V. Abramowitz, Abramowitz, Weitz, & Tittler, 1976) conducted with family therapists as subjects, it was found that mothers were judged as being more to blame than fathers for their children's problems.

Libbey (1976), developed fictitious audiotaped therapy sessions and case histories of two children. The
subjects were psychodynamically oriented psychotherapists. One client displayed defensiveness and confusion about his/her sexual identity, and the other displayed defensiveness over a study block and conflict with authority. Client sex was varied, and each subject was exposed to two audiotaped therapy sessions with the responses of the therapist deleted. The subjects were asked to audiotape their responses, and these were rated for positive emotion given to the client, specificity, and confrontation. Libbey's study found only that therapists showed greater positive emotion to female than male clients.

Similar results were obtained by Stengel (1976), who videotaped two coached clients and deleted the therapist responses. Client sex was varied along with anger and sadness. The responses were rated on genuineness, empathy, and warmth. No significant findings were reported.

Gamsky and Farwell (1966) employed four student-actors to pose as bogus clients and had them display either hostility or friendliness. Four conditions were formed consisting of: hostile male client, hostile female client, friendly male client, and friendly female client. Thirty school counselors were engaged as subjects, and led to believe that they were seeing actual clients. The counseling sessions were taped and the therapist's responses rated by trained coders. It was found that counselors reacted more negatively when hostility was directed
toward them as opposed to a third party. It was also found that the counselor's verbal responses included "more tension release, agreement, reflection, requests for information and elaboration, but less disagreement with the male hostile client than with the female hostile client" (p. 187). These findings support the idea that men expressing anger elicit responses reflecting accommodating and deference, while women expressing anger are met with responses which function to discourage such behavior.

A study was conducted (Fischer et al., 1976) in which written case histories of a 35 year-old graduate student with marital problems were presented to 135 male and female social workers. The authors varied the sex of the student along with an activity-passivity dimension, for a total of four conditions. Eleven dependent measures were employed and included things such as assessment of the client's emotional maturity, prognosis, intelligence, degree of disturbance, amount of warmth and support the client would need in treatment, and degree to which client should be encouraged to express more emotion. Females were judged as more intelligent, more emotionally mature, and were favored more than male clients. Thus these results do not support the contention that mental health professionals view active women negatively.

Bowman (1982) obtained contradictory results in a study which found that therapists did demonstrate bias
against activity in women. A total of 61 male and female psychotherapists volunteered as subjects, and each was presented with a fictitious case history. The case histories were identical except for sex which was varied. The "client" was portrayed as a person active at work, sexually, and in relationships. The client was described as assertive, ambitious, and independent. The dependent measures consisted of three open-ended questions: (a) formulation of the problem, including inferences about underlying issues; (b) issues to be explored in therapy; and (c) treatment goals. Bowman also employed one closed-ended question as a dependent measure, and this involved having the subject make a judgment as to whether the client should receive individual therapy, couples therapy, or some other form of treatment. The outcome supported the notion that bias against activity in women occurs among therapists. Bowman (1982) states that:

Bias against activity in women was demonstrated in several ways. First, the female client was seen as having an intrapsychic problem requiring individual insight-oriented therapy whereas the male client, with the same presenting problem of marital conflict was seen as having an interpersonal relationship problem requiring couples therapy. Activity in a woman was viewed as neurotic in that the conflict was conceptualized as unresolved issues about sexual identification implying femininity had not been achieved. (p. 332)

These findings also support the idea that women who display behavior which indicates they are acting in their own self-interest rather than in the interest of others,
are viewed negatively and are also assigned internal attributions to explain the cause of their behavior. Men however, displaying identical behavior are held less personally accountable for their difficulties (labeled marital in this case), and the wife or partner was implicated as involved in the problem even though she was not present. In other words, an external attribution was used to explain the cause of the man's behavior.

Only one study has been located which deals directly with therapists' responses to female client anger (Johnson, 1978), and this study reported negative findings. Forty practicing master's and doctoral level therapists were engaged as subjects and viewed one of four videotaped vignettes along with a vignette of a marital therapy session which was always viewed first. The four vignettes depicted an angry male client, an angry female client, a depressed male client, and a depressed female client. Eight dependent measures were employed, four of which were rated by the subjects themselves, and four of which were rated by judges. The dependent measures in the first group were (a) liking for client, (b) client attractiveness (to what degree would the therapist-subject like to work with this client), (c) counselor empathy, and (d) counselor comfort. The judge rated measures were (a) sympathy for client, (b) positive or negative identification with client, (c) defensiveness, and (d) anger toward
client. Data was collected from subjects individually and the entire process was tape-recorded with the judges rating the audiotapes. In addition, the subjects were asked to respond to the client directly at four points during the vignette.

Although Johnson (1978) did not obtain significant results, in her dissertation she writes that:

Three of the male therapists felt very positively about the angry female client. One said, "I'm feeling very positive about being able to do something for her . . . I really like to work with people like her because you get such fantastically quick results." Another said, "I sort of like the spirit that she's coming out with; she's coming across sort of damned cocksure . . . I think maybe I'd be seduced into wanting to step in, identification. I'd like very much to work with her." (p. 82)

In contrast, the female therapists seemed to feel less positively about the angry female client, with several describing her as "demanding" and "irritating."

Implications for Therapy

Up to this point, it has been noted that a number of researchers in the area of women's studies believe that anger displayed by women is responded to negatively, and reasons for this type of response have been delineated. In addition, although next to no research has been conducted on the effects of women's anger, research has been found in the area of sex-role stereotyping which centers around the idea that women should be passive. A good
number of these studies have reported positive findings. This section will address the work of a group of researchers who regard negative responses to female anger as an obvious phenomena; one which has been repeatedly validated through the subjective impressions of these therapists during their clinical work. This group has speculated as to how psychotherapy may function to maintain cultural prohibitions against female anger, and it is this work which will be reviewed here.

Different authors have theorized about what may occur in therapy when the female client becomes angry, and how therapists may inhibit expression of anger by women (Bernardez, 1976; Nadelson, Notman, Miller, & Zilback, 1982). It has been proposed that angry feelings displayed by women are apt to be met with a more negative response in therapy than hostility or anger displayed by men. In addition, it is thought that the female client is not made aware of the positive aspects of her angry feelings, and that the therapist may fail to recognize instances in which her anger is legitimate (Bernardez, 1976; Lerner, 1982; Nadelson et al., 1982). Lerner (1982) states that a female client's concern with women's issues or inequality within her work or home situation is not unfrequently met with an attitude that "feminist concerns may be interpreted as the patient's defensive attempt to avoid painful inner conflict by placing the blame for her unhappiness"
outside herself" (pp. 274-275). In other words, her anger may be viewed as an intrapsychic conflict lacking a sociological basis. Kaplan (1979) suggests that anger directly expressed by a female client may be met with confrontative and defensive reactions, or even a disconfirmation of her feelings. Another possible response according to Kaplan, is withdrawal and distancing on the part of the therapists. This is a reaction which suddenly reverses and becomes empathic "when the patient's anger is reduced to tears and self-blame" (p. 118).

A similar difficulty occurs when the therapist does not recognize overly passive, dependent, compliant, or submissive behavior as a problem (Bernardez, 1976; Kaplan, 1979). Instead this behavior remains unacknowledged and is possibly reinforced. Rice and Rice (1973) suggest that it is a problem when therapists use a client-centered approach in therapy with a female client who is goalless, lacking identity, indecisive, or in need of information. With these clients, they believe that therapists should be actively involved in promoting or arousing anger and encouraging the client to begin to act in her own self-interest.

In addition, it has been hypothesized that repression of anger is a causative factor in many of the psychological difficulties which female clients enter therapy with, and that many therapists likely fail in perceiving
this (Bernardez, 1985). Bernardez (1985) holds the view that depression may be the result of repressed anger and an inability to act in one's own self-interest. She believes that depression is generated by the fact that women fill a subordinate role in society, and lack the power and authority needed to change their situation. They consequently become angry over this, yet the anger cannot be expressed because it doesn't fit with the prescribed feminine role. Here the woman is essentially caught; if she rebels against the norms her sexual identity and major relational ties are threatened, if she accepts the norms, she lives a life of powerlessness and lack of control over her situation. Add to this, (Bernardez, 1985) the fact that minor tranquilizers are over-prescribed for women, and often given in order to bury symptoms such as anger and anxiety which indicate that something is wrong in the woman's life. This type of treatment also implies that there is something wrong with the woman because she can't cope psychologically with a social structure, which in fact is built upon her subordination.

Nadelson et al. (1982) offer a similar explanation for the high incidence of depression found in women. These authors believe that in women, feelings of anger are channeled into relationship building, which substitutes for direct expression of needs and wants, and it is
through relationships then that women gain a sense of power. Following this point, when a woman loses a relationship, she loses a major and possibly her only source of power and control, and the result of this loss is depression.

Depression is not the only symptom which has been related to repressed anger. It has also been noted that physical symptoms may be related to stereotypically feminine characteristics. Heiser and Gannon (1984), found that certain feminine qualities such as passivity and insecurity were related to a number of physical complaints. These authors also found that the single best predictor of physical symptom frequency for both men and women was indirect expression of hostility. This research fits with the idea of Bernardez (1985) that repressed anger is at the root of many difficulties women present with in therapy.

Although the above authors seem to suggest that female clients have the most to lose with male therapists, it is important to note that female therapists may also respond negatively to anger manifested in a female client. Female therapists may view a female client's anger as a threat to the relational tie between client and therapist (Kaplan, Brooks, McComb, Shapiro, & Sodano, 1983). In an attempt then to maintain the relationship, the therapist may discourage behavior which indicates separation or
autonomy on the part of the client. Bernardez (1976) also points out that a female therapist may respond negatively to anger in a female client, when she perceives that the client is acting out the therapist's own fears of being angry and losing control of her anger.

Summary of Literature Review

Theoretical material in the area of psychotherapeutic treatment of women suggests that anger displayed by women is apt to bring about negative consequences, which function to prohibit further expression of anger. In addition, a number of authors (Bernardez, 1985; Lerner, 1982; Nadelson et al., 1982) have concluded that therapists are biased against display of anger in female clients, and that psychotherapy fosters traditional views about women which tend to be damaging psychologically. It has however, been determined empirically that female anger is responded to negatively, and research in this area is minimal. Johnson's (1978) study has been the only work located in which the researcher directly attempted to assess responses of therapists to anger in female clients, and this study reported negative findings. Johnson's work however has been criticized (Sherman, 1980) on the grounds that not all of the dependent measures she employed were relevant to the sex-role dimension. For example, it is unclear how counselor empathy, counselor comfort, and
sympathy for client are related to cross-gender behavior. Johnson also provided subjects with very limited information about the clients. The vignettes consisted only of the anger episode and contained almost no other material on which to base clinical judgments. Given this, the therapists may have been reticent to trust their reactions or to provide judgments.

In addition, Johnson (1978) employed a method which she believes would tap the therapist's true countertransference responses. That is, she displayed videotaped vignettes and had therapists respond to the client directly. Data was gathered on subjects individually, with the entire process audiotaped and then rated by judges. One difficulty with this approach, is the possibility that the therapists censored remarks due to the lack of anonymity. The fact that the subjects were administered the treatments individually, and tape-recorded, surely could have sensitized them to the fact that some aspect of their work was under careful evaluation.

Other research in the area of sex-role stereotyping supports the notion that when women engage in behaviors which are not regarded as gender-appropriate, the consequences are negative (S. I. Abramowitz et al., 1973; S. I. Abramowitz et al., 1975; Bowman, 1982; Gamsky & Farwell, 1966; Kelly et al., 1980; Lao et al., 1975; Thomas & Stuart, 1971). Thus, it seems reasonable to postulate
that anger displayed by women (a gender-inappropriate behavior) will be viewed negatively.

Hypotheses

The main purpose of the present study was to examine the responses of psychotherapists to anger manifested in female and male clients. Based on existing theoretical and empirical work, it was hypothesized that anger displayed by a female client would be met with negative personality judgments more so than would anger displayed by a male client. One can speculate that these negative judgments serve to prohibit the display of anger by women. It was postulated that therapists would respond to anger in a female client by rendering judgments of her as having poor parenting skills, as a poor marital partner, cold and interpersonally insensitive, hysterical and therefore incompetent, rash, impulsive, unreasonable, irrational, an undesirable therapy client, and a poor therapy candidate. It was also hypothesized that the angry female client would be assessed as having a greater degree of psychopathology than her angry male counterpart. In part, this hypothesis was based on the results of the studies on attribution theory which have indicated that out-of-role behavior tends to generate internal attributions (Jones et al., 1961). The more severe psychopathologies also imply some degree of internally based conflict and tend to be
characterized by recurrent self-defeating patterns of behavior. Thus it was hypothesized that the angry female client would be diagnosed as more severely disturbed than the angry male client. These conceptualizations have been condensed into the following specific hypotheses stated here in the null form:

**Null Hypothesis 1**: No significant differences will be found between the angry female client and the angry male client on competence level.

**Null Hypothesis 2**: No significant differences will be found between the angry female client and the angry male client on degree of interpersonal difficulty.

**Null Hypothesis 3**: No significant differences will be found between the type of psychopathology ascribed to the angry male client and the angry female client.
CHAPTER III

METHOD

Subjects

Subjects were 69 professional therapists participating on a voluntary basis. Qualifications to be selected as a subject included either a doctoral degree in psychology, a limited license to practice psychology, or a masters degree in clinical social work. There were 29 female subjects and 40 male subjects. The subjects ranged in age from 26-65. Twenty-nine subjects held doctoral degrees and 40 subjects held masters degrees. Of the 29 female subjects, 12 were doctoral level therapists and 17 were masters level therapists. For the male subjects, 17 held doctoral degrees and 23 held masters degrees. Subjects were sought from hospitals, community mental health centers, private agencies, and a local psychological association in Michigan. Subjects were contacted either directly, through agency directors, or through persons known to the experimenter, and asked if they would be willing to participate in the study. All subjects were from the midwest region of the country. It should be noted that where appropriate in this text, the subjects will be referred to as therapists.
Design

A 4-factor design was employed with 1 within-subjects factor and 3 between-subjects factors. The independent variables were anger versus nonanger, subject sex, client sex, and subject level of training. Anger versus nonanger was the within-subjects factor, while subject sex, client sex, and subject level of training were the between-subjects factors. The dependent variables were ratings of client competence, interpersonal functioning, and type of psychopathology. These were measured by two questionnaires, one requiring subjects to provide personality judgments, and the other diagnostic impressions. Subjects were randomly assigned to one of two groups: Those reading transcripts of male clients, and those reading transcripts of female clients. Within these groups subjects were exposed to both angry and nonangry treatment conditions with order of administration randomly determined.

Independent Variables

Angry and Nonangry Therapy Transcripts

Client anger was manipulated through the use of two fictitious therapy transcripts, one portraying an angry client and the other a nonangry client. The angry and nonangry transcripts were different in content, and an entirely different scenario was presented in each script.
There were two versions of each script, one presenting a male client and the other a female client. Thus there were a total of four transcripts. Both transcripts may be viewed in Appendix B.

**Angry Transcript**

The angry fictitious therapy transcript was created and tested for efficacy during the pilot study. A description of the pilot study is presented in Appendix A. The script is two and one-half pages in length and portrays the first portion of a therapy session. The script depicts either a male or female client who becomes increasingly angry at the therapist and eventually verbalizes this anger. The purpose of testing the transcript during the pilot study was to determine: (a) If subjects would be able to respond meaningfully to the questionnaires given the information presented in the script, and (b) whether a range of attributions would be generated with regard to which party (client or therapist) was perceived as primarily responsible for the anger episode.

With regard to the first purpose, the distribution of responses was examined for each item on the questionnaires during the pilot study. It was hypothesized that if subjects were having difficulty responding to the questionnaires based on the information given, this might be revealed through certain response patterns, such as the
clustering of responses at the low or middle points of the scales, or a significant number of items left unanswered. Results of the pilot study revealed a relatively normal distribution of responses for most of the items and few items left unanswered, thus supporting the idea that the subjects were able to respond based on the information provided. The examiner also wanted to determine if subjects were using each of the points on the 5-point Likert scale used for the Personality Questionnaire, and each of the points on the 7-point Likert scale used for the Clinical Impressions Questionnaire. Examination of the distribution of responses for each item indicated that subjects were using all of the points on the scales in responding to the items.

With regard to the second purpose, the script was constructed in a way such that both the client and therapist could conceivably be viewed as bearing some responsibility for the anger episode. This was done in an effort to avoid creating the perception of the client's anger as largely irrational and therefore suggestive only of psychopathology. An experimental manipulation check was included in the pilot study in order to assess attributions of responsibility. Each subject was asked to rate on a scale from 1-10 the degree of responsibility which could be attributed to the client and therapist for the outcome of the therapy session (1 indicating low
responsibility and 10 high responsibility). The results indicated that the subjects' responses were sufficiently varied, thus supporting the notion that the script was effective in eliciting attributions of responsibility to both client and therapist. The distribution of responses for each item was also examined for this purpose. It was anticipated that if responses to items were consistently clustered at the positive or negative poles of the scales, subjects might be perceiving one party in an overly negative way or as clearly more responsible for the anger episode.

Unlike Johnson's study (1978) which portrayed a client who is angry at her boss, husband, therapist, and the mental health agency, the client's anger in the present study is directed primarily at the therapist. The experimenter attempted to create the impression of the anger as triggered by several of the therapist's remarks which might indicate a lack of sensitivity to the material presented by the client. After the anger is triggered however, it appears to be largely autonomous. The anger is sustained for a period of time and then decreased somewhat in intensity toward the end of the transcript.

**Nonangry Transcript**

A second therapy transcript was constructed after the pilot study which portrays the first portion of a therapy
session with a nonangry male or female client. This treatment condition was added as a control for the purpose of ensuring that treatment effects could be attributed to client anger and not to client sex alone. It was the experimenter's intent to construct a script which would appear as neutral as possible, and it was decided that a client presenting with a phase of life problem or adjustment reaction would best meet this criteria. As a result, this script depicts a client coping with the stress of caring for a severely handicapped child. This transcript is also two and one-half pages in length.

After most of the questionnaires were completed and returned, it was discovered that the nonangry transcript of the female client contained an error. On the last verbalization by the client the name was incorrectly typed in as Mark instead of Connie. To ensure that this had no effect, an analysis of variance was run comparing the group which read the transcripts containing the error to subsequent subjects reading the corrected version. Because the main analyses had revealed effects due to level of training, only the doctoral subjects in each group were used for this analysis. Analysis of variance revealed no significant effects on any of the dependent measures.

**Sex of Client**

Sex of client was manipulated through the inclusion
of the client's first name in the therapy transcript. The male versions of both transcripts use the names "Russ" and "Mark," while the female versions use the names "Janet" and "Connie." The client's name appears before each statement and also appears at one point in the text, where the therapist addresses the client by his or her first name.

Subject Sex and Subject Level of Training

Subject sex and subject level of training were measured by asking subjects to provide this information after reading the instructions. Subjects indicated their gender and educational level through circling the appropriate options provided. To measure level of training, subjects were asked to endorse the highest educational level obtained. On this basis, the subjects were divided into two categories: Those with masters level degrees (M.A. and M.S.W.), and those with doctoral level degrees (Ph.D., Psy.D., and Ed.D.). Differences within each of these categories were not considered.

Dependent Variables

Two questionnaires were constructed by the examiner and used in the pilot study. All questionnaires and the separate scales which comprise them may be viewed in Appendix C. The two questionnaires developed were labeled
the Personality Judgment Questionnaire, and the Diagnostic Impressions Questionnaire. Both are described in detail below.

**Personality Judgment Questionnaire**

The decision to construct this particular questionnaire was based on an examination of the theoretical and empirical literature in the area of sex-role stereotyping. Several key conceptions appear to lie at the essence of the theoretical work on women and anger, and it is these from which the questionnaires have been formulated. One conception is that anger in women is not legitimised (Lerner, 1977). It has been hypothesized that angry women tend to be dismissed as hysterical or irrational, and are met with responses which function to discredit the woman for expressing her feelings. The second perspective has to do with the fact that society socializes people to believe that if women are to be the caretakers of others, they cannot do things which might upset interpersonal relationships. Therefore if one is to be a competent wife and mother, a strong emotion like anger which generates interpersonal discord cannot be expressed or even experienced (Lerner, 1977; J. B. Miller 1981, 1983). If a woman uses angry or aggressive feelings in her own self-interest she may be labeled as "self-centered." This is especially harsh criticism given that for many women, it challenges
what is likely at the core of their identity.

The Personality Judgment Questionnaire was constructed based on the theoretical ideas presented above. It was anticipated that the anger displayed by the female client would be discredited or "not legitimized" (Lerner, 1977) and this would be manifested through judgments of her as immature, dependent, overdramatizing, emotionally unstable, irrational, provocative, having low intelligence, and having limited insight and therefore a poor prognosis. It was also anticipated that the anger would be seen as incompatible with other traditionally female functions, and that the angry female client would be judged as poor or incompetent in these areas. Included here would be judgments of her as cold, insensitive to the needs of others, self-centered, a poor marital partner, and poor with children. Thus the items for this questionnaire were generated with the idea in mind that the angry female client would be: (a) discredited, and (b) judged as performing poorly at tasks in which women generally perform well, and upon which sex-role identity is often based. Some of these judgments have also been used by other experimenters investigating sex-role stereotyping. Kelly et al., (1980) hypothesized that assertiveness in females would be met with devaluation and lower ratings on likability. Lao et al. (1975) and Fisher et al. (1976) both employed intelligence as a dependent measure, with
the Fisher study also asking for judgments on emotional maturity, and treatment prognosis.

The Personality Judgment Questionnaire contains 26 items presented in a format similar to that of a semantic differential. In constructing this questionnaire numerous items were generated by the experimenter to be used in the pilot study. In generating the items the experimenter anticipated that the scales derived from this questionnaire would examine the client's degree of competence and ability to function successfully interpersonally. It was also anticipated that some items might be eliminated based on the results of the pilot study. Items would be eliminated if they loaded about equally on more than one factor, or if subjects' responses were not sufficiently varied upon examination of the response distribution for a particular scale.

For this questionnaire, subjects rated the client on a number of 5-point scales with descriptors which are opposite in meaning at each end. In constructing the questionnaire the 5-point scales accompanying each item were randomized so that the positive and negative descriptors would not continually fall at one end of each scale. This was done in order to avoid the possibility of a response set. A given subject's total score was obtained by adding up the points assigned to each item loading on that particular factor. In scoring, the
negative descriptors always generated higher values than the positive descriptors. Therefore, the higher the total score for a given scale or questionnaire, the more negatively the client was rated. In carrying out this scoring procedure it was necessary to reverse score some of the items. This was due to the fact that the questionnaire was constructed such that the positive and negative poles of the Likert scales did not consistently fall at one end of the continuum or the other.

Factor Analysis of Personality Judgment Questionnaire

This questionnaire was factor analyzed for the pilot study and two scales were formulated out of the two primary factors obtained. The results of this factor analysis are presented in Table 1. The factors closely resemble those which were anticipated by the experimenter in constructing the questionnaire. Six items which appeared to load equally on both factors were eliminated leaving a total of 26 items on this questionnaire. One scale was labeled a Competency scale and is comprised of 17 items which measure perceptions of the client's general level of competence. These items asked the raters to make judgments about things such as the client's ability to work effectively, emotional stability, degree of insight, maturity, clarity of thought, judgment, rationality, and capacity to benefit from therapy.
<table>
<thead>
<tr>
<th>Item</th>
<th>Factor I</th>
<th>Factor II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good/poor marital partner</td>
<td>.808</td>
<td>.115</td>
</tr>
<tr>
<td>Clear-thinking/confused</td>
<td>.786</td>
<td>.153</td>
</tr>
<tr>
<td>Positive/negative counter/transference feelings</td>
<td>.778</td>
<td>-.055</td>
</tr>
<tr>
<td>Emotionally stable/unstable</td>
<td>.758</td>
<td>.050</td>
</tr>
<tr>
<td>Mature/immature</td>
<td>.723</td>
<td>.286</td>
</tr>
<tr>
<td>Rational/irrational</td>
<td>.712</td>
<td>.385</td>
</tr>
<tr>
<td>Good/poor judgment</td>
<td>.699</td>
<td>.201</td>
</tr>
<tr>
<td>Tolerant of/sensitive to criticism</td>
<td>.697</td>
<td>-.023</td>
</tr>
<tr>
<td>Cautious and deliberate/impulsive</td>
<td>.680</td>
<td>.181</td>
</tr>
<tr>
<td>Could/could not tolerate interpretations and confrontations</td>
<td>.670</td>
<td>.047</td>
</tr>
<tr>
<td>Competent/incompetent</td>
<td>.660</td>
<td>-.039</td>
</tr>
<tr>
<td>Would/would not progress well in therapy</td>
<td>.642</td>
<td>-.073</td>
</tr>
<tr>
<td>Analytical mind/little insight</td>
<td>.569</td>
<td>.283</td>
</tr>
<tr>
<td>Active in structuring life/passive and unable to exert control</td>
<td>.551</td>
<td>-.294</td>
</tr>
<tr>
<td>Functions well/poorly in life</td>
<td>.537</td>
<td>-.044</td>
</tr>
<tr>
<td>Exaggerates/appropriately reactive</td>
<td>.510</td>
<td>.242</td>
</tr>
<tr>
<td>Dependent/independent</td>
<td>.426</td>
<td>.020</td>
</tr>
<tr>
<td>Flexible/rigid</td>
<td>.371</td>
<td>.767</td>
</tr>
</tbody>
</table>
The second scale was labeled an Interpersonal Functioning scale and is comprised of nine items which assess perceptions of the client's capacity for rewarding interpersonal relations. The raters were asked to make judgments about the client's sensitivity to others, patience, likability, flexibility, warmth, ability to get along with others, and capacity for close interpersonal ties.

**Diagnostic Impressions Questionnaire**

The decision to construct this questionnaire was also based on an examination of the literature. Several
writers (Lerner, 1977; J. B. Miller, 1983) have raised the idea that anger in women may be viewed as a manifestation of psychopathology. Lerner (1982) discusses the idea that dissatisfaction or anger expressed by female clients over inequalities may be viewed by therapists as an essentially intrapsychic conflict as opposed to feelings which have a basis in reality. This appears to be a more sophisticated form of discrediting, and a number of researchers in the area of sex-role stereotyping have used judgments regarding degree of psychopathology as a dependent measure (S. I. Abramowitz et al., 1973, 1975; Fisher et al., 1976; Thomas & Stewart, 1971). Based on the above work, it was decided that therapists' diagnostic judgments may be indicative of bias against expression of anger by female clients.

In selecting diagnoses, the experimenter intentionally included a number of diagnoses which place the source of the client's difficulty at least partially in the environment, as well as a number of diagnoses which denote the source of the difficulty as primarily internal. This was done because it has been theorized that women tend to be held personally responsible for things which go wrong in relationships, and also readily accept this blame (Chodorow & Contratto, 1982). It was thus reasoned that the female clients might be held more accountable for the conflict in the angry therapy transcript, and that this
would be manifested through diagnostic judgments reflecting a higher degree of internally-based pathology. It was also hypothesized that when a male was involved in a conflict with the therapist, blame might be more readily assigned to external causes. This would then be manifested in the form of diagnoses which indicate that the course of the difficulty is in the environment.

This questionnaire contains 11 items all of which are DSM-III diagnoses. The subjects were asked to rate the degree to which each diagnosis applied to the client on a 7-point Likert scale ranging from strongly does not apply to strongly applies. Low ratings indicate that the diagnosis applies very little to the client, while higher ratings indicate that the diagnoses applies strongly to the client. In constructing this questionnaire the experimenter used all diagnoses that seemed even remotely plausible based on the content of the script. These ranged from marital problem to borderline personality and bipolar disorder. This was done with the intent of eliminating diagnoses which did not seem plausible to the subjects in the pilot study and hence were not used. As it turned out, none of the diagnoses were eliminated based on the results of the pilot study. The scoring procedure for the diagnostic items is such that high scores indicate a greater degree of psychopathology on that particular scale, while low scores indicate a lesser degree of

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psychopathology on that particular scale. A given subject's total score on a scale was obtained by summing the points assigned to each diagnosis loading on that particular factor.

Factor Analysis of Diagnostic Impressions Questionnaire

The Diagnostic Impressions Questionnaire was factor analyzed for the pilot study and two primary factors were obtained. Two scales were then developed out of these factors. The first factor, with the exception of one item (bipolar disorder), contained the mild diagnoses such as phase of life and adjustment reaction. The second factor, with the exception of one item (dysthymic disorder), contained the more severe diagnoses such as the personality disorders. Conceptually, the scales could be distinguished based on whether the diagnoses reflected internally-based pathology or externally-based pathology. That is, one scale would contain the diagnoses such as marital problem, adjustment reactions and phase of life problem, and the other would contain the personality disorders and bipolar disorder. The difficulty here, had to do with the fact that several of the Axis I disorders (dysthymic disorder and generalized anxiety reaction) were split between the two scales and it was unclear as to where they best fit. In addition, bipolar disorder was placed on the scale with the diagnoses which place the source of the
difficulty in the client's environment, and this seemed to 
better fit on the scale with the internally-based patho-
logies. It was decided that due to the findings obtained 
in the pilot study the factor analysis would be repeated 
for the actual study. The second factor analysis with the 
data from the main study revealed similar findings and the 
empirical results of this are presented in Tables 2 and 3. 
Reliabilities for all of the scales using Cronbach's alpha 
are presented in Table 4 for both angry and nonangry 
treatment conditions.

Table 2

Factor Analysis of Diagnostic Questionnaire 
Items for Angry Vignette

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor I</th>
<th>Factor II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline Personality</td>
<td>.786</td>
<td>-.031</td>
</tr>
<tr>
<td>Narcissistic Personality</td>
<td>.780</td>
<td>.073</td>
</tr>
<tr>
<td>Histrionic Personality</td>
<td>.670</td>
<td>-.004</td>
</tr>
<tr>
<td>Passive-Aggressive Personality</td>
<td>.644</td>
<td>.334</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>.527</td>
<td>.300</td>
</tr>
<tr>
<td>Bipolar Disorder (Manic phase)</td>
<td>.318</td>
<td>-.088</td>
</tr>
<tr>
<td>Adjustment Disorder/Anxious Mood</td>
<td>.167</td>
<td>.744</td>
</tr>
<tr>
<td>Phase of Life Problem</td>
<td>.047</td>
<td>.726</td>
</tr>
<tr>
<td>Adjustment Disorder/Mixed Emotions</td>
<td>.179</td>
<td>.713</td>
</tr>
<tr>
<td>Item</td>
<td>Factor I</td>
<td>Factor II</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Marital Problem</td>
<td>-.269</td>
<td>.556</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>.478</td>
<td>.538</td>
</tr>
</tbody>
</table>

Table 3
Factor Analysis of Diagnostic Scale Items for Nonangry Vignette

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor I</th>
<th>Factor II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcissistic Personality</td>
<td>.885</td>
<td>-.151</td>
</tr>
<tr>
<td>Bipolar Disorder (Manic phase)</td>
<td>.869</td>
<td>-.060</td>
</tr>
<tr>
<td>Histrionic Personality</td>
<td>.832</td>
<td>-.127</td>
</tr>
<tr>
<td>Borderline personality</td>
<td>.831</td>
<td>-.033</td>
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<tr>
<td>Passive-Aggressive Personality</td>
<td>.777</td>
<td>.014</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>.468</td>
<td>.304</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>.360</td>
<td>.223</td>
</tr>
<tr>
<td>Adjustment Disorder/Mixed Emotions</td>
<td>-.007</td>
<td>.862</td>
</tr>
<tr>
<td>Adjustment Disorder/Anxious Mood</td>
<td>.023</td>
<td>.830</td>
</tr>
<tr>
<td>Marital Problem</td>
<td>.143</td>
<td>.553</td>
</tr>
<tr>
<td>Phase of Life Problem</td>
<td>-.170</td>
<td>.338</td>
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Table 4
Reliabilities for all Scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Angry</th>
<th>Nonangry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence</td>
<td>.91</td>
<td>.95</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>.89</td>
<td>.91</td>
</tr>
<tr>
<td>Diagnostic 1</td>
<td>.70</td>
<td>.57</td>
</tr>
<tr>
<td>Diagnostic 2</td>
<td>.74</td>
<td>.83</td>
</tr>
</tbody>
</table>

For the main study, two scales were again formulated out of the two factors obtained from this analysis. For the angry treatment condition, one factor was composed of the adjustment disorders, phase of life problem, marital problem, and dysthymic disorder. The second factor was composed of borderline, narcissistic, histrionic, and passive-aggressive personality disorders, bipolar disorder, and generalized anxiety disorder. Results of the factor analysis for the nonangry treatment condition yielded similar findings: Factor 1 was comprised of the adjustment reactions, phase of life problem, and marital problem, and Factor 2 was comprised of the personality disorders, bipolar disorder, dysthymic disorder, and generalized anxiety disorder. It was decided to use the results of the factor analysis for the angry treatment condition in testing for treatment effects. This decision was based on the belief that these results seemed to make
greater sense conceptually. The two Axis I diagnoses (generalized anxiety disorder, dysthymic disorder) were split between the two factors for the angry treatment condition as opposed to both loading on the factor with the personality disorders for the nonangry condition. Conceptually, the generalized anxiety disorder and dysthymic disorder diagnoses seem to fit more closely with the externally generated disorders, and for the angry condition one of these loaded on this factor.

Interpretation of Factor Analysis. The disorders represented on scale 1 can be distinguished from those on scale 2 primarily on the basis of whether the pathology or source of the client's difficulties is viewed as being internal or external. The diagnoses on scale 1, with the exception of dysthymic disorder, place the source of the client's difficulties in the environment to at least some degree. Diagnoses such as marital problem or adjustment reaction implicate persons other than the client as having some involvement in the client's current difficulty. In contrast, the disorders on scale 2 imply that there is a relatively fixed flaw in the client's character structure which accounts for their difficulties. Clients with personality disorders tend to impose their internally-based pathology on the environment. Their difficulties are not primarily reactions to environmental stressors, although they also tend to not cope well with stressors.
The disorders represented on scale 1 also do not assume long-standing difficulties, and this is another basis on which the two scales may be differentiated. The disorders on scale 2 are long-term and pervasive, while those on scale 1 tend to be short-term and situational. This formulation is still consistent with the idea that the two scales can be distinguished on the basis of whether the pathology is defined as external or internal. If the source of the problem is internal, it would almost necessarily be a chronic disturbance because change in such cases is slow and often limited. In contrast, if the source of the problem is external, once the stressor is removed the person should return to his or her premorbid level of functioning. In addition, prognosis is generally thought to be more favorable when the difficulties are reactive and short-term as opposed to long-term and pervasive.

Thus this questionnaire is examining the degree of fit the therapist sees between the client portrayed and certain diagnostic categories. A high score on scale 1 was interpreted as indicating that the therapist sees a high degree of fit between the client and the diagnostic categories represented here. A high score on scale 2 was interpreted as indicating that the therapist is rating the subject high on a different (more internally based) type of pathology.

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Procedure

Willing subjects each received a packet of materials containing instructions (which may be viewed in Appendix C with the questionnaires), two written transcripts, and two copies of both questionnaires. Each subject read either two transcripts of male clients or two transcripts of female clients. All subjects were exposed to both angry and nonangry treatment conditions with order of administration randomly determined. For example, a given subject who received a packet containing male clients would read a transcript of an angry male client and a transcript of a nonangry male client. The material was stapled together and subjects were asked to complete the material in the order in which it was received. The instruction sheet stated that the participants would read one therapy transcript, and then fill out two questionnaires which ask for their judgments about the client, and would then read a second therapy transcript, with two questionnaires identical to those just completed, on which they would rate the second client. The subjects were asked to imagine themselves as the therapist while reading through the transcripts. Subjects were also instructed not to refer back to the transcripts while filling out the questionnaires. The purpose of this was to ensure, as much as possible, that the stimulus conditions were the same for
all subjects. Additionally, participants were asked to not discuss the material with any other persons until everyone in the agency participating had completed the packet. The instructions stated that the purpose of the research was to construct several clinical judgment instruments. This deception was employed in order to prevent subjects from guessing the true intent of the study. Subjects were also asked for some demographic information regarding their level of training, age, highest degree obtained, and sex.

Analysis

It was determined that a repeated measures analysis of variance would be conducted on each of the four scales derived from the factor analyses. These included the Competence and Interpersonal Functioning scales, and the Diagnostic scales 1 and 2. Descriptive statistics would also be presented for each scale, including the cell means, standard deviations, and number of subjects.
CHAPTER IV

RESULTS

Introduction

The purpose of the present study was to investigate therapists' judgments of angry and nonangry male and female clients. The independent variables included angry versus nonangry client, client sex, therapist sex, and therapist level of training. The dependent measures included therapists' judgments of client competence, interpersonal functioning, and diagnostic category. In presenting the results, each dependent measure will be considered separately. Main effects, test of major hypothesis, and interaction effects will be discussed for each dependent variable.

Competence Scale

The competence scale is comprised of 17 items which measure subject perceptions of the client's general level of competence. Included here are judgments of emotional stability, maturity, degree of insight, rationality, ability to work effectively, and capacity to benefit from therapy. Reliabilities for this scale are .91 and .95 for the angry and nonangry treatment conditions respectively.
The descriptive statistics broken down by subject sex, client sex, and subject level of training and the results of the main analysis may be viewed in Tables 5 and 6. A repeated measures analysis of variance revealed a main effect for client sex with female clients rated as more competent than male clients, $F(1, 59) = 4.32, p < .05$. This is represented by the lower mean scores in Table 5 which indicate a more positive rating on this scale. A main effect for anger was also noted, with the nonangry clients viewed as more competent than the angry clients, $F(1, 59) = 205.23, p < .001$. Again, as can be viewed in Table 5, the means for the angry conditions are significantly higher than those for the nonangry conditions indicating that the angry clients were rated as less competent.

No significant main effects were obtained for the therapist sex or therapist level of training. This indicates that therapist sex and therapist level of training were not found to be biasing factors in judgments on competence. In addition, no significant interaction effects were found. Thus the null hypothesis which stated that no significant difference would be found between the angry male client and the angry female client on competence could not be rejected. As indicated in Table 6, the client sex by client anger interaction was not significant, $F(1, 59) = .25, ns$. 

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Table 5
Descriptive Statistics for Competence Scale for Angry and Nonangry Vignettes

<table>
<thead>
<tr>
<th></th>
<th>Angry</th>
<th>Nonangry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Female Therapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>10</td>
<td>60.10</td>
</tr>
<tr>
<td>Doctoral</td>
<td>5</td>
<td>64.40</td>
</tr>
<tr>
<td>Male Client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>6</td>
<td>64.33</td>
</tr>
<tr>
<td>Doctoral</td>
<td>6</td>
<td>70.50</td>
</tr>
<tr>
<td>Male Therapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>15</td>
<td>60.47</td>
</tr>
<tr>
<td>Doctoral</td>
<td>7</td>
<td>54.43</td>
</tr>
<tr>
<td>Male Client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters</td>
<td>8</td>
<td>67.00</td>
</tr>
<tr>
<td>Doctoral</td>
<td>9</td>
<td>60.55</td>
</tr>
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</table>

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Table 6
Results of Analysis of Variance on Competence Scale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Between-Subjects Effects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within cells</td>
<td>7082.93</td>
<td>59</td>
<td>120.05</td>
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<tr>
<td>Subject sex</td>
<td>50.59</td>
<td>1</td>
<td>50.59</td>
<td>.42</td>
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<tr>
<td>Client sex</td>
<td>518.51</td>
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<td>518.51</td>
<td>4.32</td>
<td>.042</td>
</tr>
<tr>
<td>Level of training</td>
<td>121.55</td>
<td>1</td>
<td>121.55</td>
<td>1.01</td>
<td>ns</td>
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<tr>
<td>Subsx by clsx</td>
<td>53.33</td>
<td>1</td>
<td>53.33</td>
<td>.44</td>
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<tr>
<td>Subsx by lvtrn</td>
<td>107.83</td>
<td>1</td>
<td>107.83</td>
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<tr>
<td>Clsx by lvtrn</td>
<td>110.87</td>
<td>1</td>
<td>110.87</td>
<td>.92</td>
<td>ns</td>
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<tr>
<td>Subsx by clsx by lvtrn</td>
<td>37.56</td>
<td>1</td>
<td>37.56</td>
<td>.31</td>
<td>ns</td>
</tr>
<tr>
<td><strong>Within-Subjects Effects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within cells</td>
<td>6156.68</td>
<td>59</td>
<td>104.35</td>
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<tr>
<td>Anger</td>
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<td>1</td>
<td>21416.00</td>
<td>205.23</td>
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<tr>
<td>Subsx by anger</td>
<td>152.96</td>
<td>1</td>
<td>152.86</td>
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</tr>
<tr>
<td>Clsx by anger</td>
<td>25.96</td>
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<td>25.96</td>
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<tr>
<td>Lvtrn by anger</td>
<td>143.03</td>
<td>1</td>
<td>143.03</td>
<td>1.37</td>
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<tr>
<td>Subsx by clsx by anger</td>
<td>61.00</td>
<td>1</td>
<td>61.00</td>
<td>.58</td>
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<tr>
<td>Subsx by lvtrn by anger</td>
<td>303.47</td>
<td>1</td>
<td>303.47</td>
<td>2.91</td>
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</tr>
<tr>
<td>Clsx by lvtrn by anger</td>
<td>149.48</td>
<td>1</td>
<td>149.48</td>
<td>1.43</td>
<td>ns</td>
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</table>
Table 6--Continued

<table>
<thead>
<tr>
<th>Source of Variation</th>
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<th>MS</th>
<th>F</th>
<th>P</th>
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</thead>
<tbody>
<tr>
<td>Subsx by clsx by</td>
<td>.48</td>
<td>1</td>
<td>.48</td>
<td>.00</td>
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<td>lvtrn by anger</td>
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<td></td>
<td></td>
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</tbody>
</table>

Note. Clsx = client sex; subsx = subject sex; lvtrn = level of training.

Interpersonal Functioning Scale

This scale is comprised of nine items which assess the client's capacity to function successfully in relationships. The therapists were asked to make judgments about things such as the client's sensitivity to others, warmth, ability to get along with others, patience, and likability. Reliabilities for this scale are .89 for the angry condition, and .91 for the nonangry condition.

The descriptive statistics along with the results of the repeated measures analysis of variance are presented in Tables 7 and 8. A main effect was obtained for client sex, with female clients rated as better functioning interpersonally than male clients, $F(1, 55) = 5.19, p < .05$. This is evidenced by the lower mean scores in Table 7 for the female clients, which indicate a more favorable rating. A main effect was also obtained for anger, with the nonangry clients rated as better functioning interpersonally than the angry clients, $F = (1, 55) 169.15, p < .001$. This is also indicated by the consistently lower
mean scores in Table 7 for the nonangry clients. The lower scores again denote a more favorable rating. These findings parallel those found on the Competence scale where female clients were rated as more competent than the male clients, and the nonangry clients were viewed as more competent than the angry clients.

Table 7

Descriptive Statistics for Interpersonal Functioning Scale for Angry and Nonangry Vignettes

<table>
<thead>
<tr>
<th></th>
<th>Angry</th>
<th>Nonangry</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>Mean</td>
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<td></td>
</tr>
<tr>
<td>Female Client</td>
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<td>27.56</td>
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<table>
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<th>Source of Variation</th>
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</tr>
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<td>99.57</td>
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<td>1</td>
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<td>ns</td>
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<tr>
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<td>40.67</td>
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<tr>
<td>Clsx by lvtrn by anger</td>
<td>24.84</td>
<td>1</td>
<td>24.84</td>
<td>1.09</td>
<td>ns</td>
</tr>
</tbody>
</table>

Table 8

Results of Analysis of Variance on Interpersonal Functioning Scale

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No significant main effects were found for therapist sex or therapist level of training, which suggests that these are not biasing factors in judgments of interpersonal functioning. The stated null hypothesis that no significant difference would be found between the angry male client and the angry female client could not be rejected. As indicated in Table 8, the client sex by client anger interaction was not significant, $F(1, 55) = .03$, ns.

The following significant interaction effects were obtained. A significant interaction was found for therapist sex by anger. Fisher's Protected Least Significant Difference test (LSD) revealed that the female therapists rated the angry clients more negatively on interpersonal functioning than the male therapists, $t(62.00) = 2.22$, $p < .05$. Examination of the descriptive statistics in Table 7 indicates that the means for the conditions where the females rated the angry clients are slightly higher than those in which the male therapists rated the angry
clients. Again, the higher means are interpreted as a more negative rating. The Protected LSD indicated no difference between the male and female therapists on the nonangry vignette, \( t_{(66.00)} = -.54, \) ns.

A second interaction effect was obtained for therapist level of training by anger. The LSD test revealed that the doctoral level therapists rated the nonangry clients as functioning better interpersonally than the masters level therapists, \( t_{(66.00)} = 2.51, p < .05. \) This is evidenced by the lower mean scores of the doctoral level therapists for the nonangry condition, as can be seen in Table 7. A significant difference was not obtained between the masters and doctoral level therapists for the angry treatment condition, \( t_{(62.00)} = .45, \) ns. Further examination of the means in Table 7 also indicates that the doctoral level therapists assigned the lowest rating of all to the nonangry female client. Low scores denote a favorable rating, therefore this suggests that nonangry female clients may be judged to be the most successful of all clients in interpersonal functioning.

The two main effects found on the Competence and Interpersonal Functioning scales suggest that the nonangry female client was perceived as more competent and better functioning interpersonally than any other client represented.
**Diagnostic Scale 1**

This scale is comprised of 5 items all of which are DSM-III diagnoses. Nearly all of the items on this scale are diagnoses which place the source of the client's difficulties in the environment or outside of the client to at least some degree. Because of this, these disorders tend to be short-term and are often reactions to specific situations. Included here are diagnoses such as marital problem, phase of life problem, and adjustment reaction. Reliabilities for this scale are .70 for the angry condition and .57 for the nonangry condition.

The descriptive statistics and repeated measures analysis of variance for this scale may be viewed in Tables 9 and 10. As can be viewed in Table 10, no significant main effects were found for therapist sex, client sex, therapist level of training or anger. This indicates that these were not found to be biasing factors in judgments of psychopathology on this scale. In addition, the null hypothesis which stated that no significant difference would be found between the angry male client and the angry female client on type of psychopathology could not be rejected, F (1, 56) = .47, ns.
Table 9
Descriptive Statistics for Diagnostic Scale 1 for Angry and Nonangry Vignettes

<table>
<thead>
<tr>
<th></th>
<th>Angry</th>
<th>Nonangry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td><strong>Female Therapists</strong></td>
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<td></td>
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<tr>
<td><strong>Female Client</strong></td>
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<td></td>
</tr>
<tr>
<td>Masters</td>
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<td>22.40</td>
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<td><strong>Male Client</strong></td>
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<tr>
<td>Masters</td>
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<tr>
<td>Doctoral</td>
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<td><strong>Male Therapists</strong></td>
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<td></td>
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<td>Masters</td>
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<td>20.35</td>
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<td><strong>Male Client</strong></td>
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<td>Masters</td>
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<td>Doctoral</td>
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Table 10
Results of Analysis of Variance on Diagnostic Scale 1

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<tbody>
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<td>Level of training</td>
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<td>1</td>
<td>54.42</td>
<td>1.22</td>
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<td>Subsx by clsx</td>
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<td>57.61</td>
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<td><strong>Within-Subjects Effects</strong></td>
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<td>Lvtrn by anger</td>
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<td>7.09</td>
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<td>lvtrn by anger</td>
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</table>

Note. Clsx = client sex; subsx = subject sex; lvtrn = level of training.

An interaction effect was obtained between therapist level of training and anger. Results of the protected LSD suggest that the doctoral level therapists were less likely to perceive the angry clients as having externally generated difficulties, $t_{(64.00)} = 1.98$, $p < .05$. Examination of the group means in Table 9 reveals that the means are consistently lower for the doctoral level therapists in their ratings of the angry client, indicating that they are less likely to diagnose the angry clients high on this scale. A significant difference was not obtained between the masters and doctoral level subjects when comparing their ratings on the nonangry transcript, $t_{(63.00)} = .29$, ns. No other significant interaction effects were found.

Diagnostic Scale 2

This scale is comprised of 5 items all of which are DSM-III diagnoses. This scale can be distinguished from the Diagnostic scale 1 in the respect that the diagnoses
on this scale are thought to reflect a greater degree of internal as opposed to external pathology. This indicates that the source of the pathology is thought to be largely within the client. This scale contains diagnoses such as narcissistic or borderline personality disorder, which tend to be characterized by a defect in the client's psychological structure. These disorders are frequently long-term, pervasive, and chronic, as opposed to short-term and situational. Reliability for this scale was assessed at .74 for the angry condition, and .83 for the nonangry condition.

The descriptive statistics and analysis of variance results are presented in Tables 11 and 12. As can be seen in Table 12, a main effect for anger was noted, with the angry clients judged as more likely to have an internally-based form of psychopathology. $F(1, 56) = 109.58, p < .001$. This is reflected in the descriptive statistics presented in Table 11 which reveal that the means for the angry clients are much higher than those for the nonangry clients, indicating that they are more likely to be assigned a diagnosis on this scale. No main effects were found for client sex, therapist sex, or therapist level of training, which suggests that these are not factors which influence judgments of psychopathology. The null hypothesis which stated that no significant difference would be found between the angry male client and the angry
female client on type of psychopathology could not be rejected. The angry female client was not viewed as having a more internally-generated type of psychopathology when compared to the angry male client, $F (1, 56) = .73$, ns. No significant interaction effects were obtained.

Table 11
Descriptive Statistics for Diagnostic Scale 2 for Angry and Nonangry Vignettes

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<td>Female Client</td>
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Table 12
Results of Analysis of Variance on Diagnosis Scale 2

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<td><strong>Between-Subjects Effects</strong></td>
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<td>Within cells</td>
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<td>32.17</td>
<td>1.10</td>
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Table 12—Continued

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<th>Source of Variation</th>
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<th>MS</th>
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<th>P</th>
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</thead>
<tbody>
<tr>
<td>Subsx by clsx by lvtrn by anger</td>
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<td>11.66</td>
<td>.40</td>
<td>ns</td>
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</table>

Note. Clsx = client sex; subsx = subject sex; lvtrn = level of training.

Summary of Results

Based on the results of the study, none of the three null hypotheses could be rejected. The angry female client was not rated more negatively on competence and interpersonal functioning when compared with the angry male client, and was not judged to have more of an internally-based form of psychopathology when compared with the angry male client. Two main effects were obtained for client sex, with the female clients, regardless of anger versus nonanger, rated more positively on competence and interpersonal functioning. Three main effects were found for anger, with the angry clients rated as less competent, functioning less well interpersonally, and as having a greater degree of internally-based psychopathology when compared with the nonangry clients. The two main effects for client sex and client anger suggest that the nonangry female client may have been the most favored of all the clients. This is perhaps the greatest indication of possible bias obtained by results of the present study.
No main effects were found for therapist sex or therapist level of training.

Significant interaction effects were also obtained on two of the four dependent measures. On the Interpersonal Functioning scale, significant interactions were found for subject sex by anger, and subject level of training by anger. Investigation of these results indicated that the female therapists rated the angry clients as functioning less well interpersonally when compared to the ratings of the male therapists. In addition, the doctoral level therapists rated the nonangry clients as functioning better interpersonally when compared with the masters level therapists. On the Diagnostic scale 1, a significant interaction was found for level of training by anger. The doctoral level therapists perceived the angry clients as less likely to have an externally-generated form of psychopathology when compared with the masters level therapists.

No other significant interaction effects were found. A significant client sex by anger interaction on the four dependent measures would have been needed to reject the null hypotheses. However, this was not obtained in any of the cases.
CHAPTER V

DISCUSSION

The angry female client was not viewed more negatively than the angry male client in the areas of competence and interpersonal functioning, and was not judged as having more of an internally-generated type of psychopathology when compared with the angry male client. Thus the three null hypotheses could not be rejected.

It was found that the angry clients of both sexes were rated as less competent and as functioning less well interpersonally than the nonangry clients, and were also judged as having more of an internally-based type of psychopathology when compared to the nonangry clients (Tables 6, 8, 12). Female clients in both angry and nonangry conditions were rated as more competent and as functioning better interpersonally than the male clients in both treatment conditions (Tables 6, 8). On the Interpersonal Functioning scale, the female therapists perceived the angry clients more negatively than the male therapists, (Table 8). The doctoral level therapists rated the angry clients lower on the Diagnostic scale 1 than the master's level subjects (Table 10). This suggests that the doctoral level therapists judged the angry clients as less likely to have an externally-based form of psychopathology
when compared with the masters level therapists. It was also found that the doctoral level therapists rated the nonangry clients less negatively on the Interpersonal Functioning scale than did the masters level therapists (Table 8).

Overall the results of the present study generally support the position that sex bias does not exist among psychotherapists. The strongest evidence obtained of sex bias involved bias in favor of female clients. In addition, although the present study did not postulate that any differences would be found due to therapist sex, it is important to note that no differences were obtained between male and female therapists with regard to judgments made of female clients. This finding is especially important given that many researchers have attempted to implicate male therapists as promoting sex bias when treating female clients. The present study offers support for the idea that client sex, therapist sex, and therapist level of training are not influencing factors in therapists' judgments of angry female clients on competence, interpersonal functioning, and diagnostic impressions.

Theoretical Implications of Results

**Anger in Female Clients: Implications for the Proposed Hypotheses**

The results obtained raise questions concerning the
validity of the theoretical work upon which this study is based. The present study along with the only previous investigation in this area (Johnson, 1978) have both yielded negative findings. This is particularly important given that the two methodologies were diverse in significant respects. Had one of the studies obtained positive findings, this might reflect the fact that a particular method of investigation was more effective in examining stereotyping. The present study was also designed with the intention of correcting possible difficulties with the previous study. For example, the present study employed a method which ensured participating therapists anonymity, whereas this was thought to be a problem with Johnson's study, where the therapists may have been inhibited in providing genuine responses. The method in the present study which involved using written transcripts as opposed to videotapes, also enabled recruitment of a larger number of subjects ($n = 69$ versus with $n = 40$) when compared with the Johnson study. In addition, longer scripts were constructed for the present study in order to provide more material thus making it easier for the therapists to formulate judgments. Despite these differences the results are essentially the same, offering no support for the notion that therapists respond negatively to angry female clients when compared with angry male clients. Given this information, the theory upon which the present
study was based must be carefully reconsidered.

The theory behind the present study may have proved inadequate because it assumes sex-role stereotyping to be a widespread and general phenomena. Given the present findings, it may be that stereotypic responses to angry female clients by therapists are the exception rather than the rule. It is doubtful that stereotyping never occurs and there are very likely therapists who would respond negatively to angry female clients, however perhaps this is not the case with most therapists. Traditional psychoanalytic theory has been labeled a primary culprit in perpetuating negative and possibly harmful views of women (Murray, 1983). However, psychoanalytic theory has gradually come to be much less rigidly applied in practice, and some of the stereotypic views espoused by those who adhere to an orthodox stance in this area, would almost be anathema in many agencies and clinics. Thus some of the theoretical work in the area of stereotyping, may have drawn conclusions based on increasingly outdated modes of clinical practice.

Returning to the notion that some psychotherapists would likely respond negatively to angry female clients, it may be that certain personality characteristics in therapists lead to negative responses when confronted with anger in female clients. This might involve an examination of specific countertransference responses and
personality factors which may be responsible for them. This idea will be discussed in greater detail later in this chapter, however the important point rests with the fact that this area represents movement in a direction involving increased complexity. Examination of specific therapist personality variables in an attempt to account for stereotyping also implies that stereotyping is less widespread than what has been assumed in many previous studies, and including the present one. This is due to the fact that specific personality variables will almost certainly not be as pervasive as gender.

To summarize, it is the author's belief that the present results call into question the theory on which the study is based. The theory appears to fall short in its assumption that negative reactions to anger in female clients are commonplace as opposed to idiosyncratic. Of course, negative findings in two studies examining the same phenomena does not amount to absolute and conclusive support that the theory is flawed, however this author's opinion is that it is flawed in the respect that it is overgeneralized.

The Effects of Client Sex on Clinical Judgment

The finding that the angry female client was not rated more negatively on competence, interpersonal functioning, or degree of psychopathology when compared with
the angry male client contradicts the results of previous studies which found evidence of sex bias when females violated traditional standards of behavior (S. I. Abramowitz et al., 1975; Bowman, 1982; Gamsky & Farwell, 1966; Kelly et al., 1980; Lao et al., 1975). The present results, along with the findings of Johnson's study (1978), suggest that clinicians do not respond to female anger more negatively than they respond to male anger. In fact, female clients regardless of whether they were portrayed as angry versus nonangry were rated as more competent and as better functioning interpersonally than the male clients in the present study.

In reviewing the literature for effects of client sex, these results appear to be consistent with the findings of Fischer et al. (1976), where female clients were favored over male clients and judged to be more intelligent and emotionally mature. Lowinger and Dobie (1968) also found that psychiatric residents judged their female clients to be more likeable and rated them as having higher ego-strength when compared with their male clients. In yet another study, Libby (1976) found that therapists directed greater positive emotion toward female clients, although the implications of this are not clear. Lao et al. (1975) however, found that male clients were judged more intelligent than female clients, and were also rated as more likable. Kirshner (1978), upon finding that both

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female and male therapists preferred female clients over male clients postulated that perhaps women are more compliant and accommodating and therefore make better therapy clients.

Other researchers (S. I. Abramowitz, Abramowitz, Roback, Corney, & McKee, 1976; C. V. Abramowitz & Dokecki, 1977; Fabrikant, 1974), have reported findings which suggest that women are referred to individual therapy as opposed to group therapy when compared with men, and that women stay in treatment longer than men. This has raised fear and speculation that male clinicians may prolong treatment of women unnecessarily, as well as decline to give female clients options other than individual work. This interpretation of the data does not appear to be based on any information, and seems to be the most cynical of the plausible explanations. The present study does not lend support to the view that women are viewed as having difficulties which tend to run a chronic course and are therefore in need of more treatment when compared with male clients. In addition, the results do not support the view that male therapists treat women in a demeaning manner. The findings that the nonangry clients and the female clients were judged as more competent and better functioning interpersonally is perhaps the only possible indicator of bias obtained in the present study. This suggests that the nonangry female clients may be the most
favored group among psychotherapists. If this is the case, the question can be raised as to whether nonanger is reinforced for female clients as opposed to anger being responded to negatively. This is consistent with concerns raised (Bernardez, 1976; Kaplan, 1979) that therapists may fail in recognizing and challenging overly passive or compliant behavior in female clients. This however, is purely speculation. The present findings which suggest that female nonangry clients may be the most favored client group, cannot be interpreted as offering support for the idea that nonanger is therefore reinforced. The finding that female clients were favored and nonangry female clients were favored most of all, may be a reflection of bias in favor of female clients. In general, women are thought to display greater openness and receptivity when compared with men. Perhaps these qualities in a client allow therapists to have a greater impact, and this increases the desirability of females as psychotherapy clients. Although this can be construed as a negative phenomena resulting in the exploitation of women by therapists, it is not necessarily so, for it could indicate that women behave in ways which allow them to achieve maximum benefit from therapy, and therefore, they prove to be very satisfying clients for therapists.

The finding that the angry female clients were not judged as having a more internally-based form of
psychopathology when compared with the angry male clients
contradicts a rather consistent finding in the social
psychology literature that internal attributions are
usually used to explain the causes of behavior by women,
and external attributions are used to explain the causes
of behavior by men (Hansen & O'Leary, 1983). Previous
work has also indicated that behavior which represents a
departure from the norm, such as sex-role deviant be-
havior, tends to be assigned internal attributions, while
behavior consistent with role expectations is usually
assigned external attributions (Jones, Davis, & Gengen,
1961). Hansen and O'Leary note that the strongest per-
sonal attributions are made for women performing behavior
typically associated with men. Consistent with this, the
female clients in the present study, who were exhibiting
out-of-role behavior by expressing anger, should have been
assigned internal attributions in the form of being rated
higher on the more severe diagnoses when compared with the
angry male clients. However this was not found to be the
case.

Person Perception Literature

In attempting to make sense of the present findings,
it is important to take note of material which attempts to
explicate the factors which may influence judgments made
in various situations. There is some speculation (Lapp &
that stereotyping is more complex than what was originally thought, and that we cannot continue to formulate and test out sweeping generalizations such as "therapists respond to assertive female clients negatively." Locksley, Borgida, Brekke, and Hepburn (1980) state that judgments about a person are influenced more by behavioral information about the person rather than stereotypic beliefs. The clients portrayed in the present study appeared to be judged on the basis of both their behavior (anger versus nonanger) and gender. The Locksley study then goes on to state that stereotypic beliefs are used when there is minimal information about a situation and a judgment is required. Not all persons agree with this view however. Bodenhausen and Lichtenstein (1987) believe that stereotypes are used when a complex judgment needs to be made as a means of simplifying the situation. Following this hypothesis, information consistent with the stereotype is incorporated, while information inconsistent with the stereotype is disregarded or poorly integrated.

Given the above information, it is still difficult to account for the motivating factor behind the judgments made by subjects in the present study. Perhaps no evidence of stereotyping was found because there was a sufficient amount of information for subjects to respond to. However Johnson (1978) provided subjects with
significantly less information to respond to and still found no evidence of stereotyping. With regard to the work of Bodenhausen and Lichtenstein (1987), one could speculate that the personality judgments asked of the subjects were not complex, while the diagnostic judgments involved significant complexity. It would be interesting to assign one group of subjects to make the simpler judgments, and another to make only the complex diagnostic judgments. This cannot be examined in the present study where subjects were required to make both types of judgments because one set may have had an impact on the other.

Bodenhausen and Lichtenstein (1987) acknowledge that researchers have had almost no success in accounting for why stereotypic judgments have been prominent in some situations and minimal or nonexistent in others. Lapp and Pihl (1985) have moved toward a more complex model by investigating the impact of client and therapist sex-role orientation in addition to client and therapist sex. They had students serve as evaluators and observe videotaped therapy sessions with actors posing as clients. The actors were instructed to portray different "clients" having masculine, feminine, and androgynous characteristics. The sex-types of the student evaluations were determined as well. It was found that male evaluators viewed sex-role deviance more negatively than females, and the male sex-typed evaluators (of both sexes) rated the
sex-role deviant female client the most disturbed, with the masculine-typed male evaluators giving her the harshest rating of all. It was also found that the feminine typed clients (of both sexes) were rated as more disturbed by the feminine-typed evaluators (of both sexes).

The point of significance here has to do with the interactions of evaluator sex and sex-type in the judgments made about various clients. This may indicate that therapist sex alone and/or client sex alone is not enough to generate consistent results in the area of stereotyping. Based on the findings of Lapp and Pihl (1985), in the present study the angry female clients (masculine sex-typed) should have been rated more negatively by the male therapists when compared with the female therapists, and most negatively by a subgroup of male therapists holding traditional views (which was not determined). Yet, these results were not even closely approximated.

Examination of Countertransference

The research of Lapp and Pihl (1985) described above represents movement in the direction of examining certain personal characteristics of the therapist in an effort to understand how clinical judgments are made. Further along this path, it may be found that specific variables about a therapist are linked to particular countertransference reactions, thus yielding the information that therapists

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with a certain cluster of personality traits manifest a vulnerability to reacting negatively to client anger, hopelessness, or any number of variables.

To take several examples, it may be that insecure therapists or those manifesting narcissistic features are most likely to react negatively to client anger. Low self-esteem is another variable which may influence therapist's reactions to client anger. It may be that some therapists with self-esteem difficulties will tend to react defensively to client anger, while others may react with increased self-deprecation and despondency. In addition, the reactions of therapists with poor self-esteem or narcissistic features may be further influenced by client or therapist gender. Davidson (1983), in discussing research on countertransference, stresses that information about a therapist's personal history as well as current dynamics may be important indicators of how he or she reacts to particular clients.

Examination of therapist countertransference responses may eventually prove to be the key in providing an explanation for the mixed results obtained in studies investigating sex-role stereotyping. The body of theoretical material on women and anger, which stresses the point that anger in women is responded to negatively, is likely not entirely erroneous. These observations are apt to be based on something, however the crucial variable
does not appear to be client sex operating alone, nor for that matter, therapist sex. The hypothesis with the most potential is that which accounts for specific personal variables manifested in the therapist which may or may not interact with client sex. The major difference between this view and the popular view that therapists stereotype based on client sex, has to do with the fact that the countertransference paradigm does not assume that many or most female clients expressing anger will be responded to negatively. Rather the countertransference model assumes this to be a less frequent occurrence due to the fact that idiosyncratic features of the therapist are viewed as responsible for the negative reactions to anger in female clients.

The Effects of Client Anger on Clinical Judgment

A very significant finding in the present study has to do with the fact that the angry clients of both sexes were viewed more negatively than the nonangry clients of both sexes. This was especially surprising when taking into consideration that the transcript was constructed to portray the therapist as somewhat responsible for triggering the client's anger. In fact, one of the early subjects, a female doctoral level therapist, indicated to the experimenter that the therapist was a "real jerk." This elicited some concern that the therapist's
mishandling of the situation was overdone. Given the results, this was most likely not the case. Several researchers (Fremont & Anderson, 1986), found that therapists seemed to have an unspoken set of rules, one of which is that clients should appreciate the therapist's efforts to help, and should not respond to the therapist with anger or hostility. Based on the results of this study, this finding could be extended to include conditions when the therapist induces the client to respond angrily, even though this may be entirely unintentional.

The results of the present study are consistent with the findings of previous studies which have examined therapist's responses to anger in clients. These studies were not designed however, with a specific interest in client sex as a variable. In fact, a number of them employed only male clients (Bohn, 1967; Heller, Myers, & Kline, 1963; Parsons & Parker, 1968). Haccoun and Laviguer (1979) used a combination of students and experienced therapists as subjects and had coached actors pose as clients. The clients displayed either angry or sad feelings in describing a problem, and it did not appear as though the anger was directed at the therapist. The therapists completed formal evaluations on the clients after 15 minutes, and written transcripts of the mini-sessions were given to undergraduates for the purpose of examining the therapist's behavior. It was found that the
therapists judged the angry clients to be less likeable, less easy to get along with, as having more severe difficulties, and as having less self-control than the sad clients. A somewhat different methodology was used by Bohn (1967) in examining how counselors in training react to hostility and dependency in clients. Portions of fictitious and actual therapy sessions were simulated and audiotaped for subjects. At points of silence during the tapes subjects were asked to respond to the client by selecting a response out of a multiple choice list of responses. Although Bohn was looking primarily at degree of therapist directiveness with various types of clients, he also found that client anger had a significant impact on the therapist's reactions and performance. Bohn failed to elaborate on exactly what occurred with the therapists, but he did convey that the impact was negative.

In an attempt to obtain information about therapist's responses and attitudes directly from clients, Sesan (1988) surveyed female clients and found that a significant number of women felt that their therapists had difficulty accepting their feelings of anger. Unfortunately, Sesan only surveyed female clients so there is no way of knowing if anger in male clients would have been responded to differently by the therapists.

In yet another study investigating client anger, Heller et al. (1963) used 34 counselors in training as
subjects and found that hostility on the part of the client evoked feelings of hostility in the counselor. Similar findings were obtained by Parsons and Parker (1968) using fictitious audiotaped interviews of a "normal," "dependent," and "hostile" client. The researchers found that the therapists were more accepting and less anxious with the "dependent" client as compared with the "hostile" client. In a study using untrained students as subjects, Haccoun, Allen, and Fader (1976) found that angry clients, when compared with sad or neutral clients were rated as the least likeable and least easy to get along with. These researchers used audiotaped sessions with the therapist's responses deleted, and asked the subjects to select responses from a list of responses. The responses that the female subjects indicated they would give to the clients, were more receptive and nurturing than the responses given by the male subjects regardless of type of client. The female subjects also indicated more liking for the clients than the male subjects did.

Based on the above studies, it appears as though client anger directed at the therapist as well as anger directed toward an uninvolved third party results in negative judgments or a negative response on the part of the therapist. In the studies by Parsons and Parker (1968) and Haccoun and Lavigueur (1979), the clients were
simply stating a problem in a particular manner (angry, sad, neutral) with the anger not directed at the therapist. In the remaining studies (Bohn, 1967; Haccoun, Allen, & Fader, 1976; Heller et al., 1963) at least some of the anger was directed at the therapist. Despite this major difference in method, the results are similar. That client anger directed at the therapist elicits a negative response is not surprising. More surprising, is the finding that anger directed toward a third party is viewed negatively.

A possible explanation for the consistent finding that anger in clients results in negative clinical judgments, may have to do with the fact that anger is a prominent characteristic of certain types of psychopathology, such as borderline or narcissistic personality disorders. One could hypothesize that therapists are responding on this basis, particularly if other information about the client is minimal or lacking and a clinical judgment needs to be made. In the present study, the transcript was constructed to include information aside from the anger episode to avoid this pitfall. It is possible however, that when compared with a full therapy hour, the information gleaned from the transcripts was limited. In addition, it is also conceivable that therapists are sensitized to using client anger diagnostically.

Fremont and Anderson (1986) state that a negative
response to client anger on the part of the therapist is inappropriate if the therapist fails to view the client's anger as part of their pathology. The view held by the present author, is that it is clearly not inappropriate to react internally to any client behavior (Winnicott, 1958). It may be inappropriate to respond behaviorally to client anger, particularly if the response is impulsive, defensive, and not intended to be therapeutic. The questions remains of whether the client anger in the present study evoked images of work with borderline or narcissistic clients, or whether the diagnoses given were an attempt to retaliate for the verbal attack upon the therapist.

Concerning the latter possibility, several researchers (Parsons & Parker, 1968) determined that favorable personal attitudes on the part of the therapist concur with favorable clinical judgments. This raises the question of whether therapists are able to adequately separate personal bias about a client from professional appraisals.

In interpreting the present results on the effects of client anger, it should be noted that the angry and nonangry transcripts used in the present study were not identical. The transcripts portrayed entirely different clients. The nonangry transcript depicted a client coping with the stress of parenting a handicapped child, while the angry transcript portrayed a marital difficulty. In addition, in the angry transcript the client and therapist
end up dealing with a therapy process issue (the anger episode), while this does not occur in the nonangry transcript. This is to caution the reader that several other differences existed between the two treatment conditions other than just the angry versus nonangry client.

**Effects of Sex of Therapist**

The present study did not hypothesize that any differences would be found as a result of therapist sex, although some of the theoretical work on women and anger seems to imply that males respond more negatively to angry women than women themselves do. Although this was an unanticipated finding, it is consistent with the theoretical work on women and anger which suggests that women are not practiced at dealing with anger and therefore may be uncomfortable with it (Westkott, 1986). Johnson (1978) obtained results which were similar in certain respects. She found that female therapists were most uncomfortable with the angry male client and felt the most angry and defensive toward him when compared with the other clients. Interestingly, Johnson also found that the female therapists rated themselves as very empathic even with clients toward whom they felt very negatively. The female therapists were also rated by observers as angrier than the male therapists with all of the clients. In addition, Johnson found that the female therapists rated themselves
as identifying least with the angry male client. This could represent a reaction formation, whereby the female therapists unconsciously identified with the anger and were attempting to deny it. This is consistent with the information that the anger was evident to observers, yet not recognized by the therapists.

Haccoun, Allen, and Fader (1976) had untrained students listen to tape-recorded therapy sessions of angry, sad, and neutral clients and select responses off a list of responses at various points. The female subjects indicated they would use more receptive and nurturing responses than the males, and the females also rated themselves as liking the clients more than the male subjects. Because this study has subjects select responses from a list of responses as opposed to actually giving them, it is possible the female subjects chose responses consistent with how they felt they should react as opposed to how they actually felt.

Thus the present study offers some support for the idea that female therapists may have a more difficult time than their male counterparts in dealing with client anger. The other studies cited (Haccoun et al., 1976; Johnson, 1978), raise the issue of whether female therapists may deny having angry feelings in response to client anger. It may be that female therapists deny their dislike for certain client behaviors because they believe they are
supposed to feel strictly warmth and empathy. In Johnson's study, the female therapists may have believed they felt a certain way (e.g. empathic) while observers detected otherwise.

Other studies investigating the role of sex of therapist have yielded mixed feelings. Several questionnaire studies investigating attitudes toward women (Aslin, 1977; Delk & Ryan, 1977; Maslin & Davis, 1975) found that only male therapists stereotyped. Of the analogue studies, a number have reported bias against women by both male and female therapists (Bowman, 1982; Broverman et al., 1970; Gamsky & Farwell, 1966; Thomas & Stewart, 1971), while others have reported no bias from therapists of either sex (Libby, 1976; Johnson, 1978; Stengel, 1976). Sesan's (1988) study utilizing a survey also found no effect for therapist gender. Although some social psychologists believe that most stereotypes are held by both sexes (Deaux, 1976), the research continues to turn up confusing and contradictory results. The present study lends support to the view that neither male nor female therapists demonstrated stereotype bias against angry female clients. This was evident in the fact that the angry female client was not rated more negatively than the angry male client, and also in the finding that female clients regardless of anger versus nonanger were not rated more negatively than the male clients. In fact, just the
reverse was true, with female clients rated as more competent and as better functioning interpersonally.

**Personalism**

Personalism may be defined as the actor's intention to harm or benefit the perceiver (Jones & Davis, 1965). Some studies require the subject to intervene with the client directly or at least on a one-to-one basis in some form. This includes research where bogus clients are sent to interact with therapists, or where therapy sessions are taped with the therapist's responses deleted, and subjects are asked to provide a response to the client. These studies can be differentiated from those where the subject is essentially a third party and is asked to observe or critique a live, taped, or transcripted therapy session. The present study falls into the latter category. The subjects were asked to read a transcript of a therapy session and evaluate the client, yet the subjects did not actually serve as therapists. The question to be posed, is whether or not direct involvement of the subject makes a difference in the results obtained. It may be easier for a therapist to be objective when he or she is not directly involved with the client, and therefore the client's intent (in becoming angry) is not that of harming the perceiver (therapist).

In reviewing the literature, it appears as though
studies using both methods have obtained a mixture of results. Parsons and Parker (1968) obtained positive results by having subjects observe hostile and dependent clients on videotape and then choose responses. However, the subjects selected responses from a list of possible responses, thus they did not have to actually provide a verbal response. This format would seem to allow more time for processing and censorship, yet the results were significant in the hypothesized direction. Thomas and Stewart (1971) also obtained significant results in the hypothesized direction, having counselors make judgments about clients on the basis of a tape-recorded interview which did not directly involve the subjects. Other studies using methods which required direct interaction on the part of the therapist have reported both positive results (Bohn, 1967; Gamsky & Farwell, 1966; Haccoun, Allen, & Fader, 1967; Haccoun & Lavigneuer, 1979; Heller, Myers, & Kline, 1963) and negative results (Johnson, 1978; Libby, 1976; Stengel, 1976).

The degree of direct involvement on the part of the subjects is another factor which could be accounted for. Some research has therapists directly interacting with bogus clients posing as real clients, with the client seen in the therapist's office. Other studies have videotaped or audiotaped actors posing as clients with the therapist's responses deleted, and presented the tapes to
subjects in either an individual or group format. If personalism is a influencing factor, results could be expected to vary based on the degree of direct involvement in addition to direct versus nondirect subject involvement. Several groups of researchers (Gamsky & Farwell, 1966; Haccoun & Lavigueur, 1979; Heller, Myers, & Kline, 1963) employed actors to pose as clients and directly receive therapy from the subjects. This method heavily involves personalism, where the client's intent is to directly harm the therapist. Results of both studies were significant in the hypothesized direction. Other researchers (Bohn, 1967; Haccoun et al., 1976; Parsons & Parker, 1968) employed methods where subjects were still involved directly and not as a third party, but the degree of direct involvement was reduced by presenting the clients on video- or audiotape. These studies also reported positive findings in the hypothesized direction.

Additional complication arises when examining the studies which investigated how therapists respond to certain emotions in clients, in that some of the studies had the clients express anger or hostility at the therapist, while others had the clients talk about a particular problem in an angry, sad, or depressed manner. Gamsky and Farwell (1966) attempted both manipulation and found that therapists reacted more negatively when the hostility was directed toward them as opposed to at a third party.
Other researchers (Parsons & Parker, 1968) had the clients express anger both at the therapist and at others in the same vignette, thus making it impossible to ascertain differential effects. Haccoun and Lavigueur (1979) found that angry clients were judged less favorably using a method where the therapists were working directly with the client and providing judgments after the session, however the anger was not directed toward the therapists.

One could speculate that the more directly the therapist is involved with the client, the greater the impact will be, however a review of the above studies does not seem to clearly support this. In addition, it could be expected that anger directed at the therapist would produce a more dramatic response, yet there is not clear support for this position either.

The present study included a mix of factors which could have been expected to both enhance and diminish feelings of personal involvement. Factors expected to enhance feelings of personal involvement included the utilization of a written transcript as opposed to a written case summary, and the fact that the client's anger was expressed directly at the therapist in the script as opposed to a third party. Factors which could be viewed as detracting from feelings of personal involvement included the design which did not call for the subjects to serve directly as therapists, and the fact that a written
transcript was used as opposed to actual clients or even videotaped clients.

The present study obtained some highly significant results, which suggests that the subjects were responding strongly to the material in the format in which it was presented. One possibility in explaining the fact that significant findings have been achieved by a variety of methods, has to do with the degree to which the subjects can identify with the role they are expected to take. It may be that if subjects, who are practicing therapists, are asked to play that role in a given situation, the artificiality of the situation will not be a particularly important factor. The degree to which the subjects are able to identify with the role may be a factor which influences the intensity of emotional involvement in the situation.

Although having subjects directly involved with clients may produce the greater emotional impact on subjects, there is also an advantage in having subjects observe a client-therapist interaction from a third party perspective. When this occurs, the subjects are able to assess the manner in which the client responds to the therapist's attempts at dealing with the client's anger. Judgments of a client may differ depending on the client's ability to effectively process what is happening with the therapist. This author would speculate that the degree to
which effective processing of the interaction ameliorates the anger reflects the degree of psychopathology present in the client. That is, the more disturbed the client, the greater the difficulty he or she will have in listening to and considering the therapist's attempts to resolve the conflict.

Taking the above into account, the optimal research situation with respect to the influence of personalism, may be to have clients interact directly with therapists, and to also employ therapists as observers of the interactions. Feedback could be gathered from both involved and observing therapists and examined for discrepancies. This is only speculation however. Based on a review of the literature in this area, the degree to which personalism has influenced findings is still unclear and seems to require further investigation.

Practical Implications of Findings and Directions for Future Research

One important question which remains has to do with the relation of the present findings to psychotherapy practice. The present findings do not support the claim that therapists respond more negatively to anger in female clients than in male clients. In fact, the only bias obtained was bias in favor of female clients. Additionally no evidence was found of bias against female clients or angry female clients on the part of male clinicians.
This may indicate that efforts to sensitize therapists to women's concerns have possibly been effective. Regardless of how aware or unaware therapists are of particular issues which apply to women in therapy, the present results support the conception that therapists do not use stereotypic notions in providing judgments of their female clients.

Given this, what then does account for irrational, insensitive, or biased responses on the part of clinicians? As mentioned previously, these may be countertransference reactions stemming from personal conflicts and areas of difficulty in individual therapists as opposed to broad-based stereotyping. A number of possibilities for future research may be developed out of this area. Davidson (1983) provides some concrete suggestions for beginning to study countertransference phenomena. She suggests that personal information about therapists could be gained from colleagues, or professors if students are to serve as subjects, and this would be examined along with the therapist's reactions to client behaviors. She goes on to propose that researchers could study the ways in which therapists deal with fear or anxiety in sessions, and if therapist sex influences the way in which certain issues are managed. There are numerous possibilities for future work in this area, and again, the point to be emphasized is that future research will need to reflect an
increasing degree of complexity, taking into account variables other than client and therapist gender.

**Responses to Client Anger**

The one unequivocal finding, that therapists tend to judge angry clients negatively, seems very relevant to clinical practice. In examining the impact which client anger has on the therapist, Fremont and Anderson (1986) found that verbal attacks directed at the therapist produced feelings of anger in the therapist. This raises the issue of how therapists might deal with feelings of anger aroused by clients. Fremont and Anderson believe that angry feelings aroused in the therapist may be useful in the course of therapy if the therapist is able to work through enough of the hostility to use it productively and in a nonpunitive manner. In fact, this is the essence of what is taught in many psychodynamically oriented training programs, which stress that the therapist should use his or her reactions to the client as a guide in doing therapeutic work.

The results of the present study however, only suggest that anger expressed by clients is met with negative personality judgments. How the therapists would respond behaviorally to the client cannot be determined. There is some evidence that therapists intervene less with angry clients and provide less support (Haccoun & Lavigueur,
Yet, there is also support for the idea that this is influenced by training. Parsons and Parker (1968) found that while therapist's personal feelings about clients are not affected by training, their behavioral responses do seem to be affected by training. They found that more experienced therapists were less controlling and verbally assertive with angry clients when compared with less experienced therapists. Bohn (1967) also found that even a minimal amount of training resulted in greater tolerance of hostility in clients.

So it seems as though experience may enable clinicians to deal more effectively with client anger. Additional training and/or experience may teach therapists the process of examining their emotional reactions before responding. The results of the present study are not consistent with the above findings with regard to the influence of training. If a greater amount of formal training increases clinicians' tolerance of client anger, the doctoral level therapists in the present study should have rated the angry clients less negatively; however this was not the case. It was found that the doctoral level subjects rated the angry clients lower on the diagnostic scale with the more externally-generated forms of psychopathology when compared with the masters level subjects. At first glance, this might appear to suggest that master's level therapists are more comfortable in assigning
the less severe diagnoses, possibly due to less formal training in psychopathology. However if this were clearly the case, differences would have also been obtained between the two groups on the diagnostic scale with the more internally-based and chronic disorders, with the master's therapists indicating more hesitancy in assigning these diagnoses. Because this was not the case, it is difficult to establish why these particular findings were obtained. The point of importance concerning the present findings however, rests with the fact that they were not consistent with previous findings which indicated that training may result in greater tolerance of client anger.

The judgments made by therapists about angry clients in the present study may also suggest that therapists, like other persons, are vulnerable to assaults on their self-esteem and respond negatively to this. Although therapists attempt to avoid allowing negative feelings about a client get in the way of developing a working relationship and working productively, perhaps this is more difficult to carry through than what has been realized.

Limitations of Present Study

One limitation of the present study, has to do with the fact that it provides little information on how therapists might respond behaviorally to clients expressing
anger. It would appear that therapist's behavior must in some way be connected to their appraisal of the situation, yet this cannot be stated with certainty. There is some support (Bohn, 1967; Parsons & Parker, 1968) for the idea that therapists' responses don't always coincide with their feelings, although one can imagine certain situations in which they may. Future research might also address the degree to which therapists' thoughts and feelings influence their work with clients, and the behavioral manifestations of certain thoughts and feelings.

The present study also takes into account the influence of level of training. Yet this is not to be confused with level of experience. A second limitation arises in attempting to determine the effects which could be expected when taking into account both of these variables. A therapist might have a masters degree along with 30 years of work experience. Or, a therapist might hold a doctoral degree with one year of work experience. In the present study, only level of training was examined, not degree of experience, and both of these could conceivably make a difference. Nearly all studies in this area, only attempt to evaluate the effect of training or experience and not both, yet both are present in many subject pools. One method of circumventing this difficulty would be to select subjects all having the same degree, such as M.S.W., yet who vary in level of experience. For a number
of researchers however, this might result in an inability to collect a sufficient number of subjects and this needs to be considered as well.
APPENDICES
Appendix A

Description of Pilot Study
PILOT STUDY

Method

Subjects

A pilot study was conducted with 47 beginning master's and doctoral level graduate students in counselor education and counseling psychology. The purpose of the pilot study was to develop the dependent measures to be used in the actual study. Each subject was randomly assigned to read a fictitious therapy transcript of either an angry male client or an angry female client, and then asked to rate the client on two questionnaires.

Materials

Therapy Transcripts

The therapy transcript which was created portrays the first portion of a therapy session. There were two versions of this script, the only difference being that of client sex. The script is two and one-half pages in length and depicts a male/female client who gradually becomes angry at the therapist and verbalizes this anger. An experimental manipulation check was included in order to assess whether the script would generate attributions regarding responsibility of the anger episode to both the
client and therapist. The subjects were asked to rate both the client and therapist on a scale from 1-10 in assessing the degree of responsibility for the direction of the session (1 indicating low responsibility and 10 indicating high responsibility). This was done in order to avoid use of a script which portrayed one party as clearly more responsible for the anger episode than the other. A correlation scatter plot was used to examine this data.

Questionnaires

The questionnaires employed were constructed on the basis of the existing theoretical and empirical literature. It was hypothesized that anger in female clients would be met with negative personality judgments and that these clients would also be assigned diagnoses reflecting a greater degree of internally-generated psychopathology. Thus the questionnaires were developed for the purpose of measuring personality judgments and diagnostic impressions. One questionnaire was labeled a Personality Questionnaire and contained 32 items, and the other was labeled a Diagnostic Impressions Questionnaire, and contained 11 items. The questionnaires were factor analyzed for the pilot study, and the results of these analyses are discussed below.
Results

Factor analysis yielded two primary factors for each of the questionnaires. On the Personality Questionnaire two scales were formulated out of the two factors obtained. These have been labeled the Competence scale and Interpersonal Functioning scale. Results of this factor analysis are presented in Table 1 located in Chapter 3. Six items which had approximately equal loadings on both factors were eliminated. Reliability for the Interpersonal Functioning scale was assessed at .8491 using Cronbach's alpha. Reliability for the Competence scale was assessed at .9295 using Cronbach's alpha.

On the Diagnostic Questionnaire two scales were also formulated out of the factors obtained. These were labeled the Diagnostic Scale-1 and Diagnostic Scale-2. Reliabilities for these scales using Cronbach's alpha were assessed at .7126 and .7035 respectively. Scale 1 contained primarily disorders which tend to place the source of the client's difficulty in the environment to at least some degree, such as marital problem and adjustment reaction. Scale 2 contained primarily the personality disorders, which tend to place the source of the client's difficulty inside the client. Thus it was anticipated that the scales could perhaps be distinguished on the basis of whether the source of the pathology is primarily internal or external. However, because these scales also
contained several items which were difficult to place on either factor conceptually, it was decided that this factor analysis would be repeated for the actual study. The meanings which were eventually derived from both factors are discussed in full in Chapter 3. For the factor analyses on both questionnaire a Quartimax rotation was used with 2 factors specified. Additionally, analysis of variance revealed no significant effects with regard to the order in which the Personality and Diagnostic Impressions questionnaires were administered. On the experimental manipulation check, a correlation scatter plot revealed that the subjects' responses were widely distributed, thus indicating that the subjects did not consistently view one party as having greater responsibility for the evolution of the anger episode.

Summary of Pilot Study Findings

Based on the findings of the pilot study, it was determined that the fictitious therapy transcript which was created had proved sufficient and would be appropriate for used in the actual study. In addition, the two scales which were derived from factor analysis of the Personality Questionnaire were determined to be reliable and appropriate for use in the actual study. Six items loading equally on both factors were eliminated from this questionnaire based on the findings of the pilot study.
On the Diagnostic Impressions Questionnaire, the items conceptually break down into two scales, one containing the personality and more severe disorders, and the other containing the less severe Axis I, adjustment, and phase of life disorders. With the exception of one item on each scale, factor analysis did support this dichotomy, however it was decided that the factor analysis would be repeated for the actual study. In addition, it was determined after the pilot study that two nonangry control groups would be added in order to ensure that any obtained effects could, in fact, be attributed to anger as opposed to client sex. This necessitated the development of a nonangry transcript which would be used in the main study.
Appendix B

Therapy Transcripts
Instructions for Subjects

Instructions

You are about to participate in a study conducted by Counseling Psychology doctoral student, Lisa Morshhead. Participation in this study is voluntary, and you may withdraw your consent to participate at any time. This packet of materials contains two written transcripts of portions of two separate therapy sessions with all identifying information eliminated. There are also four questionnaires enclosed. You will read the first transcript and then rate the client on the two questionnaires which follow. Then you will read the second transcript and rate this client on the two questionnaires which follow. In responding to the questionnaires, you are to imagine yourself as the therapist. In addition, it is asked that you not discuss this material with any other persons in your clinic or agency until all persons have completed and turned in their materials. The material is stapled together and it is asked that you complete the material in the order in which it is presented. Once you have read a transcript, it is also asked that you not refer back to it while you are responding to the questionnaires, thus you must read it through carefully the first time. The purpose of the study, is that of constructing several clinical judgement questionnaires.

Please answer the following information about you the rater: (circle responses)

Highest Graduate Degree: M.A. M.S.W. E.D.D. Ph.D.

Sex: Female Male

Age: _______
Therapy Transcript for Angry Treatment Condition

The following is a written transcript of the first portion of a therapy session. The client is a 32 year old female and has been in therapy for a total of 10 sessions. Ms. "Janet Jones" is employed as a physical therapist and has been married for 7 years with one son aged 4.

Janet: Well... it's been an... interesting week (laughs; pause 5 seconds)

TH: What's been going on?

Janet: Interesting is not the right word . . . rotten is more like it...just...things aren't too good at home at the moment (pause 5 seconds) well... last Saturday we were supposed to go out with the other couple from work we sometimes get together with, and John (client's husband) is...we're getting ready to go out and, we have to pick up the other couple, and he's talking on the phone to someone ...I don't know who but it's obviously business. And I motioned to him that it was time to go...and he gives me an extremely irritated look, so I back off and leave the room. Well about 20 minutes goes by and by this time we're clearly late for picking the other couple up and I'm angry as all heck...and finally he gets off the phone and apologizes saying it was very important...so I asked him what it was about and he said that he and one of his... um... people he works with from the company are thinking about doing some consultation work in Austin, Texas.

TH: Oh.

Janet: He said that they got a really great offer and it would be a good deal of money. So... I assumed that this just came up...but as we got to talking about it, it came out that they got the offer 3 weeks ago, and that the job involves him being in Austin from time to time over the next 8 months...at least. And I was just plain knocked over by this...I mean...this is the absolute...worst example of what I've been talking about for the past 3 months...that I feel shut out...like I'm not a part of his life...I just totally don't matter.

TH: Yea, you feel as though you deserve some input.
Janet: Not only that but...I mean if it was me, and something big came along like that I would not just check it out with him, but I would be excited to tell him about it...but with me...nothing. And then he can't understand why I'm mad and hurt and he thinks I'm being unreasonable and making a big deal out of nothing. So here I am...screwed over again, like always. Now what do I do?

TH: How are you feeling now about you and John?

Janet: If I loved someone... I would not do to them what he does to me...If I loved someone I would want them to know plain and clear...and one of the ways of doing that would be to involve them in my major decisions. I mean...I left that night because I couldn't take it anymore...I feel so alone.

TH: Now we've talked before about John as having some difficulty in communicating with you and with distancing himself in the relationship...but your basic assumption seems to be that this indicates that he does not love you anymore...now that's an awful big leap to take. And I'm not saying that his actions don't hurt you or make you angry, but do they indicate that he no longer loves you?... Could they stem from problems John may have, which are independent of and...and maybe have preceded the relationship between the two of you?

Janet: (pause 5 seconds) I don't know...all I know is that I'm sick of feeling this way...sick of being dumped on, and it's not getting any better...in fact it's getting worse.

TH: But let's look at whether or not other people really have that intent...that is, that they just see you as someone they can dump all over...or is that an inaccurate perception of yours?

Janet: I don't care (emphasized) whether or not they mean to do it...all I know is how I feel about it (pause 5 seconds) I'm getting more confused about all of this.

TH: All of what?

Janet: These problems in my life... and coming to therapy for them. I feel like you think there's something wrong with me...you know...because of all these questions you ask like "have I thought of this" or "have I thought of that"...like it's always my problem because I don't see something a certain way. And I guess I'm supposed to figure all this out, only it's not happening...and I think I feel worse than when I started...things are jumbled and...
confused...and you make me feel like the "sick" one you
know?...Like I'm the one with something wrong with me
because I don't like being ignored and shut out by other
people.

TH: Ok, you're feeling like I'm not understanding you,
and all the external things in your life maybe that impact
upon how you feel and act. (pause) Does it seem to you
as though you think most people don't understand how you
feel?

Janet: We've talked about me thinking that about other
people. (sounding irritated) It seems like we've talked
about the same things a million times and don't get any­
where with them...except I get more confused, like what
purpose is there to this? I'm here 'cause I thought maybe
you could help me straighten things out because I just
don't know...I just plain don't know anymore, and...and
its like everyday it gets worse... and if you can't do
better than this I'd like to know right now, 'cause I
don't see any point in wasting more of my time. I guess
I'm supposed to be getting some great insight into all my
problems so I can go take care of things but it sure as
heck isn't happening... and any ways, I hate (emphasized)
it when you make me feel like I'm the one with all the
problems...well I'll tell you what. You can live my life
for a week and then sit there and insinuate that all these
things are wrong with me.

TH: Things aren't coming together for you and...

Janet: (interrupting) You're damn right things aren't...
and I've come here all this time and I'm more confused
than ever about everything and you don't seem too bothered
by it, and you act like you care and you understand, but
let me tell you that you don't. How come I feel worse now
than I did 3 months ago? I can't figure any of this out
and you just plain couldn't care less. You keep on like
always...ignoring how I'm doing...that's how I feel.

TH: This sounds like it has been building up in you for a
while Janet, and you've forced yourself to live with these
feelings? I wonder why it had to wait so long?

Janet: Because you don't understand me... everything that
seems to happen to me you see as being my fault and my
responsibility...and if I wasn't having "inaccurate per­
ceptions" my whole life would be wonderful.. Well I think
you're wrong and I feel worse now then when I started, and
everything's just one big mess.
Therapy Transcript for Nonangry Treatment Condition

The following is a written transcript of the first portion of a therapy session. The client is a 37 year-old male and has been seen in therapy for a total of 6 sessions. Mr. "Mark Smith" is employed as a high school science teacher and has been married for 12 years. The client and his wife have an 8 year old son who is severely mentally and physically impaired, and an 11 year-old daughter.

Mark: Well...we are totally exhausted (grins, slumps down in chair to make point). It has just been a totally hectic week. On Tuesday we drove "Frank" (their son) all the way to University Hospital for one of his doctor's appointments...and were there about 7 hours altogether, after we got done with his lab work, then the appointment, x-rays, then billing...we still don't have things straightened out with our insurance company yet. (pause 10 seconds). I also talked with "Susan" (wife) about me not doing summer school this year...it would be somewhat of a loss financially, but then again if I taught we'd end up having to pay a sitter for that time anyway.

TH: Where are you at with the options we talked about last week concerning Frank?

Mark: Well...good question...um...I did some searching in the newspaper for qualified caretakers...and told Susan I thought maybe we should put an ad in the paper...which doesn't commit us to anything you know...if we didn't like anyone we saw we could just forget it...or try again, or something. But...and this is another problem...I'm beginning to think that Susan is not going to commit to anything...or even try anything. When I brought up the idea of the ad she became evasive and told me to wait...when we had already decided that Frank's care is too much for us to handle alone...she's the one who was practically having a nervous breakdown over this 3 weeks ago... and now I'm supposed to wait? For what? I mean this is not exactly easy for me either.

TH: Um hm.

Mark: So I tried to get her to see that getting a full-time caretaker in the home for Frank is probably our best bet...even though I'm not sure how long we'll be able to afford it...but I can stay home with him this summer which should help out some. And then she says that she doesn't
like the idea of a stranger coming into our home and taking care of our son while we're not there...that we'd have no way of knowing if he was being neglected or abused because he, of course, can't communicate these things to us.

TH: Well, I assume you would ask for references and do some careful screening.

Mark: Right...and that's exactly what I told her. And then this fight erupted and somehow I came out looking like the bad guy because I wanted to "pan our son out to strangers" is how she put it. So now we're back to square one...which is the very situation we couldn't tolerate in the first place. I wasn't, after this, going to bring up the idea of possibly institutionalizing him...she would have...threatened to divorce me probably. But anyway, I think I have to admit that I don't want to institutionalize him...at least at this point. If things continue to get worse it might be something we'll have to look at in the future...but not for now.

TH: I know that the past couple weeks we've talked a lot about your various options with regard to Frank...but...we haven't talked about the how this is affecting you and Susan...this situation would be bound to put strain on any marriage.

Mark: Yea...well it is. You know...now that I think about it...there's been virtually no communication between Susan and I, for about the past two months, that hasn't centered on Frank. And then "Sarah" (their daughter) gets practically ignored most of the time...which we feel terrible about. Every time we try to do something for her...like going to her tennis league, or even to a movie...something always comes up with Frank. I mean...how far does this go?...or should it go before we say "enough"? How far does it go before we have to decide that the rights of this one person can't outweigh the rights of the entire rest of the family? I just don't know.

TH: Yes, that's an awful kind of decision to have to make Mark...and maybe it will never seem totally "right" to you. There's bound to be some anguish that you'll need to work through no matter what.

Mark: It would be so much easier if we thought there'd be hope that his condition would improve....or be amenable to treatment. But instead the medical procedures become more complex, frequent, expensive... and simply exhausting. And as each year goes by it gets worse because as Frank
gets older it becomes harder and harder for us to manage him. He needs to be taken care of like an infant yet he's 8 years old...and I don't know what in the world we'll do with him when he's 16...I mean...It's going to get to the point where he'll need two people home at all times to handle him, and do the lifting and carrying...and...then what do we do? Susan is having trouble even now moving him around by herself, I don't know what she thinks is going to happen in 5 or 6 years.

TH: Sounds like it's her denial of the problem that's creating some of the strain you're feeling now.

Mark: Yes...and, you know it's hard for me also...to look at the possibility of institutionalization sometime in the future, but I think we need to get ourselves prepared for it...because it's going to come you know...and it'll be worse to just wake up one morning and all of a sudden realize we're in a desperate situation which we can't handle. And I guess the worse thing right now, is my being label as "the bad guy" because I am looking at this and thinking ahead and am talking about possible institutionalization.

TH: That's hurtful.

Mark: Yes... because my caring about this situation is being construed as "selfish"...and it hurts me to think that they are starting to see me that way.
Appendix C

Scales Comprising Questionnaires and Questionnaires
Competence Scale

1) exaggerates and over-dramatizes
   / / / / / / / appropriately reactive to stimuli
2) works in a cautious and deliberate manner
   / / / / / / / works in a rash and impulsive manner
3) has an analytical mind and capacity to benefit from insight-oriented therapy
   / / / / / / / has little insight and minimal capacity to understand self and world
4) immature
   / / / / / / / mature
5) dependent
   / / / / / / / independent
6) actively involved in structuring own life experiences
   / / / / / / / passive and unable to exert control over life
7) would progress well in therapy
   / / / / / / / would not progress well in therapy
8) could not tolerate interpretations and confrontations in therapy
   / / / / / / / could tolerate interpretations and confrontations in therapy
9) clear-thinking
   / / / / / / / confused
10) tolerant of criticism
    / / / / / / / sensitive to criticism
11) functions poorly in most aspects of life
    / / / / / / / functions effectively in most aspects of life
12) would bring about positive countertransference feelings in therapy
    / / / / / / / would evoke a negative countertransference response in therapy
13) competent
    / / / / / / / incompetent
14) exhibits good judgement and use of common sense
    / / / / / / / exhibits poor judgement and lack of common sense
15) irrational
    / / / / / / / rational
16) emotionally stable  ___/ ___/ ___/ ___/ ___/ emotionally unstable

17) a good marital partner  ___/ ___/ ___/ ___/ ___/ a poor marital partner
### Interpersonal Functioning Scale

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>warm and loving</td>
<td></td>
<td>cold and callous</td>
</tr>
<tr>
<td>2</td>
<td>insensitive to the needs of others</td>
<td></td>
<td>sensitive to the needs of others</td>
</tr>
<tr>
<td>3</td>
<td>capable of close relationships</td>
<td></td>
<td>incapable of close relationships</td>
</tr>
<tr>
<td>4</td>
<td>inpatient and intolerant with children</td>
<td></td>
<td>very patient and tolerant with children</td>
</tr>
<tr>
<td>5</td>
<td>provokes and arouses anger in others</td>
<td></td>
<td>gets along well with others and makes them feel good</td>
</tr>
<tr>
<td>6</td>
<td>rigid</td>
<td></td>
<td>flexible</td>
</tr>
<tr>
<td>7</td>
<td>concerned about others</td>
<td></td>
<td>self-centered</td>
</tr>
<tr>
<td>8</td>
<td>unlikeable and irritating</td>
<td></td>
<td>pleasant and likeable</td>
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<tr>
<td>9</td>
<td>demanding with others</td>
<td></td>
<td>accommodating to others</td>
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Diagnostic Scale 1

1) Adjustment Disorder with Anxious Mood

2) Marital Problem

3) Phase of Life Problem or Other Life Circumstance Problem

4) Adjustment Disorder with Mixed Emotional Features

5) Dysthymic Disorder

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Diagnostic Scale 2

1) Borderline Personality Disorder
   ___/___/___/___/___/___/___/

2) Historic Personality Disorder
   ___/___/___/___/___/___/___/

3) Narcissistic Personality Disorder
   ___/___/___/___/___/___/___/

4) Passive-Aggressive Personality Disorder
   ___/___/___/___/___/___/___/

5) Bipolar Disorder (manic)
   ___/___/___/___/___/___/___/

6) Generalized Anxiety Disorder
   ___/___/___/___/___/___/___/
Personality and Clinical Judgement Questionnaire

Please rate the client on the following items using the 5-point rating scale given along with each item.

Example: Happy / / / / / Sad
         A  B  C  D  E

The letters form a scale between the two extremes. You are to place a check mark at the point on the scale which you believe best describes the client from the therapy transcript you have just read. For example:

A= the client may be described as happy
B= the client may be described as for the most part happy
C= the client may be described as moderately happy
D= the client may be described as for the most part sad
E= the client may be described as sad

1) exaggerates and over-dramatizes / / / / / appropriately reactive to stimuli
2) works in a cautious and deliberate manner / / / / / works in a rash and impulsive manner
3) warm and loving / / / / / cold and callous
4) has an analytical mind and capacity to benefit from insight-oriented therapy / / / / / has little insight and minimal capacity to understand self and world
5) immature / / / / / mature
6) insensitive to the needs of others / / / / / sensitive to the needs of others
7) capable of close relationships / / / / / incapable of close relationships
8) dependent / / / / / independent
9) actively involved in structuring own life experiences / / / / / passive and unable to exert control over life
10) would progress well in therapy / / / / / would not progress well in therapy

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<table>
<thead>
<tr>
<th></th>
<th>11) could not tolerate interpretations and confrontations in therapy</th>
<th>could tolerate interpretations and confrontations in therapy</th>
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<tbody>
<tr>
<td>12)</td>
<td>clear-thinking</td>
<td>confused</td>
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<tr>
<td>13)</td>
<td>tolerant of criticism</td>
<td>sensitive to criticism</td>
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<td>14)</td>
<td>functions poorly in most aspects of life</td>
<td>functions effectively in most aspects of life</td>
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<td>very patient and tolerant with children</td>
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<td>16)</td>
<td>would bring about positive countertransference feelings in therapy</td>
<td>would evoke a negative countertransference response in therapy</td>
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<td>17)</td>
<td>provokes and arouses anger in others</td>
<td>gets along well with others and makes them feel good</td>
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<td>18)</td>
<td>rigid</td>
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<td>19)</td>
<td>competent</td>
<td>incompetent</td>
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<tr>
<td>20)</td>
<td>exhibits good judgement and use of common sense</td>
<td>exhibits poor judgement and lack of common sense</td>
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<td>21)</td>
<td>concerned about others</td>
<td>self-centered</td>
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<td>22)</td>
<td>unlikeable and irritating</td>
<td>pleasant and likeable</td>
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<td>23)</td>
<td>irrational</td>
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<td>24)</td>
<td>emotionally stable</td>
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<td>25)</td>
<td>a good marital partner</td>
<td>a poor marital partner</td>
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<tr>
<td>26)</td>
<td>demanding with others</td>
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Diagnostic Impressions Questionnaire

Indicate the degree to which you think the client could be diagnosed as having each of the following disorders using the 7-point scale described below.

<table>
<thead>
<tr>
<th>Does not apply</th>
<th>Does apply</th>
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<tbody>
<tr>
<td>1 = strongly does not apply</td>
<td>7 = strongly applies</td>
</tr>
<tr>
<td>2 = for the most part does not apply</td>
<td>6 = applies for the most part</td>
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<tr>
<td>3 = somewhat does not apply</td>
<td>5 = somewhat applies</td>
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<td>4 = slightly applies</td>
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1) Adjustment Disorder with Anxious Mood

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<th>1</th>
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2) Borderline Personality Disorder

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3) Marital Problem

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4) Bipolar Disorder (Manic Phase)

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5) Phase of Life or Other Life Circumstance Problem

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6) Histrionic Personality Disorder

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7) Adjustment Disorder with Mixed Emotional Features

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8) Narcissistic Personality Disorder

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9) Generalized Anxiety Disorder

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10) Dysthymic Disorder (Depressive Neurosis)

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11) Passive-Aggressive Personality Disorder

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