The role of gender bias in the therapy setting

by

HEATHER NICOLLE

B.S. Program in Psychology

Mansfield University

for

PSY 4490, Senior Seminar

Dr. Gretchen Sechrist

16 April 2018
Abstract
While there have historically been significant women in changing psychology, the field was founded and dominated by men. As time progresses, the field has become increasingly populated with women, so much so that they now outnumber men. Bias is automatic and gender bias is no exception. Across multiple studies, it was found that clients of both genders preferred female therapists. Also found was that men with female disorders are perceived negatively by the public, especially by other males. Therapists having a gender bias of this population was congruent with the public; however, contradicting evidence was found on if this bias affected the process and outcome of treatment of such individuals. Contradicting evidence for the therapists’ role in diagnosing and treating specific gendered clients was also seen. While some studies had support for the therapists evaluating their clients differently and some had support against, it was found that there were no outcome differences based on gender of either party or the reaction of the two. In conclusion, gender has a complex role in therapy that has not been sufficiently studied to give a wholistic explanation of the relationship.
The role of gender bias in the therapy setting

Karen Horney was a pioneering woman in psychology. She rebutted Freud’s belief that women experience penis envy with the notion that men experience womb envy by overcompensating because they cannot bear children. Horney also coined the Theory of Neurotic Needs, which explains the overuse of coping skills to deal with basic anxiety. Furthermore, she believed that people can take a personal role in their own mental health (Cherry, 2017). While Horney did make considerable contributions to psychology and paved the way for women to take more of an active role, historically, psychology was a male dominated field.

Wilhelm Wundt was a German psychologist who studied structionalism. He was named the “father of psychology,” due to opening the first formal psychology lab in 1879 (Boundless psychology, n.d.). Other well-known men of early psychology are: Edward Tichener (structuralism), William James (functionalism), Sigmund Freud, Carl Jung, Alfred Adler, and Erik Erikson (psychoanalysis), and John B. Watson and B.F. Skinner (behaviorism) (Introduction to psychology, 2015). While these men, as well as others not listed, all contributed to the field of psychology, Freud was the first to introduce psychotherapy. Psychotherapy, also known as the “talking cure,” is based on the belief that early childhood experiences are critical and explores the unconscious in human behavior (Introduction to psychology, 2015). This is the basis of what is thought of as traditional therapy today.

What was once a male dominated field is now exceeded by females. In 1970, women were only 20% of the recipients of a Ph.D. in psychology. In 2005, they made up 72% (Cynkar, 2007). According to Diamond, the significant increase of females in the field of psychology could be due to several reasons. One of the reasons is that men have gone into professions that have a higher pay, due to the association of wealth with power and status, and to make a decent
living to provide for their families. Extending on this idea, women are traditionally not the breadwinners of the family, so they are supported by their partners to pursue the less lucrative profession of psychotherapy. Additionally, therapists are lumped together with other genetic health providers, unlike psychiatrists, which is still a predominately male profession—relating back to the association of wealth with status and power. There has also been a trend of females only seeking treatment from female therapists, which affects the caseloads of the male therapists even further (Diamond, 2011).

There is undoubtedly a change in the prominence of gender in the psychotherapy field, which raises questions about the perception of such a phenomenon. It is human nature to have automatic biases; these biases are controlled by the Automatic System, found in the oldest part of the brain (Denney-Stone, 2017). A study exploring the effects of color-gender associations on automatic expression of gender stereotypes resulted in four findings: gender-stereotyped colors are an overarching influence on one’s choice for children’s commodities; color-gender associations impact children’s behaviors; color-gender associations automatically recall stereotypes in adults; and color-gender associations show a bias in impressions of males and females (Cunningham & Macrae, 2011). For the last result, it was found that feminine qualities were given to men and women wearing pink shirts and masculine qualities were given to men and women wearing blue shirts. Imagine a pink shirt was a “female” mental health disorder and a male was wearing or diagnosed with it. Feminine, or anti-masculine, attributes are associated with the individual because of automatic societal cognitive bias. These assumptions have been taught through cultural gender normative notions to make automatic biases for associations.

This paper explores the role that female and male gender bias plays in therapy. Client preferred therapist gender, gender bias’s impact on diagnosis and treatment of males with
“female” disorders, and the influence that therapists’ genders have on diagnosis and treatment of different gendered clients will be discussed. This is worth examining because it would be beneficial for individuals entering and in the psychology field to be aware of the effects of this bias. This is an interesting topic, due to bias being an automatic, natural part of human nature. Having more information and knowledge about this bias allows for it to be challenged and could lead to more gender sensitive practices in therapy. The goal of this paper is to provide information for the readers to gain a comprehensive knowledge of the subject and to be aware of its implications.

**Assumptions of Therapists Based on Gender**

An exception to the general preference for therapist gender may be based on a client’s history with a particular gender. For example, if a client is a trauma survivor or has had a bad experience with a therapist, they may have adverse reactions to a therapist with the same gender as their perpetrator or as their previous clinician. In this case, one gender may be better suited and more effective than the other for a client with this type of history (Enns, 2000). Other factors that can be an obstacle for the therapist-client relationship is countertransference, the use of feminine, for example humanistic, or masculine, for example cognitive behavioral, perspectives, and personal consciousness of inner femininity and masculinity. As Diamond (2011) explains, men and women innately have different perspectives, personalities, and life experiences. Due to this, each gender brings certain strengths and weaknesses to therapy.

**Client Preference for Therapist Gender**

Despite the belief of innate gendered characteristics, clients of both genders seem to prefer female therapists. Stamler, Christiansen, Staley, and Macagno-Shang (1991) suggests that
until recently, both genders preferred male therapists because they associated males with having more competence in the field. It is thought that empathy has gained way into the definition of competence in the psychotherapy field, which may explain why preference has migrated towards female therapists. This study also showed that women were more likely to have a preference for therapist gender over men, supporting Diamond’s earlier statement on this trend. In a second study, consisting of 41 males and 75 females whom filled out a questionnaire, it was revealed that clients of both genders also preferred female therapists to male therapists. For most, this was due to two reasons: the client believes that a therapist of a certain gender will have a better understanding of their issues and are more comfortable talking to one gender over the other (Pikus, 1996).

**Gender Difference in Self-Disclosure**

One of the findings of the previous study was that clients preferred female therapists because they felt more comfortable talking to one gender over the other. When looking at the gender differences in self-disclosure, several happenings were found. A meta-analysis by Dinddiak and Allen (1992), consisting of 205 studies, found that female and same-sex partners disclosed more than males and different-sex partners. When the person had a relationship with whom they were talking to, women disclosed more (found in self-report and observation). In self-report studies, when the person was talking with a stranger, men and women disclosed about the same, but in observational studies, it was seen that women disclosed more than men.

These findings provide support for females preferring female therapists, due to them disclosing more to females, but does not provide support for males preferring female therapists for this reason. This is interesting because, in self-reported studies, it was found that the amount of disclosure was the same by males and females to a stranger, no matter the gender of the
stranger. This finding can be applied to when a client meets a therapist for the first time, the therapist being the stranger, in suggesting that there would not be a difference between genders of clients self-disclosing to therapists of either gender, although there was a significant preference in therapist gender shown in the previous studies. The limitation of this study could be subject matter and the environment in which it is discussed.

**Diagnosis of Males with Female Disorders**

Some mental health disorders are perceived as feminine or masculine because their symptomologies are congruent with cultural beliefs of gender stereotypes. A female disorder is a term used to describe when female gender stereotypes intersect with mental health disorders, creating feminine gendered mental disorders. There has been evidence for the existence of gendered stereotypes of mental health disorders found in a report, done by Boysen, Ebersole, Casner and Coston (2014), consisting of three studies examining this relationship. The first two studies provided support that certain disorders are viewed as being masculine or feminine. The perceived masculine disorders were externalized disorders, such as antisocial personality disorder, addictions, and paraphilias, and the perceived feminine disorders were internalized disorders, such as eating disorders, histrionic personality disorder, body dysmorphia, and orgasmic disorder. Study 3 concluded that these gendered stereotypes are even extended to solitary symptoms as well, not just full diagnoses.

**Biases of Males with Female Disorders by the Public**

Perceptions of disorders as feminine or masculine does not mean that only females are diagnosed with feminine disorders or that males are only diagnosed with masculine disorders. The overlap of males being diagnosed with feminine disorders is paired with strong biases. As
seen in studies one and two of Boysen and colleagues (2014), masculine disorders are accompanied with the stigma that they are more negative and fearful. Males with feminine disorders do not hold this stigma, but are perceived with another.

In a study where college-aged males were invited to join a discussion-based focus group about Anorexia Nervosa, a perceived female disease. The discussion was taped and transcribed. Several negative biases were seen when the discussion was directed towards men. Anorexia Nervosa was automatically associated with women. When asked to discuss men with Anorexia Nervosa, the group of males responded with negative biases within the themes of the weakness of femininity and that it goes against masculine invulnerability. The disorder was distanced from any cultural gender-normative beliefs of masculinity (McVittie, Cavers & Hepworth, 2005). This negative bias of males with female disorders has also been reported by a study examining therapists’ biases of this population.

**Biases of Males with Female Disorders by Therapists**

Borderline Personality Disorder (BPD) and Major Depressive Disorder (MDD) are also perceived as feminine disorders, due to them being internalized disorders (Boysen et al., 2014). A study conducted by Liebman and Burnette (2013) examined 506 clinicians’ countertransference reactions of clients with BPD. Countertransference is the unconscious reactions or emotions a therapist feels towards a client. Client’s age and gender as well as clinician age, discipline, clinical experience, and training were examined. Each clinician was sent identical vignettes describing an undiagnosed client with symptoms of BPD, varying on age and gender of client, through an online survey. They were asked to diagnose the client and answer questions regarding their reactions towards the client. A second survey was given,
describing the same client, but he/she was facing charges for assault. The clinicians then answered questions regarding the client’s dangerousness.

The findings provided support that overall a BPD diagnosis was associated with negative countertransference reactions, lower levels of empathy, and the clients are viewed as more ill. Clinicians were more likely to diagnose adults and women as having BPD, were more accurate in diagnosing women with BPD, and perceived adolescents as more dangerous and “bad.” In addition, it was also found that clinician attitudes/countertransference of individuals with BPD depend on their prior experiences, personality, and the interaction of these factors (Liebman & Burnette, 2013). Although a gender difference in countertransference was not found, there may be a bias in over diagnosing women and underdiagnosing men. This could be due to BPD being stigmatized as a female disorder and provides concern for treatment delivery, specifically in males.

Zlotnicl, Elkin, and Shea (1998) studied the topic of gender bias of males with female disorders through examining the treatment and outcomes of persons with MDD in relation to whether the gender of the therapist and the client is the same or different. Of the participants, 28 females and 13 males were seen by a female therapist and 113 females and 49 males were seen by a male therapist all for an average of 14.69 sessions. Before treatment, the participants filled out an Attitudes and Expectations instrument to measure their bias thoughts on which gender of therapist would be most helpful to them. Pre- and post-treatment, a 23-item Hamilton Rating Scale for Depression was completed. After the second session and after treatment was completed, the Empathy Subscale of the Barrett-Lennard Relationship Inventory as used to measure the client’s belief of level of empathy their therapist possessed.
Therapist gender, therapist gender matching/mismatching client gender, and therapists’ amount of experience were all not significant factors to affecting the level of posttreatment depressive symptoms or either score (early vs. posttreatment) on empathy. This study did not find support for the hypotheses that gender influences the process and outcome of treatment for clients with major depressive disorder. In addition, client’s original bias about what gender therapist would be most helpful to them, and whether they received a therapist of that gender or not, had no impact on the process or outcome of therapy (Zlotnicl, Elkin, & Shea, 1998). These two studies provide insight into the presence of gender bias in the therapist population and that this gender bias, although present, is not a significant factor in affecting the process and outcome of therapy, with the exception of the possible under-diagnosis of BPD in men.

**Therapist’s Gender Role in Diagnosing and Treating Specific Gendered Clients**

It has been found that clients generally prefer a female therapist, compared to a male therapist, because they essentially think that a female therapist will be more effective and they will be more comfortable disclosing to them. In the previous section, there was contradicting information on whether gender bias has an impact on the process and outcome of treatment of males with female disorders. This section of the paper is going to examine the differences of diagnosing and treating clients of each gender in relation to the therapists’ gender.

**Support for Different Evaluation**

There has been evidence that therapists do evaluate female and male clients differently. A study of 103 clinical social workers were sent a one-page clinical vignette randomly varying in sex and age of client. Six of the symptoms described were symptoms of major depressive disorder in the DSM and the rest resembled adjustment disorder. In addition, each clinical social
worker was also sent a questionnaire to rate a series of issues for the client on a scale ranging from 1-7, eight possible treatment recommendations according to appropriateness and importance, the client’s projected acceptability of treatment and prosocial functioning, and to give a diagnosis.

A 2x2 comparison of gender and bias was done to exemplify the similarities and differences between female and male therapists regarding diagnosis severity and overall reactions to the clients. The findings show that male and female therapists rated female clients as having a higher psychosocial functioning, although female therapists did rate all clients higher as a whole, and that female therapists also rated issues more important for younger clients than older clients, no matter the gender. This study provides support that therapists do evaluate males and females differently, even when they have the same symptoms. Female patients are generally seen as more favorable, suggesting that men with the same symptoms are perceived as more impaired (Hansen & Reekie, 1990).

Support Against Different Evaluation

While there is evidence supporting that male and female therapists evaluate different gendered clients differently, there is also support for male and female therapists not evaluating their clients differently based on gender. A study was done to examine if therapists’ gender bias is reflected in the perception of the client’s experience of therapy and in their treatment outcomes. This study was broken into two parts: from the therapists’ perspective and from the clients’ perspective.

From the therapists’ perspectives, women report their clients, no matter the gender, as having a higher level of issues in sexual adjustment, showing more improvement, and as having
greater overall success. Therapists rated the clients that were the same gender as them as having higher expectations for improvement and enjoyed them as clients more. Men therapists assume a more critical perspective on their female clients, compared to female therapists, but male and female therapists have a more congruent perspective on their male clients. From the clients’ perspectives, both genders, if seen by a female therapist, report having greater energy. Female clients report having more ability to handle personal problems. There was a minimum of a mandatory 8 sessions, but when the therapist and client were of the same gender, the number of sessions were longer. Clients of women scored higher on therapeutic alliance, which correlates with study 1 where female therapists said that their clients showed more improvement. In addition, therapist neutrality is more easily achieved with same-gendered therapy pairings.

The keys findings of the study are that sex bias does not adequately describe the complexities of gender in therapy. The differences between male and female therapists in therapy is their abilities, skills, attitudes, and emotional capabilities. While former clients reported that female therapists more readily formed a stronger therapeutic alliance and that same-gender pairings for females did constitute greater improvements, male therapists’ female clients still showed significant improvement (Jones & Zoppel, 1982). While there are sex biases seen, these are not largely significant nor do they mean than one gender is improving subpar. This finding is also seen in a second study where it is reported that nonprofessionals are greatly influenced by sex role stereotypes in mental health judgements of poor mental health and adjustment. However, with mental health professionals, sex role stereotypes are seen, but they are unaffected by them in the therapeutic setting and when making mental health judgments (Whitley, 1979).

No Outcome Differences
While there is support for and against therapists of each gender evaluating clients of different genders differently, it has been found that this does not affect the outcome differences of the therapeutic process. Wampold and Brown (2005) conducted a study consisting of 581 therapists and 6,146 patients to examine the outcomes of treatment varying due to the therapist. An outcome questionnaire that measures subjective discomfort, interpersonal relationships, and social role performance was given to the clients at the first, third, and fifth session and every fifth session after that for at least 6 months. The results were that client age, gender, and diagnosis as well as therapist age, gender, experience, and professional degree accounted for very little of the variability in outcomes among the therapists---about 5%. There are not significant differences in outcomes of therapy dependent on the gender of the client or the gender of the therapist and the interaction of the two.

**Comparison and Evaluation of Studies**

There are conflicting findings for the role of gender bias in therapy. Some studies support it having a significant part in the therapeutic process, while others do not; however, it is found that perceptions of gender bias and actual outcomes of therapy are different. An interesting observation of the research discussed is that most of the studies were done looking from the perspective of women, having to realign the results to present data for the male point of view. The research that was originally done from the male perspective was limited. Further research needs be done for a more wholistic explanation of such a complex relationship.

The alternative perspective for the role of gender bias in therapy would be that there is no role; the differences between genders in therapy is due to something else entirely. An example of an outside explanation could be the belief of traditional gender roles in society. In this possible explanation, attributes are assigned to one gender over the other, depending on the culture,
making the variances in therapy a result of cultural expectation, not whether an individual is male or female. This alternative perspective could also provide insight into why the data of the studies vary, due to the participants’ range of age. It is possible that this gender bias effects older populations more than younger populations because the gender roles gap is closing; men and women’s roles are not as contrasted in society now.

A limitation of the research reviewed, as mentioned above, is that most of the data was presented from the female perspective. In addition, much of the research was collected by the measure of self-report. This means that the validity of the data would be at the discretion of the participants’ honesty and accuracy. This is especially important to note with studies examining biases where participants could be aware of the social undesirability of certain answers, because of the possibility of skewed data.

**Conclusion**

The main research question is: what is the role of gender bias in the therapy setting? To answer this, gender bias has the potential to have an insignificant role in affecting diagnosis, treatment, and outcomes in therapy. Gender bias is automatic, with all populations experiencing it, but, in therapy, the role or level of power that it is allowed to have is at the discretion of the therapist and the client. Gender bias has a very complex role in therapy. There are many variables and extraneous factors that influence the implications of therapy. In sum, gender bias is not a sufficient term to describe the complexities of the role of gender in the diagnosing, process, and treatment that takes place in psychotherapy. This analysis allows for an increase of awareness to the reader of the role of gender bias in the therapy setting and provides information to form a further understanding of how it can impact effectiveness, diagnosing, and treatment to clients. In addition, the audience should be cognizant of personal and professional characteristics
that may present as obstacles in therapy. Further research on this topic is recommended to add to the information already given. There is a beginning of ample research, but the results of the studies are not yet externally valid and are limited in perspective.
References


Introduction to Psychology. (2015, October 26). Retrieved February 26, 2018, from


THE ROLE OF GENDER BIAS IN THE THERAPY SETTING

HEATHER NICOLLE
OVERVIEW

- History of gender in psychology
- Societal cognitive bias
- Therapist gender
- Female disorders
- Evaluation differences of each gender of therapists
- Limitations
- Alternate perspective
- Conclusion
HISTORY OF GENDER IN PSYCHOLOGY

- Significant women in history that changed psychology
  - Karen Horney

- Still founded and dominated by men
  - Wilhelm Wundt
  - Sigmund Freud

- Currently a female dominated field
Bias is automatic

Automatic system

Assumptions are taught to society based on cultural gender-normative behavior to make automatic biases

Imagine color-gender associations were extended to mental health disorder associations
Gender roles play what part in therapy?

- Is there a client preferred therapist gender?
- How does gender bias impact diagnosis and treatment of males with “female” disorders?
- Does the therapist’s gender effect diagnosis and treatment of clients?
One gender therapist may be better suited/more effective for a specific client

- Past experiences with a therapist
- Trauma survivor
- Personal consciousness of inner femininity/masculinity
- Countertransference
Clients prefer female therapists

- Pikus (1996)
- Participants filled out a questionnaire
- Clients of both genders preferred female therapists
- For most, this was due to two reasons:
  - The client believes that a therapist of a certain gender will have a better understanding of their issues
  - The client is more comfortable talking to one gender over the other
FEMALE DISORDERS

- When female gender stereotypes intersect with mental health disorders
- Boysen, Ebersole, Casner, & Coston (2014)
  - Evidence for existence of gendered stereotypes about mental disorders:
    - Masculine externalized disorders
    - Feminine internalized disorders
  - Gendered stereotypes extended to solitary symptoms
McVittie, Cavers, & Hepworth (2005)

College-aged males in a discussion-based focus group about Anorexia Nervosa

- Anorexia Nervosa was automatically associated with women
- Discussion of men with Anorexia Nervosa:
  - Weakness of femininity
  - Goes against masculine invulnerability
Liebman & Burnette (2013)

Identical vignettes: undiagnosed client with symptoms of BPD---Varied on age and gender
- Diagnose and answer questions about their reactions
- Client facing assault charges---answer questions on dangerousness

Results:
- BPD had negative countertransference reactions, lower empathy, clients viewed as more ill
- More likely to diagnose adults and women

Gender difference in countertransference not found
- Over diagnosing women, underdiagnosing men
Hansen & Reekie (1990)

Clinical vignette---varying in sex and age of client
- Rate a series of issues and possible treatments, predict acceptability of treatment and psychosocial functioning, and give diagnosis

Results:
- Male and female therapists rated female clients as having a higher psychosocial functioning
- Female therapists rated all clients higher and rated issues more important for younger clients
- Female patients are generally seen as more favorable
  - Men with the same symptoms are perceived as more impaired
THERAPISTS OF EACH GENDER DO NOT EVALUATE DIFFERENTLY

  - Examined therapists’ gender bias through therapist and client perspective
    - Perception of the client's experience of therapy
    - Treatment outcomes
  - Results:
    - Clients reported female therapists formed a stronger therapeutic alliance
    - Same-gender pairings for females = greater improvements
    - Male therapists’ female clients still showed significant improvement
NO OUTCOME DIFFERENCES

- Wampold & Brown (2005)
- Client age, gender, and diagnosis and therapist age, gender, experience, and professional degree
  - Accounted for 5% of the variability in outcomes among therapy
- No significant differences in outcomes dependent on:
  - Gender of client
  - Gender of therapist
  - Interaction of the two
LIMITATIONS

- Mostly presented from the female perspective
- Most data were collected by the measure of self-report
- Validity of the data at the discretion of the participants’ honesty and accuracy
  - Participants could be aware of the social undesirability of certain answers
The differences in therapy between genders is due to something other than gender bias.

Example:
- Belief in stereotypical gender roles
  - Culturally defined---variances in therapy a result of cultural expectation, not whether male or female
- May affect older populations more because the gender roles gap is closing
  - Men and women’s roles are not as contrasted in society now
WHAT IS THE ROLE OF GENDER BIAS IN THE THERAPY SETTING?
CONCLUSION

- Gender bias has a very complex role in therapy
  - Many variables and extraneous factors influence therapy
- Gender bias = not sufficient to describe its complexities in the diagnosing, process, and treatment
- This analysis:
  - Increase of awareness of the role of gender bias in the therapy setting
  - Provide information to further understanding of how it can impact effectiveness, diagnosing, and treatment to clients
  - Cognizant of personal and professional characteristics that may present as obstacles in therapy
QUESTIONS?