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# An Investigation of Therapist Gender in the Intake Evaluation of Male and Female Clients at College Counseling Centers

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**AN INVESTIGATION OF THERAPIST GENDER IN THE INTAKE  
EVALUATION OF MALE AND FEMALE CLIENTS AT COLLEGE  
COUNSELING CENTERS**

**PROFESSIONAL DISSERTATION**

**SUBMITTED TO THE FACULTY**

**OF**

**THE SCHOOL OF PROFESSIONAL PSYCHOLOGY  
WRIGHT STATE UNIVERSITY**

**BY**

**HARRY PITSIKALIS, M.A., ED.S.**

**IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE  
OF  
DOCTOR OF PSYCHOLOGY**

**Dayton, Ohio**

**September, 2013**

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June 25, 2012

I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **HARRY PITSIKALIS** ENTITLED **INVESTIGATION OF THERAPIST GENDER IN THE INTAKE EVALUATION OF MALE AND FEMALE CLIENTS AT COLLEGE COUNSELING CENTERS** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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Robert A. Rando, Ph.D., ABPP  
Dissertation Director

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La Pearl Logan Winfrey, Ph.D.  
Associate Dean

## **Abstract**

The current study examined gender as a potential contributing factor in the increase in psychopathology at college counseling centers. As university and college counseling centers are moving away from a developmental model and toward the medical model, the effect of gender and the increased use of the DSM-IVTR could influence the perception in an increase of psychopathology by mirroring DSM-IVTR base rates. This study attempted to discover if gender influenced therapists to diagnosed depression, anxiety, substance abuse, and adjustment disorders differently amongst the male and female clients. Results indicated that neither male therapists nor female therapists diagnosed depression, substance abuse disorder, and adjustment disorders in male and female clients differently during their intake sessions. However, there were statistically significant findings for female therapists as they were more likely to diagnose female clients with an anxiety disorder compared to male therapists. The finally hypothesis revealed a significant effect between the client's gender on the Global Assessment of Functioning (GAF) score assigned. The mean GAF of male clients was 68 compared to female clients with a GAF rating of 66.

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## Chapter 1

The responsibilities of college counseling centers have changed over the last three decades. Counseling centers have seen a rise in students and an increase in severity of presenting problems (Heppner et al., 1994; Pledge et al., 1998; Benton et al., 2003; Erdur-Baker et al., 2006). These factors have influenced the needs and demands of counseling center professionals. As a result, staff, directors, and administrators have been compelled to alter their approaches to training and treatment planning to assist their population. Stone and Archer (1990) predicted that in the 1990's, as well as in the 21<sup>st</sup> century, students' psychological needs would increase as the cultural background of student's changes. Gallagher's (2008) national survey data collection from the mid 1990's through 2008 corroborated those claims. The survey demonstrated that directors are seeing an increasing trend in psychopathology (Gallagher, 2008). More recently, Barr, Rando, Krylowicz, and Winfield's (2009) data supported Gallagher's survey as both surveys demonstrated an increase in students seeking counseling services and an increase in severe psychopathology over the past years.

There has been a lack of evidence over the last 20 years supporting the increase of psychopathology (Sharkin, 1997; Sharkin and Coulter, 2005). Sharkin (1997) suggested that there might be an increase in the perception of psychopathology but provided little empirical evidence to support the claim. However, the author stated that data collection should be based on objective information instead of clinical perceptions. Sharkin (1997)

believed that an operational definition of psychopathology would alleviate the ambiguity of identifying the increase in severity. The author proposed that “For college students, the term psychopathology should perhaps be restricted to cases of psychological dysfunction that significantly disrupts the student’s ability to adequately function within the university setting or require mental health care beyond the resources of the average campus counseling services” (Sharkin 1997, p. 276).

Sharkin and Coulter (2005) considered is whether the increase in severity is actually linked to a rise in psychopathology or rather to a greater emphasis on clinical assessment training. Many counseling centers are integrating the traditional developmental model and medical model of psychological issues which includes adopting the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV TR). They believed increased use of the DSM-IV TR in college counseling centers supports an increase in the diagnosis of psychopathology. The authors added that some centers might begin to over diagnose, under diagnose, or misdiagnose students. Because of the inconsistency in diagnostic methods, staff members are faced with the challenges stemming from such variability.

The current study examined if therapist gender and client gender, as well as diagnosis are interrelated as a potential contributing factor in the increase in psychopathology at college counseling centers. Historically, studies examining gender bias investigated the data of hypothetical male and female case studies (Becker and Lamb, 1994; Flanagan and Blashfield, 2005; Hansen and Reekie, 1990; Kaplan and Free, 1995 Loring and Powell, 1988; Edwards, 1994; Wrobel, 1993). Unfortunately, no research examined the therapist’s gender and client gender at college counseling centers.



Therefore, one of the more noteworthy studies related to the current study was *sex-role stereotypes and clinical judgments of mental health* by Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel (1970). In this study, the researchers examined 79 clinicians, which comprised psychologists, psychiatrists, and social workers, to discover if a standard of mental health of an unspecified healthy adult would match that of a healthy male or healthy woman. The results of this study revealed significant discrepancies between what constitutes a healthy adult, a healthy male, and a healthy female. In addition, Broverman et al. (1970) also reported that clinicians were more likely to assign socially desirable male characteristics to mentally healthy adults, whereas they were less likely to assign socially desirable female characteristics to healthy adults.

Much of the literature suggests that mental health professionals are apt to stereotype gendered behavior, which could influence their clinical judgment (Vogel, Epting, and Wester, 2003; Becker and Lamb, 1994; Hansen and Reekie, 1990; Loring and Powell, 1988). Wisch and Mahalik (1999) examined interaction between male therapists and male clients. The authors believed that when male therapists encounter a male client who does not adhere to traditional masculine roles, the therapist ratings of client's level of functioning and client's prognosis seem to be negative. The results suggested that traditional masculine therapists overpathologized angry non-traditional male clients while less traditional therapists underpathologized sad non-traditional male clients. The data indicated that male therapists need to be conscious of their client's gendered behavior as well as their own perceptions of the client.

Loring and Powell (1988) sought to discover whether mental health professionals made differential clinical judgments based on their clients' gender. They found that

mental health providers perceived and diagnosed men and women differently, although they presented similar behaviors. The author believed that male psychiatrists over diagnose females with emotional problems.

### **Aim and Purpose**

The purpose of this study was to increase the understanding of gender on the treatment of college students. This information is valuable for professionals that counsel in this area. In 2009, close to 2.6 million students were eligible for counseling services at their institutions, and approximately 10.4% of students sought counseling (Barr, Rando, Krylowicz, & Winfield, 2009). The final purpose of this study was to assist college counseling center therapists by increasing their awareness of gender bias. Therapists may be unaware that they hold two different standards of mental health, and therefore, if therapists possess these different standards, they need to focus on bringing their bias into awareness.

This research adds to the discipline of clinical psychology by providing information about psychopathology among college students and about their therapists' perceptions on diagnosis after an intake session. This research could also increase the awareness of staff, directors, and administrators by focusing attention on possible influence of therapists' gender bias on college students. The knowledge obtained from this research could help therapists working with students by increasing their gendered awareness and improve assessment interviews. Similarly, Brown (1990) mentioned that neglecting the influence of gender and its interaction with behaviors during assessment procedures could lead to an inaccurate understanding of the client symptomatology. Lastly, this study facilitates future studies on gender bias and accurate assessments, and it

offers an understanding of gendered characteristics of students who visit college counseling centers.

## **Chapter 2**

### **Review of the Literature**

The purpose of this chapter is to report on the current literature related to the increase of client severity at college counseling centers and therapist gender bias. This chapter is organized into two subsections—each building on the conceptual framework for examining the therapists gender bias at college counseling centers. The first subsection outlines counseling center director's and staff's perception of psychopathology, trends in client problems and the literature concerning the lack of evidence supporting the increase of client severity. The second section explores the therapist perception of a health adult and their beliefs, gender bias in clinical judgment, and gender bias in diagnostic criteria.

#### **College Counseling Center**

**The directors and staffs' perception of psychopathology.** Over the past 30 years, many college-counseling centers have reported a significant increase in psychopathology, according to the data gathered through surveys on the perception of directors (Gallagher, Zhang, & Taylor, 2011. Robbins, May, and Corrazzini (1985) wrote a seminal paper on the increased psychopathology at college counseling centers. The authors sought to answer questions such as a) did staff members perceive changes in clients' presenting issues of counseling centers, b) did staff address changes in perceived agency expectations, and c) did staff feel competent in fulfilling the student's expectations. From a random sample of college counseling centers around the United

States, the authors selected 110 counseling centers from which 216 directors or staff members agreed to participate. The participants were asked to compare changes over the last three years. The survey had five sections: (a) demographic data, b) ratings of familiarity with client problems, c) ratings of client problems categories, d) ratings of perceived expectations of the counselor by an agency, and e) self-rating of counselor competency. It was reported that section C, the ratings of client problems categories helped directors and staff members understand better the level of psychopathology of students who seek assistance from the selected counseling centers. Participants responded to these five categories on a continuum from low emotional distress, needing informational/educational support, to high emotional distress, needing extensive psychological or psychiatric support. The results indicated that staff members noted an increased number of students with “ chronic enduring needs rather than informational or educational counseling needs”. Although the limitation of this study was that the data were generated from a self-report questionnaire, the authors stated that the staff members’ perspective service demand is increasing and clients show more distress than previous years.

Another study conducted by O’Malley, Wheeler, Murphey, O’Connell and Waldo (1990) surveyed 98 college and university counseling center directors from various demographic settings. The directors were asked to answer a questionnaire if they thought there was a change in the level of student psychopathology during the last five years (1983-1988) in contrast to the preceding five years (1978-1983). Furthermore, the authors asked the participants, “ To what do you attribute any changes that you may have noted above?” The results indicated that 85% of participants had noticed an increase in

the level of psychopathology. Despite the favorable findings, there was no pattern found in the demographic data. Furthermore, the directors endorsed an increase in clients' severity to:

- a) greater levels of untreated mental illness in society resulting from economic pressures, family dysfunctions, and mental illness de-hospitalizations; b) greater awareness of, and willingness to seek, treatment for mental health problems; c) changes specific to the student, including increased diversity, age, and increased pressure; and d) changes in a counseling center's services, diagnostic procedures, and record keeping (O'Malley et al., 1990, p. 462).

The authors cautioned that because of the study's limitations, additional research ought to examine their claims and identify what type of psychopathology is increasing.

In 1981, Robert Gallagher at the University of Pittsburg developed a survey to examine the trends and concerns of college counseling centers regarding " budgeting, innovative programming, confidentiality, waiting lists, and a number of other administrative, ethical, and clinical issues" (Gallagher, 2009). The researcher's sample was obtained via an email to a multiple list serves of college counseling center directors. Since 1988, the survey has included a question asking whether there is an increase in college student's psychological problems. At that time, 56% of the directors noted an increase in severe psychological problems (Gallagher, 1993). Approximately 10 years later, by 1997, 82.8% of the directors reported an increase in students with severe psychological distress. The latest 2009 survey of 302 directors reported that 93.4% of them noted a recent trend to a greater number of students with severe psychological

problems and that 48.4% of their clients presented severe psychological problems (Gallagher, 2009). In short, some of their limitations are that the findings appear to be the directors' impressions and their perception may not be based on actual counseling center statistics (Sharkin, 1997).

Barr, Rando, Krylowicz, and Winfield (2009), affiliated with the Association for University and College Counseling Center Directors (AUCCCD), developed another annual survey to gain insights into the functioning of college and university counseling centers. During the fall 2009, 752 directors were solicited to complete the online survey; 385 directors actually completed the survey. The directors were asked to report on the trend occurring from September 1, 2008 through August 31, 2009. From the 385 directors polled, 73% reported there had been an increase in students seeking counseling services, and 71% stated that there had been an increase in severe psychopathology in the past year. In addition, 94% of the directors also mentioned they were concerned about students with significant psychology distress (Barr, Rando, Krylowicz, & Winfield, 2009). Although these findings, which were similar to Gallagher's annual survey findings, reported an increase in psychopathology at college counseling centers, it seemed unclear from the survey whether the directors' perceptions affected the results or whether the recollections were based on actual agency data (Sharkin, 1997). Despite any of the limitations, there seems to be an increased demand for psychological services for students across college and university counseling centers.

**Trends in client problems.** Heppner, Kivlighan, Good, Roehlke, Hills, and Ashby (1994) studied the intake interviews at a college-counseling center to develop a categorization scheme for classifying clients' presenting distress. The participants

included 611 self-referred students at a major public university in the Midwest. Overall, 36.5% did not participate in previous counseling, 25.7% participated in less than 10 sessions, 27.2% participated in more than 10 sessions, and 4% had been involved in long-term counseling (Heppner et al., 1994). A cluster analysis categorized the client sample into nine different categories. Cluster 1 indicated severe generalized distress and contained clients who reported significant mood and interpersonal problems. Cluster 2, labeled as high-generalized distress, endorsed similar distresses as cluster 1 but with less number of days of coping with more than one stressor. Overall, both clusters contained 10% of the sample and recognized global problems instead of isolated events. The authors suggested that despite clustering, many clients were entering the counseling center with severe psychological problems; for instance, 10.6% of the clients in this study reported that they thought about suicide more than one day a week. The results of this study would be consistent with the directors' surveys that suggested an increase in client severity. Heppner et al. (1994) pointed out that a limitation to this study was the absence of stressors, such as incest, rape, sexual assault, career or educational concerns, eating disorders, and sexuality concerns. The authors mentioned that any of these issues could have skewed clients' clusters.

Pledge, Lapan, Heppner, Kivlighan, and Roehike (1998) continued investigating increasing psychopathology at college and university counseling centers. Over a 6-year period (between 1989 and 1995), the authors studied 2,326 clients at a large mid-western public university who sought counseling services. Using the Computerized Assessment System for Psychotherapy Evaluation and Research (CASPER), Pledge et al. (1998) reviewed the intake composite scores from the following



categories: chemical, interpersonal, mood, physical, suicide, thought, and global. The authors found no significant difference over the 6 years; although, Pledge et al. reported a slight insignificant increase in mood, anxiety, fear of loss of control, and personal distress. They suggested this data supports the notion that psychopathology has reached a ceiling effect for interpersonal concerns, vegetative symptoms, depressive symptoms, and behavioral concern.

Benton, Robertson, Tseng, Newton, and Benton (2003) conducted another study tracking the trends in college counseling centers. The authors examined archival data from 1988-1989 to 2000-2001. They began collecting data on intake and discharge to assess the level of severity and psychopathology of clients. The sample included 13,257 students who received counseling services at a large mid-western university. The Case Description List (CDL) measured the clients' symptoms based on the therapists' responses to 30 questions at the time of discharge. Overall, 19 items on the CDL referred to a specific client's distress, such as "depression, personality disorder, or relationship problem." The results indicated that clients who obtained counseling services were more distressed and received counseling for more than typical college related developmental issues, including anxiety, depression, suicidal thoughts, sexual assault and personality disorders (Benton et al., 2003). Furthermore, the data showed that the rates of depression doubled; students with suicidal ideas tripled; and sexual assaults quadrupled. Even typical college developmental and relationship stressors showed a significant increase. Benton et al. (2003) suggested that these results provide empirical support for the fact that college counseling centers have been encountering an increasing trend of severe psychopathology compared to a decade ago.

Erdur-Baker, Aberson, Barrow, and Draper (2006) conducted an additional study to support the rising severity of psychopathology. The authors used a 42-item Presenting Problems List as a baseline measure developed from 12 counseling centers to determine the fluctuations over time and then explore the nature and severity of presenting problems among three student samples. The 1991 clinical sample comprised 32 counseling centers and 3,049 students while the 1997 sample consisted of 4,483 students. In addition, the 1994-1995 non-clinical samples consisted of 2,718 students. Erdur-Baker et al. (2006) found a significant worsening of student symptoms over the six years data collection. Specifically, the results suggested that in 1997, students encountered greater academic concerns, relationship issues, and depression compared to 1991. The authors reported that the clinical sample experienced more problems compared to the students from the non-clinical sample. Their findings support the directors' perceptions of increased client severity.

**Alternate views of increased severity.** Cornish, Riva, Henderson, Kominars, and McIntosh (2000) conducted a study on perceived distress of students treated at a college counseling center. The authors wanted to examine if distressed students increased during the 6-year period. In their study, they used 982 students from a small, private university in a large metropolitan city of the Western United States who utilized services from 1986 to 1992. Upon intake, the clients were asked to complete the Brief Symptom Inventory (BSI; Derogatis, 1993) and perceived distress was measured by using the Global Severity Index, a subscale of BSI. Over the five-year period, the authors did not find any increase in overall psychopathology. Cornish et al. (2000) suggested their results most likely reflect that college students' distress have stabilized at

high levels since the studies conducted in the 1980's focused on psychopathology at college counseling centers. Their findings also demonstrated a small increase in extremely distressed clients. Cornish et al. (2000) stated that even a couple of highly distressed clients could strain and stretch thin an already overworked college counseling center to perceive an increase in overall psychopathology. On the other hand, six years was likely not long enough to discover a meaningful trend, which was one of the limitations of this study. Finally, the authors used only intake data and did not utilize other measurement, which would be receptive to the client's improvement overtime.

Kettmann, Schoen, Moel, Cochran, Greenberg, and Corkery (2007) stated that the staff and directors at college counseling centers around the country claimed that there has been an increase in psychopathology, without having empirical data to support their argument (Sharkin & Choulter, 2005). In their study, they wanted to understand why the staff and directors believed that psychopathology has increased at most college counseling centers. They examined the changes in severity at a large Midwestern university's counseling center from 1999 to 2005. The participants included 827 students who sought counseling. Unlike previous studies, which used subjective measures, such as therapist perception or client self-report, Kettmann et al. (2007) utilized objective measures. They used DSM diagnosis, objective client self-report (OQ-45 total score), counseling history or psychiatric hospitalization, psychologist rating of client's Global Assessment of Functioning (GAF), and therapist rating of severity of diagnosis. The authors concluded that there was "no meaningful trend increase in severity of psychopathology in this population."

Lastly, Kettmann et al. (2007) explained the rationale behind the perception of

increased psychopathology at college counseling centers. First, they that the perception of increased psychopathology may be due to counselors interacting with more challenging clients rather than due to overall increase in psychopathology. For instance, Cornish et al. (2000) concluded that a small increase in complex cases might create an impression of increased psychopathology. Second, another possibility is concerns added external pressure with the loss of staff positions, administration demands, the increased demand for services, and the fact that counselors may be working in a stressful environment. Finally, Kettmann et al. (2007) stated that some campuses actually have increased rates of psychopathology because of environmental stressors (e.g., natural disasters, campus violence, and tuition increases).

Rudd's (2004), he wrote that there has been an increase in psychopathology at college counseling centers and that the students' demands for services will continue to increase in the future. The author stated that college counseling centers across the country would more closely resemble a community mental health center. The reason for this shift from previous decades regards the financial benefits seen in higher education, which also means that more people are attending colleges and universities, leading to an increased demand for these services. Because of increased counseling services demands, the counseling centers will serve a more diverse population, reassembling the outpatient clinic. According to the author, because of increases in mental health services will counseling centers will have to improve their ability to provide treatment for long-term care and medication management. Rudd suggested that directors and staff members would need to collaborate with inpatient and outpatient providers, as it appears that college counseling centers are becoming an addition to community mental health

centers.

Stone and Archer (1990) wrote an influential article on the challenges that college counseling centers faced in the 1990's and into the 21<sup>st</sup> century. They determined that three environmental assumptions would influence future counseling trends in college-counseling centers. First, the cultural background of student would change. Consequently, students' psychological, medical, and financial needs would increase over time and would lead to an increased competition for resources. Finally, they also suggested that counseling centers would encounter an increasing number of distressed students. The authors claimed that these assumptions would present a framework for counseling centers to recognize changes in future service delivery to college students. Stone and Archer (1990) stated that the explanation the increasing demand of psychological service is an increasing campaign on campus and in the media about psychological awareness, forcing counseling centers to provide preventative measures and recommendation for students.

**Lack of evidence supporting the increase of client severity.** Sharkin (1997) examined the position of Stone and Archer (1990) that the level of psychopathology at college counseling centers has increased during the last 20 years. The author suggested that a closer examination of the literature suggests that there is an increase in the perception of psychopathology but little empirical evidence supports that claim. Sharkin stated that Stone and Archer (1990) did not operationalize "psychopathology" and failed to differentiate between normal developmental stressors and psychological distress. For instance, one counselor's severe psychopathology is another counselor's troubled student. To deal with such inconsistencies, the author

offered a vast review of the research and operationalized the term psychopathology among college students. Sharkin (1997) defined psychopathology as “cases of psychological dysfunction that significantly disrupt the student’s ability to adequately function within the university setting or require mental care beyond the resources of the average campus counseling center”. Although Sharkin acknowledged that college counseling centers have been increasingly encountering severe psychopathology among students, from the current research, “it can only be concluded that there is *a perception* among college counseling administrators and practitioners that problems presented by students have become more severe”.

Sharkin (1997) discussed implications for future research on psychopathology in college counseling centers. The author stated that counselors should be consistent in their definition of psychopathology. Next, they should evaluate the changes in symptomatology over at least ten years or more. In addition, data collection should be based on objective information instead of clinical judgment or perceptions. Finally, most of the data has been accumulated from Midwestern college counseling centers and it would be preferable to use a range of counseling centers throughout the country. Sharkin claimed that his recommendations for future research may be difficult to attain because counseling centers have little time or resources to engage in an investigation. However, the attempts to increase research at college counseling centers would likely contribute to our understanding of whether there is a true increase in psychopathology.

In another paper examining the existing research, Sharkin and Coulter (2005) inspected the reports regarding an increase in psychopathology at college counseling centers. The authors mentioned that regardless of the perception of an increase in

severity, empirical research does not provide direct support to collaborate that claim. Sharkin and Coulter (2005) also found that most studies failed to use appropriate research methods. With this in mind, strained counseling centers have to face the methodological challenges when trying to determine if there is a trend of increasing psychopathology, the administrative crisis at college counseling centers involving limited resources and lack of adequate amount of counselors, or students who present as difficult. Moreover, the authors suggested that stressed counselors might be prone to distort the severity of client problems. Next, Sharkin and Coulter (2005) stated that in an attempt to use objective data, researchers studying this phenomenon have only used one measure such as client self-report (Cornish et al., 2000; Pledge et al., 1998) or counselor diagnostic report (Benton et al., 2003), as opposed to various methods for assessing psychopathology.

Another issue that the authors considered is whether the increase in psychopathology actually relates to an increase in psychopathology or rather to better clinical assessment training. They believe that the increase in psychopathology over time could actually reflect an increase in the diagnosis of psychopathology. The increased use of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV TR), in college counseling centers supports this notion. Finally, Sharkin and Coulter (2005) discussed that counselors are aware that the age of onset for most psychopathology is during college time. The authors advised that there is no diagnostic consistency within counseling centers; therefore, some centers may over diagnose, under diagnose, or misdiagnose.

### **Therapist Gender Bias**

**Therapist Perception of a Healthy Adult.** Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) conducted one of the most well known studies on gender bias. The purpose of the study was to discover if a standard of mental health for an unspecified healthy adult would match that of a healthy male or healthy woman. They suggested that the study confirmed the existence of a double standard of mental health between men and women. Broverman et al. used a group of 79 clinicians, which consisted of psychologists, psychiatrists, and social workers and asked them to complete the Stereotype Questionnaire (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968). This measure included 122 bipolar items that displayed stereotypic masculine characteristics on one pole and stereotypic feminine characteristics on the other pole. The clinicians were assigned one of three sets of instructions labeled “male”, “female”, or “adult”. One group received the following instructions: "think of a normal adult man and then indicate on each item the pole to which a mature, healthy, socially competent adult man would be closer". The other group received similar instructions concerning "normal adult females" and the last form instructed the clinicians to think of "normal adult persons". The authors concluded there were no significant differences between ratings of male and female clinicians. The data suggested that clinicians agreed on what constitutes a healthy adult, a healthy male, and a healthy female. They found that clinicians were more likely to assign socially desirable male characteristics (independence, assertiveness, competitiveness, and emotional stability) to mentally healthy adults, whereas they were less likely to assign socially desirable female characteristics (submissiveness, dependence, less aggressiveness, and greater emotionality) to healthy adults. According to Broverman et al., "a double standard of



health exists for men and women, that is, the general standard of health is actually applied only to men, while healthy women are perceived as less healthy by adult standards”. The author suggested that this dilemma reflects gender stereotypes in society and clinicians should examine their attitudes and beliefs towards sexism.

Widiger and Settle (1987) sought to demonstrate that the results of Broverman et al. (1970) were not due to gender bias but to the influence of the dependent variable that was used to measure whether a double standard exists between men and women. The authors raised the issue of methodological problems within the Broverman et al. study because they found that “mean health scores were simply the result of the fact that 71% of the items were male valued”. Widiger and Settle attempted to support their claim and replicated the Broverman et al. study by manipulating the dependent variables with items that were 71% male-valued, 71% female-valued, and non-biased. The authors followed similar procedures used by Broverman et al. (1970). The results demonstrated that the male-biased items duplicated Broverman et al.’s study and found no significant difference between healthy adult and healthy females on female-biased items. In addition, when the authors used non-biased items, they found no significant differences between the means of a healthy adult, healthy male, and healthy female scores. Widiger and Settle concluded that the Broverman et al.’s (1970) findings was “a result of the ratio of male-valued to female- valued items in the dependent measure. The sex bias was in the inventory, not the subjects”.

Approximately two decades later, Beckwith (1993) reexamined the classic Broverman et al.’s (1970) study with mostly female second year nursing students (89% female) that the author divided into three groups. Group 1 contained 30 students, group 2

comprised 15 students, and group 3 contained 30. Similar to Broverman et al., the author followed the same procedures and instructions. The results showed that males were perceived differently from the healthy generic adult. The healthy adult was characterized as less easily influenced, emotionally expressive, less blunt, competitive, empathetic, more logical, and more interested in personal appearance than the healthy adult male. Furthermore, the data displayed some gender stereotypes that did not influence masculinity but characterized males as more “emotionally repressed and socially crude” compared to the healthy adult female. Beckwith suggested that the healthy adult was more similar to the healthy female rather than to the healthy male. However, the author quickly noted that a main limitation of the study, which needed to be considered, was the limited generalizability because the majority of participants were females.

In another replication of the Broverman et al.’s (1970) research, Seem and Clark (2006) investigated whether the conclusions from the classic study still hold true in the 21st century. In this study, the authors wanted to assess gender role stereotypes held by counselor trainees regarding their views of the healthy adult female, healthy adult male and healthy adult. In addition, they wanted to determine if gender role stereotypes for men and women have changed since the 1970 study. Seem and Clark (2006) used 121 master’s level counseling students from two counseling programs in the northeastern United States. The researchers asked them to complete three Stereotype Questionnaires, as in the Rosenkrantz et al. (1968) research. Similar to Broverman et al. (1970), the authors followed the same procedures. The results demonstrated that participants perceived the healthy female as traditionally feminine as well as traditionally masculine; however, they viewed the healthy male solely in terms of masculine

characteristics. Furthermore, participants endorsed more overall traits for the healthy female than in the past. According to Seem and Clark, the findings indicate that both genders believe that women are now expected to be more androgynous. In contrast to the healthy adult female, the authors implied that the counselor trainees suggested that a soft, sensitive man would be perceived as less healthy. In comparison to the Broverman et al.'s (1970) study, the authors did not find significant changes in overall gender role stereotypes. Although they did not suggest the healthy male was seen as the norm, they found that the few characteristics used to portray the healthy adult continue to be masculine. In spite of everything, Seem and Clark believe that the most important discovery is that the perception of the healthy adult female continues to be significantly different from that of the healthy male or the healthy adult.

**Therapist Gender Beliefs.** Kaplan and Free (1995) sought to examine the gender beliefs of psychotherapists. The authors asked a sample of 115 social workers and clinical psychologists to complete the Bem Sex-Role Inventory and a questionnaire in which participants identified healthy psychological characteristics of a hypothetical client portrayed as “a 35-year-old employed woman/man in psychotherapy with difficulties in intimate relationships and work satisfaction”. Although participants did not endorse gender stereotypes in the hypothetical client, the results revealed a significant difference between the responses of male and female therapists. Female therapists were likely to select the androgynous category (forceful, affectionate, sympathetic, assertive, leadership abilities, and loves children) while male therapists were more likely to select the undifferentiated category comprising low femininity and low masculinity. Kaplan and Free followed Bem's (1976) notion that androgyny constitutes optimal mental health

for both sexes and suggested the researchers found a change in the double standards of gender roles but no evidence that both genders are moving towards androgyny. The data demonstrated that compared to male participants, female participants were more likely to perceive androgyny as optimal mental health. Kaplan and Free suggested that this is indicative that society is more acceptable when women exhibit masculine traits rather than when men exhibit feminine traits. On the other hand, the male participants were least likely to select masculine traits as healthy for both hypothetical clients. Kaplan and Free believed this phenomenon is likely related to the social stigma that men who choose a helping profession place a higher value on traditional feminine traits.

After examining 70 book chapters and journal articles on sex, gender roles, and psychotherapy, Mintz and O'Neil (1990) found that male and female therapists interact differently with opposite gendered clients. The authors hypothesized gender bias occurred in the interaction between patient, therapist, and the gender roles of each. They suggested that the relations between a male therapist and female client are different from a male therapist working with a male client. In addition, the same dynamics are observed for female therapists and male clients, as their interaction is different from interaction between female therapists and female clients. The authors mentioned "counselors are subject to the same gender role socialization as other members of our culture" (p. 383). Given differing socialization between males and females, Mintz and O'Neil found therapists have to demonstrate empathy and authority at different times during sessions. Since empathy is perceived as a traditionally feminine trait and authority as a masculine trait, a male therapist working with a male client might discover that male clients may restrict their emotions because of the perception that empathy will be reciprocal and will

threaten the client's masculinity. The conflict for the male therapist is therefore to temper his socialization towards assuming authority versus empathy. Regarding the male therapist and female client dyad, the authors suggested male therapists might interact depending on their perceived gender role towards women. On the other hand, female therapists working with the female clients are challenged to acknowledge the role of their power as therapists (Kaplan, 1979). Mintz and O'Neil found that female therapists and male clients interaction usually represents a typical caregiver pattern, which is normally observed in our culture. However, this dyad could be problematic since male clients may feel uncomfortable to relinquish power to female therapists (Carlson, 1987). Overall, the authors concluded that not all literature agrees on the same findings. They believe that most "research has demonstrated association between an androgynous gender role orientation, and variables such as self-disclosure, empathy, and interpersonal flexibility, and androgynous counselors have been hypothesized to be superior practitioners".

Wisch and Mahalik (1999) examined interaction between male therapists and male clients with traditional and nontraditional masculine characteristics. Specifically, the authors believed that when male therapists encounter a male client who does not adhere to traditional masculine roles, the therapist ratings of liking the client, empathy for the client, client level of function, and client prognosis seem to be negative. Wisch and Mahalik selected 196 male psychologists from the Division of Psychotherapy from the American Psychological Association and asked them to respond to four hypothetical case studies. The four clients presented either a traditional or a non-traditional male who displayed either an angry or sad mood. In addition, the participants completed the Gender Role Conflict Scale (GRCS; O'Neil et al., 1986) that measures rigidity in

traditional masculinity to determine if participants would be placed in either the traditional or non-traditional category. The results suggested that traditional therapists overpathologized angry non-traditional male clients while less traditional therapists underpathologized sad non-traditional male clients. Additionally, the male therapists appeared to often evaluate negatively male clients displaying non-traditional masculine characteristics. The data indicated that male therapists need to be conscious of the client's gendered behavior and their perception of the client. Wisch and Mahalik advised that male therapists, as well as those who train them, should increase their self-awareness of gender issues in order to be aware of the relationship between gender role conflict and gender bias.

Mental health counselors form impressions within moments of meeting their clients and can base their clinical judgments from split second opinions. Vogel, Epting, and Wester (2003) examined the perceptions of counselors of their male and female clients after an intake. Using archived intake data available at a large southern university counseling center, the authors randomly selected 59 intake reports that included sections on presenting problem, background history, process notes, case conceptualization, and treatment recommendations. From the 59 written case reports, female counselors conducted 31 intakes and male counselors conducted 28 intakes. In addition, 37 case reports were written about female clients and 22 about male clients. Using a grounded theory approach, the results demonstrated the counselors' perceptions were similar for male and female clients, but some differences were discovered in the degree of importance regarding certain themes. For female clients, themes of "vulnerability" and "paying attention to how much the client asserts [herself]" were more salient. In these

categories, words such as “feeling overwhelmed, desperate, hurt, feeling inferior, insecure, premature, need a safe place, self is vulnerable, and feels vulnerable” were commonly reported. Regarding male clients, themes of being “stuck” and “paying attention to how much the client is connected to others” appeared to be more accessible. In these categories, words such as “he does not learn, he is stuck, difficult, has difficulty speaking, difficulty in interpersonally relating” were commonly reported. Vogel et al. suggested the counselors’ portrayal of the clients appeared to be consistent with the direction of traditional gender roles. Female clients were typically observed as open and expressive in therapy while male clients were viewed as emotionally deprived. Although counselors believed they are helping clients, in actuality, they are subscribing to therapeutic goals based on traditional gender roles, reinforcing the status quo. Therefore, the authors’ results support the idea that unintentional gender bias could affect the counselors’ perception of treatment (Stabb, Cox, & Harber, 1997).

Although Vogel et al. (2003) researched the counselors’ gendered perception after intake from written case notes; the authors did not directly examine counselors’ perspectives. However, Trepal, Wester, and Shuler (2008) investigated the counselors’ perception of gender directly using 29 volunteer counselors in training, 12 masters, and 17 doctoral degree students from a counseling program in the Midwest. Twenty-one participants were female and eight were male. Each participant was asked to rank 37 gender characteristics and read the following instructions “sort the cards according to whether you believe the characteristics is a perceived feminine trait or a perceived masculine trait” (p. 152). After the subjects sorted the statements, the researcher conducted a semi-structured interview individually. The interview aimed at assessing the

participants' perception of their rankings and experiences of masculinity and femininity. Using a Q methodology to measure and organize the participants' subjective experience, the authors found that a majority of subjects perceived male and female gender roles as traditional, perceiving both genders as essentially opposite. The majority of participants described females as "sensitive, emotional, and verbal" and their primary role as being a caretaker. On the contrary, the participants observed males as "stoic, dominant, aggressive, and independent." In addition, the subjects believed men have a difficulty expressing emotions other than anger and are more likely to have trouble establishing intimate relationships. The author suggested these gender stereotypes could potentially harm clients in counseling process. If counselors have gender biases based on their own socialization, they could indirectly influence the conceptualization and treatment goals of the client. Trepal et al. cautioned that these results cannot be generalized because of the subjectivity of the data, but they could spawn a debate about gender and stereotypical assumption of counselors and future mental health professionals.

**Gender Bias in the DSM.** For women to be considered healthy, they must behave the way men are supposed to act but should not overly conform to the masculine gender roles. On the other hand, if women act too feminine, they are again pathologized for their behavior (Broverman et al., 1970). This catch-22 suggests women can be labeled psychologically unhealthy either way. Kaplan (1983) argued that a reason for gender bias in treatment for mental illness is that "masculine-biased assumptions about what behaviors are healthy and what behaviors are crazy are codified in diagnostic criteria." The author mentioned that these are most overtly observed within the DSM's personality disorders. Kaplan further stated that when women behave in a stereotypical



feminine manner, they are observed as experiencing distress in social or occupational functioning. The author illustrated that behaving in a feminine manner will warrant a diagnosis of dependent or histrionic personality disorder but behaving in a masculine manner will not. For a masculine stereotyped individual, to be diagnosed, their behavior alone cannot just be remarkably masculine. Masculinity alone is not clinically relevant, however, femininity alone is (p. 791). Kaplan concluded that the diagnostic system resembles the perceptions of society and is male centered, thus, therapists could diagnose women for either overconforming or underconforming to traditional gender roles.

In a counter response to Kaplan's (1983) article, Kass, Spitzer, and Williams (1983) mentioned that personality disorders such as antisocial, paranoid, and schizoid occur more frequently in men compared to women. In addition, Kass et al. suggested that Kaplan's assumption of gender bias in personality disorder criteria holds no basis as female clients were no more likely than male clients to be diagnosed with a personality disorder. They concluded that some personality disorders are simply more prevalent in males and others in females.

Hartung and Widiger (1998) commented on one of the most controversial issues facing mental disorders, gender differences in the diagnostic system. The authors focused on gender prevalence rates of 101 Axis I and Axis II psychological disorders in the DSM. They argued that many gender prevalence rates appeared exaggerated and that some of the psychological disorders are gender specific. Hartung and Widiger mentioned that the difference in gender prevalence rates could be an accurate reflection of gender or assessment bias. They pointed out that in an ideal world, the diagnostic criteria would be "gender neutral," in reality however, criteria often excessively favor maladaptive

behaviors in one gender compared to the other. For that reason, gender neutrality is difficult to attain because psychological disorders appear differently in men and women. Hartung and Widiger explained that females, on an average, are more emotionally expressive than males; thus, it would be expected that females would dominate diagnostic criteria that characterize excessive emotionality. The authors indicated that any disorder than involves gender related behavior would be suspect to gender bias. For instance, Hartung and Widiger cited Frances et al.'s (1995) research as they made a complementary point that the assessment of histrionic personality disorder has placed "too little emphasis on items and examples that would tap the parallel 'macho' male version expressing exaggerated masculine traits" (p. 373). As a result, it could be possible that there might be as many males experiencing histrionic personality disorder as females. The authors believed that in the DSM Axis II disorders seemed to display interesting information about sex ratios because these disorders revealed that gender roles might account for gender difference in both internalizing and externalizing symptoms (Cooper, 1994). The most commonly diagnosed personality disorders in males were Paranoid, Schizoid, Schizotypal, Antisocial, and Narcissistic, with a 3:1 male to female ratio. In females, the most commonly diagnosed Axis II disorder was Borderline with a 3:1 female to male ratio. In addition, Histrionic and Dependent personality disorder occurs also more likely in females. Only Avoidant Personality Disorder seemed to occur equally likely in males and females. Overall, Hartung and Widiger, influential researchers of Axis II disorders, emphasized that most personality disorders appear to display significant gender prevalence rates when diagnosing mental disorders. If changes in these rates are to be resolved, conceptual problems need to be addressed. Therefore, in

the assessment of personality disorders that appear to be gender specific, it would be important to include both genders within clinical research to guarantee that findings are not biased towards one gender.

In an influential study examining gender bias in diagnosis, Loring and Powell (1988) sought to discover whether psychiatrists made differential clinical judgments based on the clients' gender and race. The author randomly selected 290 psychiatrists' to partake in this study, with a rather equal representation of male and female participants as well as African Americans and Caucasians. Each psychiatrist was asked to read two case vignettes with different gender and race and to complete a questionnaire assessing a client's DSM Axis I and Axis II undifferentiated schizophrenia and dependent personality disorder. Next, the psychiatrists were asked to select one of the six Axis I diagnoses as well as one of six Axis II diagnoses. The results indicated that all psychiatrists diagnose Axis I with undifferentiated schizophrenia at a similar rate. In addition, African American male and female psychiatrists, as well as Caucasian male psychiatrists, are more likely to diagnose undifferentiated schizophrenia sexing clients whose gender and race match their own. In regards to the Axis II diagnosis, dependent personality disorder was most frequently diagnosed. Once again, in all the participants, they were likely to diagnose dependent personality disorder when the case vignettes matched their own sex and race. Based on the data, when gender and race of the participant matched that of the case vignette, an accurate diagnosis was assigned. In addition, they found that mental health providers perceived and diagnosed men and women differently, even though they presented similar behaviors. Loring and Powell claimed that they found another interesting discovery; they observed that male

psychiatrists were more likely than any other group to diagnose major depressive disorder and histrionic personality disorder when the case vignette portrayed a female client. Loring and Powell believed that this should direct attention to possible gender bias towards women as male psychiatrists are overdiagnosing depression in women. The author believed that male psychiatrists overdiagnose females with emotional problems. Overall, the findings suggest that males are stereotyping female behavior, which could influence their clinical judgment.

In another investigation of gender bias, Becker and Lamb (1994) examined therapists' clinical judgments of both DSM diagnosis of borderline personality disorder (BPD) and posttraumatic stress disorder (PTSD). The authors hypothesized that therapists often diagnose female clients with BPD and male clients with PTSD. In their study, they randomly selected 311 participants, 39% social workers, 36% psychologists, and 24% psychiatrists. Becker and Lamb asked them to respond to a case vignette describing a male and female client with PTSD and BPD as well as insufficient criterion to diagnose either disorder. Still, the participants were asked to rate all criteria for the disorder on a 7-point Likert scale ranging from 1, disorder is not present, to 7, meets all the criteria. Furthermore, the participants were asked to write three questions they would want to ask the client. Becker and Lamb found that therapists diagnosed BPD more frequently than any Axis I or Axis II disorder, followed by Dysthymia, Self-Defeating personality disorder, and then PTSD. In regards to gender bias, females were diagnosed significantly more with BPD compared to males. The gender of the therapist also influenced the client's diagnosis. Compared to male therapists, female therapists diagnosed both male and female case vignettes with PTSD more. In addition, therapists

rated female clients higher on histrionic personality disorder compared to male clients, and they rated male clients higher on antisocial personality disorder compared to females. The authors believed that the therapists' gender bias was present in this study as they tended to underdiagnose BPD in males and overdiagnose BPD in females. However, they cautioned that one limitation to this study was that the therapists might not necessarily be biased, instead, they could be diagnosing in accordance with base rates when deciding on ambiguous cases. In the end, Becker and Lamb suggested that the results still display base rates bias.

Flanagan and Blashfield (2005) argued that simply presenting therapists with case vignettes would not provide any new information on the influence of gender bias. With this in mind, the authors created a computer program that would present an identical case history of a male or female with either histrionic personality disorder (HPD) or antisocial personality disorder (APD) traits described in one to two sentences at a time. The authors randomly selected 99 participants, 75% psychologists and 25% psychiatrists. Then, they asked them to either select from a list of personality disorders or select "no personality disorder." The results were similar to previous findings showing that most therapists diagnosed females with HPD and males with APD. In addition, Flanagan and Blashfield found that while presenting one line at a time, therapists made no diagnoses when age, gender, and marital status were presented. Alternatively, gender influenced the interpretation of diagnostic criteria. The authors believed that since gender is the first characteristic observed, therapists have a preconceived notion about clients. Therefore, they claimed that the therapists evaluated the criteria by judging that a "female HPD," "male HPD," and "HPD" are all different. Another discovery showed that when the case

studies presented both antisocial and histrionic traits, a majority of therapists diagnosed borderline personality disorder. However, no gender differences were found. The authors stated their data was consistent with previous research in that a mixed presentation of antisocial and histrionic traits was often diagnosed as BPD (Ford & Widiger, 1989).

**Gender Bias in Clinical Judgments.** In Brown's (1990) article, the author examined the ways in which psychologists could improve assessment interviews. Brown mentioned that neglecting the influence of gender and its interaction with behaviors during assessment procedures could lead to an inaccurate understanding of the client symptomatology. The author stated, "regardless of the culture in to which a person is born, his or her apparent biological sex will become very powerful and almost immediate determinant of experience" (p. 13). A person's gender crosses all boundaries of race, class, and socio-economic status. "Gender membership is an extraordinarily powerful factor in identity development" (p. 13). Since Western culture has valued male behavior as the mental health norm, any deviation from this standard is considered mental illness. Brown suggested that utilizing a "gender role analysis" during assessments would offset therapists' from pathologizing gendered behavior. A gender role analysis based on ignoring gender role compliance and helping clients explore the effects of gender on their presenting problems could permeate through the therapists' gendered expectations. In addition, the author mentioned that one strategy therapists could employ is a self-assessment of "normal" gendered behavior and gender influences on client's experiences. Every person is consciously or unconsciously gender biased, and this bias influences the therapists' clinical judgment; therefore, an assessment procedure might not accurately

diagnose the client's symptoms if gendered behavior is not taken into consideration. Brown believed that the lack of professional training on gender deters therapists' ability to assess the clients' behaviors accurately; therefore, therapists often mistakenly pathologize gendered behavior. Brown mentioned the therapist should understand that certain diagnoses retain very high base rates towards males and females, and their clinical judgment could influence how the presenting behavior is perceived. Thus, the author explained that a culturally sensitive assessment procedure gives equal weight to the counselor's perception and the clients' perception.

Hansen and Reekie (1990) examined gender bias through therapists' clinical judgment. In particular, the authors wanted to explore whether therapists would evaluate a case differently depending on the clients' gender. Hansen and Reekie used 103 clinical social workers (38% male and 60% female) and randomly distributed a one-page clinical vignette to each participant along with a questionnaire that presented 6 symptoms of depression. In addition, the hypothetical clients' gender and age was either a 32-year-old male or female. The results suggested that the therapists evaluate cases based on gender, leading to different psychological adjustment and prognosis in males and females. The hypothetical female clients seemed more optimistic in recovery compared to hypothetical male clients who presented similar symptoms of depression. Male clients with similar symptoms experienced more psychological problems compared to female clients. Overall, Hansen and Reekie suggested that although it appeared that psychological health of female clients has improved since the 1970's, therapists also tend to have a lower standard of mental health of females compared to males, "so that women presenting symptoms are seen as less deviant than men with the exact same symptoms (p.

60).” The author did caution that a limitation to this study was that it could not be generalized to other mental health professionals, as the research was restricted only to social workers.

In a similar study using case vignettes, Wrobel (1993) examined the influence of gender on clinical judgment. The author stated that gender appeared to highly affect the perceptions and decisions regarding diagnosing clients with depression. Wrobel randomly selected 209 psychologists (100 male and 109 female) and asked them to decide on an appropriate course of treatment for a hypothetical male or female client with symptoms common in depression. The results showed that psychologists viewed female clients as more depressed when considering three factors: difficulty maintaining hygiene, appearance, and keeping up with household tasks. Wrobel believed that the possible gender bias in their clinical decisions regarding women resulted from the therapist traditional perceptions of gender roles. In addition, the author’s study contributed to the existing literature, which shows that during intakes, therapists focus on different information based on gender. The implication of psychologists’ decisions for both male and female clients entering treatment is that the therapists’ perceptions of gender roles still influence their recommendations.

### **Research Questions and Hypotheses**

The purpose of the present study is to explore gender as a potential contributing factor in the increase in psychopathology at college counseling centers. Barr, Rando, Krylowicz, and Winfield (2010), exhibited in their annual survey a 20% increase in the use of DSM-IVTR from 2006 to 2010. In general, in using the DSM there has been much controversy concerning the likelihood of gender bias in diagnosis (Widiger &



Clark, 2000; and Hartung & Widiger, 1998). Ideally, diagnostics criteria should be gender neutral; however, gender is one of the first aspects processed and men and women express and display symptoms differently (Flanagan & Blashfield, 2005). Consequently, as college counseling centers are moving away from a developmental model and toward the medical model, the effect of gender and the increased use of the DSM could influence the perception in an increase of psychopathology by mirroring diagnostic bias rates. The first hypothesis states that therapist's gender, client's gender and diagnosis of depressive disorders are independent. The second hypothesis states that therapist's gender, client's gender and diagnosis of anxiety disorders are independent. The third hypothesis states that therapist's gender, client's gender and diagnosis of an adjustment disorder are independent. The fourth hypothesis of this study suggests that therapist's gender, client's gender and diagnosis of substance disorders are independent. Therefore, the null hypothesis is that therapist's gender; client's gender and diagnosis are not independent. Therefore, the null hypothesis is that therapist's gender; client's gender and diagnosis are not independent. Lastly, therapists would be more likely to give a higher GAF rating to male clients, compared to female clients. The null hypothesis is that there is no relationship between the therapists rating of GAF scores that they provided to male clients and female clients.

## Chapter 3

### Methods

#### Participants

The data for this study has already been collected and held securely in a password-protected computer at the counseling center. The participants for this study were 322 clients who sought counseling at a Midwestern university counseling center between September 2008 and August 2010. When seeking services at the counseling center, students were required to complete intake paperwork as part of treatment. The data for student participants, who completed the intake session and started individual therapy sessions, were selected from archival data sources. In addition, this study comprised first time clients who sought services for at least one year but less than two years.

Table 1 summarizes the demographic characteristics of the sample. Overall, 156 males (48.4%) and 166 females (51.6%) participated in this study. The students in the sample were identified as 71.4 % Euro-American/white, 15.5% African American/black, 5% Multiracial, 3.1% Asian American/Asian, 1.2% Hispanic/ Latino/a, 3.7% Prefer not to say. In addition, 82.9% were identified as heterosexuals, 10% were identified gay/lesbian/bisexual and 7.1% preferred not to say. The average age was 24 ( $M = 23.57$ ,  $SD = 5.656$ ). Study participants had various DSM-IV-TR diagnoses, including Axis I and Axis II disorders (Table 3). Table 2 summarizes the therapists'

demographics. Overall, male therapists (43.2%) and female therapists (56.8%) participated. Finally, approximately 36% of the therapists were psychology trainees, 31% were psychiatric residents, 11% were pre-doctoral interns, 11% were professional psychologists, and 11% were psychiatrists.

## **Materials**

**Client Demographic Information.** The clients' intake paperwork gathered through Titanium, electronic health records software for counseling centers that records general demographics and clinical information from each client seeking services, was the main source of information. Titanium contains a number of pre-defined data forms assessing demographic information in addition to a psychological assessment. Before the initial meeting with a therapist, students were required to complete a demographic survey and a 38-item Counseling Center Assessment of Psychological Symptoms (CCAPS) questionnaire, which measures how people feel about, act towards, and consent to different treatment forms. For this study, each participant's ethnicity, sexual orientation, registered disability, religion, age, gender, prior counseling, Axis I, Axis II, and Axis V diagnosis will be obtained from the archival database. This information will be used to obtain a diverse sample of participants. Finally, all data obtained from the counseling center at the time of intake contained no identifying information (each client was assigned a client code at intake).

**Global Assessment of Functioning (GAF).** The GAF scale is described in the DSM as a measure for mental health professionals to assess a clients' global level of functioning in psychological, occupational, and social domains. The scale of 1–100 divided into 10-point increments to outline general functioning ability.

## **Procedures**

This study involved gathering archival data for two consecutive school years, September 2008 to August 2009, and September 2009 to August 2010. Only the data from the clients' first visit will be included with data from subsequent visits being excluded. For clients with a dual diagnosis, an individual appraisal of the archival data will be performed to obtain the client's primary diagnosis after the intake session. The primary diagnosis will be the first clinical disorder listed on Axis I from the DSM-IV-TR Multi-axial assessment. In addition, the diagnoses selected were those disorders (mood, anxiety, adjustment issues, and substance use) most often encountered in college counseling centers. It is also important to note that some diagnoses were changed or added through the duration of therapy; however, for this study, this study utilized the initial diagnosis recorded at the intake session.

## **Design**

All the archival data will be entered into an SPSS data document and a statistical analysis will be run. An initial data analysis will provide descriptive information about the sample. Descriptive statistics, such as means and percentages, will describe the data and the distribution of the data. Chi-square test's for independence will be used to determine the relationship between the therapists' gender and the clients' diagnosis. Too few diagnosis of Borderline Personality Disorder prohibit the use of the chi-square analysis which was originally planned. A final hypothesis which suggests that therapist's are likely to give a higher global assessment of functioning (GAF) rating to male client, was explored using a factorial ANOVA.

Table 1

*Demographic Characteristics of Clients*

Characteristics	N	%
<b>Gender</b>		
Female	166	51.6%
Male	156	48.4%
<b>Race/Ethnicity</b>		
Euro-American/White	230	71.4%
African-American/Black	50	15.5%
Multiracial	16	5.0%
Prefer not to say	12	3.7%
Asian- American/Asian	10	3.1%
Latino/a	4	1.2%
<b>Religion</b>		
Catholic	134	41.6%
None, Agnostic, Atheists	92	28.6%
Protestant	37	11.5%
Other religion	31	9.6%
Prefer not to say	27	8.4%
<b>Sexual Orientation</b>		
Heterosexual	267	82.9%
Gay/Lesbian/Bisexual	32	10.0%
Prefer not to say	23	7.1%
<b>Prior Counseling</b>		
Yes	139	43.2%
No	182	56.5%

Table 2

*Demographics of Therapists*

Characteristics	N	%
<b>Gender</b>		
Female	183	56.8%
Male	139	43.2%
<b>Title</b>		
Psychology Trainee	116	36.0%
Psychiatric Resident	101	31.4%
Pre-doctoral Intern	38	11.8%
Staff Psychologist	36	11.2%
Staff Psychiatrist	31	9.6%

Table 3

*DSM-IV TR Diagnoses by Gender*

Diagnosis	Gender		N	%
	Male	Female		
<b>Depression</b>				
			81	25.2%
Major Depression	22	43		
Dysthymia	2	4		
Depression NOS	6	4		
<b>Substance Abuse</b>				
			58	18.0%
Alcohol Abuse	31	12		
Alcohol Dependence	6	1		
Cannabis Abuse	6	0		
<b>Anxiety</b>				
			47	14.6%
Generalized	3	16		
PTSD	2	8		
Anxiety NOS	4	3		
Social	6	0		

Panic Disorders	1	3	
Adjustment Disorder			34 10.6%
With Depressed mood	5	7	
With Anxious mood	2	6	
Mixed	4	8	
V-Codes	19	26	45 14.0%
Other			41 12.7%
Bipolar	5	6	11 3.4%
ADHD	14	5	19 5.9%
No Diagnosis	7	3	16 5.0%
Personality Disorders			
Borderline	2	9	11 3.4%
No Diagnosis			52 16.3%
Diagnosis Deferred			248 77.7%
Other			2.4%

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## **Chapter 4**

### **Results**

To test our hypotheses, chi-square tests for independence were used to examine the relationship between the therapist's gender, client gender, and diagnosis of depression, anxiety disorders, adjustment disorders, and substance abuse disorders. Factorial ANOVA was used to analyze the relationship between therapist's gender, client gender, and GAF rating.

#### **Depressive Disorders**

The first hypothesis stated that it is likely that therapist's gender, client's gender and diagnosis of depressive disorders are independent. Depression was collapsed into one category due to limited responses in each depression diagnosis (Major Depression, Dysthymia, and Depression Not Otherwise Specified). Although the diagnosis of depression was somewhat more frequent for female clients (63%) compared with male clients (37%), the results were not statistically significant,  $\chi^2(2, N = 81) = .431, p = .512$ . Additionally, there was no statistically significant association between the male (n = 20) and female therapists (n = 31) in diagnosing depression in female clients. These data suggest that neither therapist gender nor client gender affects the diagnosis of depression.

#### **Anxiety Disorders**

The second hypothesis stated that it is suggested that therapist's gender, client's gender and diagnosis of anxiety disorders are independent. Anxiety was collapsed into one category due to limited responses in each anxiety diagnosis (PTSD, Generalized



Anxiety, Panic with/without Agoraphobia, Social Phobia, Specific Phobia, and Anxiety NOS). The results were statistically significant,  $\chi^2(2, N = 47) = 5.328, p = .021$ , and the obtained Phi of .34 indicated a moderate relationship between the female therapists and female clients in terms of anxiety diagnoses.

### **Adjustment Disorders**

The third hypothesis stated that it is likely that therapist's gender, client's gender and diagnosis of an adjustment disorder are independent. The results were not statistically significant,  $\chi^2(2, N = 34) = .189, p = .664$ , indicating that male and female therapists diagnose adjustment disorders in male clients similarly.

### **Substance Abuse Disorders**

The fourth hypothesis stated that therapist's gender, client's gender and diagnosis of substance disorders are independent. Substance abuse was collapsed into one category due to limited responses in various substance abuse categories (Alcohol Abuse and Dependence, Cannabis Abuse, Opioid Abuse, and Amphetamine Dependence). Although the diagnosis was shifted toward male clients, the results were not statistically significant,  $\chi^2(2, N = 58) = .029, p = .865$ . This suggests that male and female therapists diagnose substance abuse in male clients similarly ( $n = 20$  and  $n = 24$  for male and female therapists, respectively).

### **GAF Score**

The final hypothesis stated that therapists would be more likely to give a higher GAF rating to a client who is male rather than female. A factorial ANOVA with therapist gender (male vs. female) and client gender (male vs. female) as the independent variables, and GAF as the dependent variable, showed that there was a significant main

effect of the client's gender on the GAF score,  $F(1, 320) = 5.68, p = .018$  (See Graph 1), with males obtaining a higher GAF score than females. The main effect of the therapist's gender did not approach significance,  $F(1, 320) = 2.71, p = .101$ . In addition, the interaction between the therapist's gender and the client's gender in GAF scores was not significant,  $F(1, 320) = 1.70, p = .193$ . Taken together, these data suggest that the client's gender influenced the GAF rating, regardless of the therapist's gender.

## **Chapter 5**

### **Discussion**

The primary objective of this study was to explore if there was a significant gender difference in the diagnosis of clients at intake using the DSM-IVTR. The first hypothesis stated that it is likely that therapist's gender and client's gender has or had an influence on the diagnosis of depressive disorders. Although the results did not reach statistically significant, female clients, compared to male clients, were diagnosed with depression with the ratio of approximately 2:1. This finding seems to be a trend that the perception of women are more likely to be diagnosed as depressed compared to men, in part because of their higher prevalence of depression, which could be based on several factors (Wrobel, 1993). First, women are more likely to seek treatment for depression; therefore, are more likely to be diagnosed as depressed. Second, female clients in the study could have been less symptomatic compared to male clients, but more likely to express depressive symptoms (Hansen and Reekie, 1990). Thus, depression in this study could have been underdetected among men, and overdetected among women.

Traditionally, men may be less likely to express their feelings overtly compared to women, thus limiting the ability to detect depression (Vogel, et al., 2006). In this study, male therapists diagnosed depression in 25% of female clients, whereas female therapists diagnosed depression in 38% of female clients. This difference may be explained by the idea that female therapists are better able to pick up the subtle signs of depression in same gender. Therapists may be biased because of the belief that women will discuss

symptoms whereas men will refrain from doing so (Kilmartin, 2005). Therapists may therefore be less likely to ask men about their symptoms, thus decreasing the likelihood of identifying depression in men.

The second hypothesis suggested that therapist's gender and client's gender has or had an influence on the diagnosis of anxiety disorders. The results revealed that female therapists were significantly more likely to diagnose female clients with an anxiety disorder compared to male therapists. Only 34% of male clients were diagnosed with an anxiety disorder, compared to 66% of female clients. When exploring the therapists' gender, female therapists diagnosed anxiety in 77% of female clients while male therapists diagnosed anxiety in 23% of female clients. Female therapists diagnosed PTSD and Generalized Anxiety to 19 female clients compared to 2 male clients. These results are similar to the community surveys, which confirm that women are twice as likely as men to develop an anxiety disorder. It is possible that female clients find self-disclosing to female therapists easier about traumatic experiences. They may feel comfortable on an initial session sharing emotionally laden topics, especially when it involves a history of sexual or emotional abuse. This belief could explain why female therapist diagnosed female clients in this study more often. For instance, Mintz & O'Neil (1990) found that due to female client's and female therapist's similar socialization, female clients felt empathized and a fuller interpersonal relationship with female counselors. Thus, it is possible that female clients in the current study might have felt safer and more understood than male therapist.

The third hypothesis stated that it is likely that therapist's gender and client's gender has or had an influence on the diagnosis of an adjustment disorder. A substantial

portion of college students experience adjustment symptoms that meet the adjustment disorder criteria. On the other hand, another portion of students report adjustment difficulties that are challenging, but do not meet the DSM criteria. It appears that female students tended to report more adjustment symptoms compared to male students. In this study, although not statistically significant, females (62%) were more likely compared to males (38%) to meet the adjustment disorder criteria. Both male and female therapists diagnosed female clients with this disorder more than they did male clients. A plausible explanation for these findings, as explained by Sherman (1980), is that therapists apply lower standards of mental health to women compared to men, so that women presenting symptoms similar to those presented by men are still seen as more psychologically unstable. For instance, the diagnostic criteria of an adjustment disorder in the DSM-IV-TR are considered a mild diagnosis, compared to not diagnosing a client on Axis I. In this study, male clients (69%) were more likely to be assigned no diagnosis on Axis I compared to female clients (31%). These results were consistent for both male and female therapists, where therapists likely perceived female clients having a more difficult time adjusting to a stressor compared to male clients. For instance, this is partly due to the fact that women will “admit” to having a hard time whereas many males will not due to the “stiff upper lip” training in childhood (boys don't cry). These different observations during the intake evaluations between male and female clients suggest the continual notion of a form of gender role stereotyping among therapists.

The fourth hypothesis suggested that therapist's gender and client's gender has or had an influence on the diagnosis of substance disorders. Although the diagnosis was favorable for 76% of male clients compared to only 24% of female clients, the results did

not reach statistical significance. Both male and female therapists equally diagnosed male clients with a substance abuse disorder. The increased drug and alcohol abuse among college populations, although considered pathological, is widely accepted during college. Knight et al. (2002) found that one-third of college students reported engaging in drinking behaviors that were consistent with alcohol abuse. One reason for these results is that in many instances, male rather than female college students are more likely to engage in risky behavior, while females are more likely to perceive drugs and alcohol as a greater risk. Thus the data suggests that females' perceptions of risk seem to differ significantly from males' perceptions, whereas male college students may be relying on alcohol and drug use as a form of gender expression.

The final hypothesis stated that male and female therapists would be more likely to give a higher GAF rating to male rather than female clients. The interaction between male and female therapists and male and female clients was not significant, but the main effect of the clients' gender on the GAF score was significant. Male clients obtained a mean GAF score of 68, compared to a mean GAF score of 66 for female clients. Therapists in general were more likely to view men as demonstrating better social, occupational, and psychological functioning, while viewing women as less psychologically healthy. This finding is consistent with results of other articles, which suggest that if a therapist has a particular belief about gender based on their own socialization, they may be forming a clinical judgment based on this belief (Brown, 1992; Cook, 1992). Additionally, clinical judgments have been shown to be susceptible to biases. Garb and Shramke (1996) explored this notion by examining biases in the clinical judgments of mental health professionals, where they discovered that African-Americans

and Hispanics were more likely to be misdiagnosed with schizophrenia. The overall results indicated that gender appears to be a factor in the intake evaluation process.

### **Limitations**

The presented results should be interpreted with caution given several limitations of the current study. First, the study may have limited generalizability. The sample was drawn from a large Midwestern university, and data were collected from one College Counseling Center. The potential issue with this sample is that the counseling center may serve a population that may not be representative of other populations sampled in a similar study. The location of the counseling center may be a factor regarding the type of psychopathology observed, given that the college is located in an urban setting. Another factor is that the participants included psychiatrists, psychiatric residents, pre-doctoral psychology interns, psychologists, and practicum students. The different clinical backgrounds, therapeutic orientation, training, and level of experience could have affected GAF ratings and diagnosis. Therefore, the data of this study is restricted in understanding how the male and female therapists made their diagnostic decisions.

### **Future Directions**

Based on the current findings future research should explore whether or not different mental health standards exist for men and women. Therapists may be unaware that they hold two different standards; thus, that they may be subjecting patients to gender bias. If therapists do hold different standards, additional diversity training in graduate schools and in the workplace needs to focus on bringing the idea of gender bias into awareness to avoid misdiagnosis and underserving the clientele. Future research would also benefit from observing trends in areas of multiple diversity identities, such as

gender, sexual orientation, religion, SES, and ethnicity, to ensure that researchers are not selecting one subgroup of students, which could be the source of further bias.

If this study were to be replicated to assess the potential that the therapist gender impacts in evaluation and diagnosing of client's numerous modifications should occur to improve its efficacy. First, I would select psychiatrists, psychologist, psychiatric residents, psychology interns and trainees from several university and college counseling centers with an equal representation of male and female therapists. I would ask them to read a hypothetical clinical intake vignettes with different genders but similar symptoms, and have therapist diagnosis the clients. This data would allow me to explore the therapist's gender bias and notice if providers diagnose men and women differently, even though they presented similar behaviors.



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