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# Gender Effects on Recall, Clinical Judgement and Treatment Recommendations for a Combination of Major Depression and Alcohol Dependence Symptoms

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GENDER EFFECTS ON RECALL, CLINICAL JUDGEMENT AND

TREATMENT RECOMMENDATIONS FOR A COMBINATION OF MAJOR

DEPRESSION AND ALCOHOL DEPENDENCE SYMPTOMS


by

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ABSTRACT

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This study investigated the effect of client gender on
several aspects of clinical decision-making processes and
clinical judgement when a client presented with a combination
of depressive and alcohol-dependent symptoms.  Forty-four
male and 44 female clinicians, from various mental health
disciplines (i.e., psychology, social work, counseling,
nursing, and psychiatry), volunteered to participate as
subjects.

The subjects heard one of four audiotapes (two male
tapes and two female tapes) in which mock clients gave the
same initial presentation of symptoms and problems.  After
listening to the tapes, the clinicians were asked to engage
in a number of tasks related to clinical judgement including
the following:  recall, question generation, diagnosis,
attribution of etiological factors, prognostic judgements,
and therapeutic recommendations of modality, style and length
of treatment.

These results revealed that there were only significant
client gender main effects for recommendations for
therapeutic modality.  Those clinicians who did not
recommend individual therapy were most likely to recommend

the male clients for group therapy and to recommend the
female clients for marital therapy or medication evaluation.
Also, there were significant interactions involving client
gender by tape version and clinician gender by tape version.

It seems that client gender may not be a predominating
influence for the clinical decision-making processes of
recall, question generation, and diagnosis when a client
presents with objective and behaviorally-anchored symptoms.
However, client gender may play a significant role in the
outcome decision of recommended therapeutic intervention.
The complex interactions between client gender and clinician
gender with the tape version suggest that subtle, vocal
differences between the four actors influenced clinicians'
judgements, and this phenomenon needs further investigation.

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## DEDICATION

I dedicate this dissertation to my family—John, Bonnie, Nathan, Kathy, Gramceil and Granny.  Their love and support was unwavering, and they believed in me when I was unsure.

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Perhaps most importantly, I would like to thank all the clinicians who took the time to participate in my study. Without their generosity of time and patience, this study would not have been possible.

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I would also like to acknowledge the time consuming and demanding contributions of the actors who made the audiotapes--Kathy French, Keith Myer, Brian Wiggins, and Cathy Baker and the raters--Bonnie French, Karen Boyd and Joan Crownhart. Their dedication and unwavering friendship in the face of frustration and fatigue was deeply appreciated.

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Previous research has indicated that sex stereotypes may influence the diagnosis and treatment provided by mental health professionals (Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970; Fabrikant, 1974). Subsequently, there have been studies investigating client gender effects on diagnosis and treatment recommendations for *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition, Revised, American Psychiatric Association, 1987) (*DSM-III-R*) Axis II diagnoses which have disproportionate sex ratios (Ford & Widiger, 1989; Hamilton, Rothbart & Dawes, 1986; Warner, 1978, 1979). That is, these studies examined whether a client's gender influenced clinical judgements more than presenting symptoms (Ford & Widiger, 1989; Hamilton et al., 1986; Warner, 1978, 1979). Generally, these studies have found some support for the hypothesis that client gender does affect clinicians' diagnoses and treatment recommendations (Ford & Widiger, 1989; Hamilton et al., 1986; Warner, 1978, 1979).

There has been little experimental literature which investigated the influence of client gender on Axis I diagnoses and related treatment recommendations (Fernbach, Winstead & Derlega, 1989). The *DSM-III-R* diagnostic criteria for major depression and alcohol dependence were chosen as the focus of the case material for the present study because these diagnostic categories have disproportionate sex ratios according to epidemiological data (Nolen-Hoeksema, 1987; Weissman & Klerman, 1987; Zucker, 1986). Specifically, males are over-represented for alcohol dependence, and females are over-represented for major depression (Nolen-Hoeksema, 1987;

Weissman & Klerman, 1987; Zucker, 1986).

Prior studies of gender effects on clinical judgements have primarily utilized written vignettes as stimulus case material (Fernbach et al., 1989; Ford & Widiger, 1989; Hamilton et al., 1986; Warner, 1978, 1979). The present study increased the similarity to real clinical phenomena by having client case material presented by an audiotape of a mock client. A few studies have investigated client gender influences on the information-processing aspects of clinical judgement including recall of clinical material and question generation in initial interviewing (Buzcek, 1984; Buzcek, 1987). These studies found evidence suggesting that client gender did affect clinician recall and question generation (Buzcek, 1984; Buzcek, 1987).

In summary, this study investigated the effect of client gender on several aspects of clinical decision-making processes and clinical judgements when a client presented with a combination of depressive and alcohol-dependent symptoms. The specific components of clinical decision-making that were investigated included the following: recall, question generation, diagnosis, attribution of etiological factors, prognostic judgement, and therapeutic recommendations of modality, style and length of treatment. The primary focus of this study was to investigate whether client gender was a predominating influence on the above mentioned components of clinical judgement.

Gender Differences in Epidemiology of Mental Health

Epidemiological data have suggested that since World War II (WWII), women have had increasingly higher rates of mental

illness than men (Gove, 1979; Gove & Tudor, 1973). Various hypotheses have been offered to explain the gender differences in mental illness rates. Gove (1979) proposed that women's subordinate and oppressed role in society creates a vulnerability to psychological stress and mental illness. Others have proposed that women are more likely than men to be diagnosed mentally ill because of their increased utilization of health professionals' services (Cafferta & Meyers, 1990; Gove, 1979). Dohrenwend and Dohrenwend (1974) suggested that gender differences in mental illness rates can be explained by methodological factors in data collection. These factors included the development of increasingly broad definitions of a "psychiatric case" and evidence suggesting that, prior to WWII, more sources of data were available about male-related problems (e.g., police records) than women's more private manifestation of problems (Dohrenwend & Dohrenwend, 1974). These authors proposed that more research should focus on explaining why men and women express their problems in different ways (e.g., women display neuroses and depression, and men display irresponsible and antisocial behaviors) rather than emphasizing higher mental illness rates for women.

Several *DSM-III-R* categories have disproportionate sex ratios for their prevalence rates (American Psychiatric Association, 1987). That is, for several *DSM-III-R* diagnoses, males and females are over or under-represented to a greater degree than would be expected in light of the percentages of men and women in the normative population. Some *DSM-III-R* Axis I diagnoses and diagnostic categories in

which males are over-represented included psychoactive
substance use disorders, obsessive-compulsive disorder,
paraphilias, factitious disorders, and impulse control
disorders; the Axis II diagnoses included paranoid
personality disorder, antisocial personality disorder, and
obsessive-compulsive personality disorder. Some Axis I
diagnoses and diagnostic categories in which the *DSM-III-R*
reported disproportionately higher percentages of females
included depression, dysthymia, panic disorder, agoraphobia,
social phobia, simple phobia, somatization disorder,
somatoform pain disorder, multiple personality disorder,
insomnia, and parasomnia. The Axis II diagnoses included
borderline personality disorder, histrionic personality
disorder, and dependent personality disorder.

One path of research has begun to examine explanations
for the differential sex ratios of women and men within
certain diagnostic categories (Weissman & Klerman, 1987).
Although various hypotheses explaining these differences may
apply across the specific diagnostic categories, some general
explanations have been proposed. One explanation is that
these differences may reflect real variances in the symptoms
experienced by men and women. Other hypotheses include: (a)
differing sex-role expectations influence the manifestation
of men and women's psychological problems; (b) women and men
are more likely to report different symptoms based on sex-
stereotyped social demands; (c) biological factors predispose
men and women to express psychological problems differently;
(d) certain diagnostic criteria have an inherent sex bias;
and (e) clinicians' diagnostic and treatment decisions are

influenced by their expectations of gender differences (which then leads to over or underdiagnosis) (Bardwick, 1974; Dohrenwend & Dohrenwend, 1974; Fernbach, Winstead & Derlega, 1989; Gove, 1979; Warner, 1978, 1979; Weissman, 1980). The last hypothesis, which proposes that client gender affects clinician diagnostic and treatment decisions, has been investigated for various diagnoses (Fernbach, Winstead & Derlega, 1989; Ford & Widiger, 1989; Warner, 1978, 1979). It is this hypothesis that is being explored in the present study. Specifically, this study will investigate whether client gender is an overriding influence on clinician information-processing and clinical judgement when male and female clients present with identical symptoms, including those that are consistent with both sex-stereotyped expectations and base rates as well as those that are not.

Gender Differences in Depression. Depression has been found to have one of the highest prevalence rates of any mental disorder (Meyers et al., 1984; Robins et al., 1984; Weissman, 1980). The *DSM-III-R* criteria for major depression include the presence of at least five of the symptoms listed below for "the same two week period [and] which represents a change from a previous level of functioning" (p. 222). At least one of the symptoms must be either depression or loss of interest/pleasure. The symptoms are as follows: (a) depressed mood; (b) markedly diminished interest or pleasure in all, or almost all, activities most of the day; (c) significant weight loss or weight gain when not dieting; (d) insomnia or hypersomnia nearly everyday; (e) psychomotor agitation or retardation nearly every day; (f) fatigue or

loss of energy every day; (g) feelings of worthlessness or excessive or inappropriate guilt; (h) diminished ability to think or concentrate, or indecisiveness, nearly everyday; (i) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a specific plan for committing suicide (pp. 222-223). Thus, there are relatively specific and objective criteria for depression which are designed to increase the consistency and reliability of diagnosis across practitioners (American Psychiatric Association, 1987). The *DSM-III Diagnostic and Statistical Manual of Mental Disorders* (Third edition, American Psychiatric Association, 1980) (*DSM-III*) diagnostic category of major depression from which these criteria are derived had a relatively high demonstrated interrater reliability ranging from .62 to .75 (American Psychiatric Association, 1987; Spitzer, Forman, & Nee, 1979; Lieberman & Baker, 1985).

Two separate reviews concluded that women are over-represented among depressives both in the general population and in psychiatric settings (Nolen-Hoeksema, 1987; Weissman & Klerman, 1977). Specifically, more than a decade ago, Weissman and Klerman (1977) reviewed studies presenting epidemiological data regarding depressive mood disorders for the prior forty years. They relied on four sources of data: (a) clinical observations of people entering treatment, (b) community surveys of nontreatment populations, (c) studies of suicide and suicide attempters, and (d) investigations of grief and bereavement reactions. They concluded that in the United States (U.S.), a 2:1 ratio of female to male depressives was a reliable estimate, and that in most other

countries, more women than men were diagnosed depressed. The exceptions were India, Iraq, New Guinea, Rhodesia, Finland and Norway. Although men may be more likely to complete suicide, women are twice as likely to attempt it (Weissman & Klerman, 1977). When examining studies of depression resulting from bereavement (grief), few sex differences were found. This review suggested that the unequal sex ratio seems to be robust and to exist in many different cultures.

Nolen-Hoeksema (1987) also did an extensive literature review of epidemiological data for depression. This review relied on data from treated cases of depression and community surveys. Inclusion criteria included: a) utilization of standardized assessment procedures (such as instruments and classification systems), b) large sample sizes (greater than 50), c) reliance on random selection, and d) separation of unipolar from bipolar depression. Evidence suggested an overall ratio across all studies of 1.95:1. That is, almost twice as many women as men had been diagnosed with depression. Studies conducted outside the U.S. revealed a mean ratio of 2.39:1 (women to men) while community surveys in the U.s. found a mean ratio of 1.65:1. Four subgroups in American studies did not reveal this sex ratio: Old Order Amish, university students, bereaved adults, and the elderly. General population studies of depression conducted outside the U.S. resulted in a mean ratio of 2.08:1. However, rural and nonmodern areas of Iran and Nigeria did not indicate a significant sex difference. Generally, Nolen-Hoeksema (1987) reached the same two conclusions that Weissman and Klerman (1977) had ten years before: a) sex differences do exist in

psychiatric diagnoses using data from both treatment centers and community surveys, and b) more women than men are diagnosed with depression.

Murphy (1986) reviewed four longitudinal studies that spanned the third quarter of this century (i.e., approximately 1950-1975). Two of the studies were conducted in the U.S., one was in Sweden and one was in Canada. In terms of methodology, two studies involved cohort follow-up (U.S. and Sweden), and two were repeated cross-sectional studies (Canada and U.S.). Although, there was some variation in diagnostic procedures, the four studies shared a similar methodology in that they asked participants about anxiety and depressive symptoms. Generally, the results revealed that women reported affective symptoms more frequently than men at the mid-century mark (1950). Three of the four studies found that women's increased reporting of affective symptoms persisted into the end of the third quarter (1975). In addition, these three studies found that men's rate and reporting of affective symptoms had increased over the 25 year span and more closely approximated women's in some or all age groups by the end of that time. One study found that middle-aged women's rates were falling and that middle-aged men's did not rise or fall. In sum, there is some evidence that the base rates for depression may be changing slightly to reflect less of a sex discrepancy.

Several hypotheses have been posited to explain sex differences in depression (Nolen-Hoeksema, 1987; Weissman & Klerman, 1977). These include biological, psychological, psychosocial, sociological and artifactual. Biological

explanations in terms of genetics and endocrine levels are
not consistently substantiated (Nolen-Hoeksema, 1987;
Weissman, 1980; Weissman & Klerman, 1987). A psychoanalytic
perspective based on the hypothesis that women's inadequate
resolution of the Oedipal complex predisposes them to
depression is primarily theoretical and has not been
adequately investigated by research (Nolen-Hoeksema, 1987).
Some psychosocial explanations which also need further
investigation include the following: a) propositions that
the disadvantaged, lower socioeconomic status of women in
society may cause more psychological distress, and/or b) that
women may develop "learned helplessness" due to the passive,
subservient stereotyped female role (Weissman, 1987; Weissman
& Klerman, 1980). These are controversial hypotheses and are
not likely to account fully for the consistently reported
differences (Nolen-Hoeksema, 1987; Weissman, 1980; Weissman &
Klerman, 1987). Sex-role explanations have argued that
women's greater emphasis on relationships in addition to
societal undervaluing of the traditional feminine role make
women more vulnerable to depression. The evidence supporting
this hypothesis is mixed and inconclusive (Nolen-Hoeksema,
1987). A related artifactual explanation is that men and
women express feelings of depression differently. Thus, men
are more likely to "act out" with such antisocial behaviors
as drug and alcohol abuse and women respond passively with
sadness and crying (Nolen-Hoeksema, 1987; Weissman & Klerman,
1987). Nolen-Hoeksema (1987) argued that women are
socialized to deal with depression through passive and
introspective ways that increase depression while men are

socialized to respond to affective distress by a distracting activity which tends to lessen depression. Other artifactual hypotheses that have not been consistently supported by research included the following: (a) women have more stressful life events; (b) women are more likely to perceive events as stressful; (c) women report more symptoms; and (d) women have a more frequent help-seeking pattern (Nolen-Hoeksema, 1987; Weissman, 1980; Weissman & Klerman, 1980; Weissman & Klerman, 1987). Weissman & Klerman (1987) and Nolen-Hoeksema (1987) concluded that there is insufficient evidence to suggest that substance abuse and depression are different manifestations of the same disorder or that this factor could sufficiently explain the sex differences.

In summary, there is consistent evidence that sex differences in reported prevalence rates of depression for women and men exist. None of the previously posited explanations including artifactual, psychological, psychosocial, biological and sociological explanations have been shown to explain this difference fully. It seems likely that a complex interaction of these factors accounts for the sex differences in epidemiology of depression (Weissman & Klerman, 1987). Longitudinal studies further suggest that gender differences may be narrowing and that base rates may be gradually changing over time. These data suggest that sex-role expectations and epidemiological base rates are equivalent for the diagnosis of depression. However, it is still not clear to what extent artifactual factors, such as clinician sex-stereotyped expectations, may influence diagnosis, and subsequently, base rates (Fernbach, Winstead &

Derlega, 1989).

Gender Differences in Alcohol Dependence. Alcoholism

and substance abuse have recently drawn increased public

attention. In a review of the Epidemiological Catchment Area

Surveys (ECA), Zucker (1986) concluded that, based on *DSM-III*

criteria, substance abuse is the most common diagnostic

category (16.7% lifetime prevalence). He concluded that

approximately 40% of all psychiatric difficulties are

alcohol-related. Thus, it seems that alcohol and substance

abuse warrant attention as prominent mental health concerns.

The *DSM-III-R* differentiates between psychoactive

substance dependence and substance abuse, and more

specifically differentiates the diagnoses of alcohol

dependence and alcohol abuse. Of the two disorders, alcohol

dependence reflects a more chronic and severe disorder. The

diagnostic criteria for psychoactive (alcohol) dependence

includes at least three of the following symptoms: (a)

substance often taken in large amounts or over a longer

period than the person intended; (b) persistent desire or one

or more unsuccessful efforts to cut down or control substance

use; (c) a great deal of time spent in activities necessary

to get the substance, taking the substance or recovering from

its effects; (d) frequent intoxication or withdrawal symptoms

when expected to fulfill major role obligations at work,

school or home; (e) important social, occupational, or

recreational activities given-up or reduced because of

substance abuse; (f) continued substance use despite

knowledge of having a persistent or recurrent social,

psychological or physical problem that is caused by or

exacerbated by the use of the substance; (g) marked tolerance, need for increased amounts of the substance (i.e., 50%) in order to achieve intoxication or the desired effect with continued use of the same amount; (h) characteristic withdrawal symptoms; and (i) substance often taken to avoid withdrawal symptoms (American Psychiatric Association, 1987, pp. 167-168). In addition, these symptoms must have persisted for at least one month or have occurred repeatedly over a longer period of time (American Psychiatric Association, 1987, pp. 167-168). The *DSM-III* diagnostic category of alcohol dependence from which these criteria are derived had a relatively high interrater reliability, ranging from .74 to .90 (American Psychiatric Association, 1987; Spitzer, et al. 1979; Lieberman & Baker, 1985).

It is well-established that men are over-represented in the prevalence of cases of alcohol abuse and dependence (American Psychiatric Association, 1987; Boyd et al., 1984; Corrigan, 1985; Gomberg, 1980; Myers, et al., 1984; Robins et al., 1984; Zucker, 1986). However, the exact male to female ratio has been found to vary depending on the source of the data and can range from 1:1 when data comes from physicians in private practice, to 9:1 from community treatment centers in Iowa (Corrigan, 1985; Gomberg, 1980; Jones & Helrich cited in Gomberg, 1980; Mulford, 1977). In general, a 4-5:1 (male to female) sex ratio is supported by research (American Psychiatric Association, 1987; Calahan, Cisin, & Crossley, 1969; Corrigan, 1980).

Some studies have shown that the margin of difference in alcohol use between the sexes has narrowed for some age

groups and may be continuing to decline (Calahan et al., 1969; Corrigan, 1980; Gomberg, 1980; Zucker, 1986). Calahan, Cisin and Crossly (1969) indicated that the percentage of alcohol users has risen for both sexes from 75% to 77% in men and from 56% to 60% in women. Corrigan (1980) also argued that the ratio of male to female alcohol abusers is likely to be closer to 4:1, reflecting an increase in alcohol abusers among women. In a 1981 survey, Wilsnack, Wilsnack and Klaussen (1986) concluded that, although there were no dramatic increases in drinking or heavy drinking among women between 1971 and 1981, the percentage of women ages 35-49 who were heavy drinkers rose by 4%. They also concluded that "young women aged 21-34, never-married and divorced or separated women, unemployed women seeking work and women cohabitating with quasi-marital partners" (p. 97) were at an increased risk for "becoming heavy drinkers and/or developing drinking problems." (p. 97). In fact, this survey suggested that both men and women aged 21-34 were "most likely to report drinking problems, alcohol dependence symptoms and episodes of heavy drinking and intoxication" (p. 104).

Fillmore (1984) conducted a female respondent cohort analysis for five cohorts born between the years of 1905 and 1935. This analysis was based on data from three surveys: (a) a survey conducted in 1964; (b) a 1967 follow-up survey; and (c) a separate 1979 survey. Fillmore (1984) concluded that

> possibly major changes are currently taking place among younger cohorts as they age—heavy-frequent drinking is more common in the younger age groups as compared to the older cohorts measured at the same age. (p. 29)

The results of these studies indicate that the gap between the sexes in terms of alcohol use is narrowing.

Some studies have identified differences between male and female alcoholics in terms of drinking patterns, family history, psychosocial factors and alcohol-related problems (Bromett & Moos, 1976; Gomberg, 1974; Pinhas, 1987). However, a more recent study by Windle and Miller (1989) found few differences between men and women convicted of driving while intoxicated (DWI) in terms of demographics, alcohol use or related problems. However, the disproportionate number of men (425:36) and Caucasians make the results difficult to generalize. In an investigation of psychosocial correlates for men and women with alcohol abuse and familial alcoholism, Glenn and Parsons (1989) also found few gender differences. Specifically, they found few differences across the following variables: (a) family of origin; (b) childhood attention, conduct and learning disorders; (c) psychological variables (anxiety and depression); (d) peers and family of procreation; (e) sociocultural and community variables. They concluded that "the factors of alcoholism and family history seem to operate in a similar fashion for male and female populations" (p. 125). Similar to the results of epidemiological data, studies of the psychosocial correlates of alcohol abuse and dependence for men and women suggest that previously existing gender differences may be declining.

Some explanations for the decreasing, though still existing, gender differences in epidemiology, diagnosis, alcohol use patterns and psychosocial correlates of alcohol

dependence can be proposed. Biological evidence suggested that, since women have larger amounts of body fat, they are unable to drink equal quantities as compared to men with the same body weight (Corrigan, 1985). Thus, women have to drink less to become intoxicated and may combine prescription drugs with alcohol (Blankfield, 1989; Corrigan, 1985). If women drink less to achieve intoxication, then current diagnostic "thresholds" of alcohol consumption may not be appropriate for women. Also, there is increasing social acceptability of alcohol use by women, particularly in public settings (Fillmore, 1984; Gomberg, 1974; Gomberg, 1980). However, as Gomberg (1974) noted in her review of the literature, societal tolerance of drunkenness and intoxication in women may continue to be restrictive. Therefore, the settings in which women feel comfortable drinking excessively may have resulted in the traditional stereotype of women drinking at home and alone (Corrigan, 1980; Gomberg, 1980). Related to this explanation is that women tend to use more mind-altering prescription drugs such as barbiturates, mild tranquilizers, antidepressants and other hypnotic drugs than men (Corrigan, 1980; Corrigan, 1985; Gomberg, 1974; Gomberg, 1980). These prescription drugs are more socially sanctioned, and therefore, do not require women to step outside the "traditional" feminine role (Corrigan, 1980; Corrigan, 1985; Gomberg, 1974). A final hypothesis is that clinicians may be influenced by sex-stereotyped expectations and may overlook clues for alcohol abuse and dependence in women because female alcoholics are crossing culturally-influenced, sex-role expectations.

Alcoholism and Depression. The relationship between alcoholism and depression for both sexes is complex, and there is evidence that the two disorders often coexist (Corrigan, 1980; Petty & Nassorlah, 1981; Schuckit, 1979; Weissman & Klerman, 1979; Weissman & Klerman, 1987; Windle & Miller, 1989; Winokur, 1979; Woodruff, Guze, Clayton & Carr, 1979; Zucker, 1986). Tyndel (1974) found that 35% of alcoholics had a history of serious depressive symptoms. Winokur (1972) found that 53% of patients diagnosed as alcoholic had secondary depression. Also, several studies have found evidence indicating that alcoholism and depression occur in the same families (Winokur, 1979; Schuckit, 1979). In addition, there has been a recent focus of research on individuals who present with a "dual diagnosis" of alcoholism and another major psychiatric disorder (such as affective disorders and personality disorders) and related treatment issues (Mirin, Weiss, & Michael, 1988; Mulinski, 1989).

Windle and Miller (1989) made a comparison between their convicted DWI sample and Moos et al.'s (cited in Windle & Miller, 1989) clinically depressed and community adult samples for depression. They found that the DWI sample had a higher rate of depression than the community sample but lower than the clinically depressed sample. Their study provided some evidence suggesting that the more severe the alcohol problem, the more severe the depression. Glenn and Parsons (1989) also found that their alcohol-dependent sample had more anxiety and depressive symptomatology than their control sample.

It has been proposed that depression may be underdiagnosed in men and, as stated earlier, it seems reasonable to propose that alcohol dependence could be underdiagnosed in women (Corrigan, 1980; Gomberg, 1979; Schuckit, 1979 Weissman, 1980; Winokur, 1979). Corrigan (1980) indicated that "depression was the paramount illness as women entered treatment [for alcoholism]" and that

> a review of the symptoms in a classic psychiatric
> sense could easily lead to a diagnosis of
> depression because many [women alcoholics] are
> isolated from friends, have difficulty sleeping,
> have strong feelings of hopelessness and show poor
> concentration. (p. 164)

She warned that this may result in misdiagnosis since "it seems clear that depressive symptoms in reality oftentimes mask alcoholism, which is the primary illness" (p. 164). Thus, there seems to be some evidence that depression and alcoholism coexist in women.

Wilsnack et al. (1986) concluded that inquiring about women's current level of drinking during depression might be misleading and that there is a need to ask about lifetime experience with excessive drinking. The results of a path analysis which attempted to discern possible etiological factors in women's drinking patterns found that prior depression increased the chance that women drinkers would develop symptoms of alcohol dependence. In particular, they found that young women drinkers were more likely to have depression and anxiety that triggered a reliance on alcohol.

Some have suggested that, as with the prevalence of depression in the general population, depression is likely to be more prevalent for women with alcohol dependence than men with alcohol dependence (Goodwin, 1979; Weissman et al.,

1977). Surprisingly, some studies have suggested that comparable rates of depressive symptoms exist for males and females with alcohol dependence (Bromett & Moos, 1976; Glenn & Parson, 1989; Windle & Miller, 1989). Specifically, Bromett and Moos (1976) compared married and unmarried men and women alcoholics that had just completed a residential alcohol program. They did not find any significant main effects for sex differences in depression or anxiety.

Glenn and Parsons (1989) compared a relatively equal sample of men and women alcoholics that had just completed treatment and did not find any sex differences between the male and female alcoholics in anxiety or depression. Although Windle and Miller (1989) found that women who were alcohol dependent had higher rates of depressive symptoms than alcohol dependent men, both groups had significant depressive symptoms. Taken together, these studies suggest that there may be relatively equal numbers of men and women with coexisting alcohol dependence and depression. Consequently, in the same way that depression may mask alcoholism in women, alcoholism may mask depression in men. That is, clinicians may tend to expect similar base rates of depression for this sub-population as for the general population; however, this assumption would result in neglect of depression in men with alcohol dependence. In fact, in an analysis of the National Ambulatory Medical Care Survey data, Hoffman (1989) found that physicians tended to underdiagnose alcohol dependence and depression in both men and women.

In summary, studies on epidemiology for alcohol dependence and depression are prone to certain methodological

difficulties such as inconsistent diagnostic definitions of
alcoholism, alcohol dependence, alcohol abuse and depression;
thus, making comparisons across studies hazardous.
Nonetheless, despite these potentially biasing factors,
relatively consistent data suggest that depression and
alcohol dependence often coexist for both males and females.
Therefore, clinicians are likely to be encountering men and
women who display a combination of depressive and alcohol
dependence symptoms and fail to recognize both aspects of the
clinical picture.

## Sex Stereotypes and Mental Health

Since the advent of the women's movement there has been
increased concern about the influence of sex stereotypes on
diagnosis and treatment of men and women by mental health
professionals (American Psychological Association, 1975;
Broverman, et al., 1970). Some evidence has suggested that
women and men may be treated differently due to different
sex-role expectations by clinicians (Broverman et al., 1977;
Fabrikant, 1974).

The landmark study by Broverman, Broverman, Clarkson,
Rosenkrantz and Vogel (1977) supported contemporary concerns
about women's differential treatment with their findings that
clinicians had double standards for men and women in terms of
mental health. They presented 79 clinicians (46 men and 33
women) with the Stereotype Questionnaire consisting of 122
bipolar adjectives. Each clinician was given one of three
sets of instructions that asked them to identify which
adjective of the two would most closely describe the
following: a) a mature, mentally healthy man; b) a mature,

mentally healthy woman; or c) a mature, mentally healthy adult. These authors found that the clinicians' ideas of a healthy man and a healthy adult were the same while their standards for a healthy woman were different. Thus, according to these standards, a woman could not be both a healthy adult and a healthy woman. This study, then, reinforced the concerns of some mental health professionals that women in therapy were being encouraged to conform to sex-role stereotypes (Broverman et al., 1970; Sturdivant, 1980).

Fabrikant (1974), in a partial replication of Broverman et al. (1970), asked psychotherapists to respond to an adjective check list that described sex-role characteristics which may apply to a male or a female. Both male and female therapists used the following adjectives to describe the male: aggressive, assertive, bold, and independent. They also agreed that the adjectives describing women included chatterer, dependent, dizzy, domestic, overemotional, passive and virtuous. Both male and female therapists rated the male characteristics as more positive while the female characteristics were considered more negative. Thus, these results were consistent with Broverman et al.'s (1970) prior results. In one component of a second study with slightly different methodology, Fabrikant asked 25 male and 25 female therapists to respond to a list of questions and a shortened list of adjectives describing sex-role traits. Thirty-one therapists responded (12 female and 19 male). The researchers found that several of the "positive" characteristics had changed from being considered primarily

male to being equal for both sexes, and some of the "negative" adjectives were no longer considered primarily female but were equal for both sexes. Interestingly, this study revealed that therapists' sex-role views were changing somewhat. They found that both sexes were viewed as capable of assertiveness and nurturance (which had previously been ascribed to males and females, respectively). However, this study also revealed the continued influence of sex-stereotypes in the therapists' ratings of male characteristics as being more "positive" while typically female characteristics were seen as more "negative".

These concerns were also supported by The Task Force on Sex Bias and Sex Stereotypes' (1978) survey of 320 female psychologists. This survey inquired about the psychologists' experiences with their own therapists in the following areas: (a) fostering traditional sex roles; (b) bias in expectations and devaluations of women; (c) sexist use of psychoanalytic concepts; and (d) responding to women as sex objects (American Psychological Association, 1975). The reports from these psychologists suggested that clinicians foster traditional sex roles, have biased expectations for women, devalue women by encouraging dependence and passivity in therapy, and respond to women as sex objects.

In a review of the literature investigating the influence of patient variables on clinical judgement, Abramowitz and Dokecki (1977) concluded that the analogue studies (primarily focused on diagnostic and prognostic decisions) failed to reveal consistent gender differences in clinicians' judgement, while the archival data did find

gender differences. They proposed that the lack of evidence in analogue data is due to clinician reactivity to concerns of being considered discriminatory. These authors stressed the importance of developing new and less transparent methodology.

Smith (1980) also reviewed studies addressing the question of whether client gender influences counselor judgement and treatment in a sex-stereotyped and biased manner. Her review found that the studies investigating the presence of sex-role stereotyping by clinicians have mixed results. Her review of 14 analogue studies and one archival study suggested that the results are inconclusive about the presence of gender bias. Smith (1980) found that some cases reflected bias for women rather than against them. However, the analogue studies Smith (1980) reviewed are also subject to the criticism of transparent methodology and social desirability bias.

Davidson and Abramowitz (1980) reviewed 14 analogue studies conducted since 1977 assessing client gender effect on clinical judgement (Abramowitz & Dokecki, 1977). These studies also consistently reflected negative results which they attributed to methodological confounds including transparency and social desirability. They proposed that researchers turn to archival and naturalistic studies to address the issue of bias in clinical processes and to avoid the methodological problems.

Sherman (1980) reviewed 16 studies investigating sex-role stereotyping of mental health standards. She concluded that only one of the 15 studies conducted in North America

revealed no sex-stereotyping. Twelve of the 16 studies
suggested that sex-role stereotyping does exist, and only
four studies found no evidence of sex-role stereotyping in
judgements of mental health. Overall, the results indicated
that sex-role stereotyping by clinicians does occur.
However, stereotyping does not occur in all situations, and
it is manifested in degrees more than an absolute, either/or
occurrence (Sherman, 1980). She also reviewed eight
counseling analogue studies and concluded that the five most
methodologically sound studies revealed evidence of sex-
stereotyping. In her review of 16 clinical analogue therapy
studies investigating sex-role stereotyping, she reached
similar conclusions. Nine of these studies strongly and
consistently revealed sex-role stereotyping while the other
seven were "unclear and/or negative" (p. 57). Sherman
concluded that sex-role stereotyping of mental health
standards does exist. She stressed the distinction, which is
not made in all studies, that sex-stereotyping may occur and
yet not be manifested in clinical judgements of increased
severity, poorer prognosis or diagnosis. She concluded that
under "controlled" analogue conditions, clinical judgements
of women are not necessarily more severe than their male
counterparts. Sherman also pointed to methodological
problems across studies in this area, particularly in terms
of inconsistent conceptualization of variables and the lack
of attempts to validate the effectiveness of the experimental
manipulation.

Much controversy appears to exist regarding the question
of whether clinicians engage in sex-role stereotyping and its

subsequent influence on clinical judgements. Overall, the data seem to suggest that clinicians have sex-role stereotyped standards of mental health (Broverman et al., 1970; Fabrikant, 1974, Sherman, 1980). What is not clear is whether these sex-role expectations are manifested in clinical judgements of diagnosis, prognosis and treatment recommendations (Abramowitz and Dokecki, 1977; Davidson and Abramowitz, 1980; Sherman, 1980; Smith, 1980). In addition, several reviewers have raised methodological concerns about the validity of results from analogue studies investigating these questions due to their vulnerability to social desirability influences of the clinicians and the lack of validation regarding the transparency of the experimental manipulation (Abramowitz and Dokecki, 1977; Davidson and Abramowitz, 1980; Sherman, 1980).

In an overview of the literature, Barak and Fisher (1989) reviewed studies specifically related to gender bias and explored conceptual and methodological concerns. These authors focused on the lack of consistency across studies in the definitions of "gender bias" versus "gender role bias". They suggested reliance on Betz and Fitzgerald's (cited in Barak & Fisher, 1989) definitions that are as follows: (a) Gender bias is "any set of attitudes and/or behaviors which favor one sex over the other" (p. 83), and (b) gender role bias is "any set of attitudes or behaviors which favors sex-role congruent behavior and negatively evaluates sex-role incongruent behavior" (p. 83). Barak and Fisher (1989) also proposed adding a new category called

    gender effects, which refers to any set of
    attitudes or behaviors that affect the genders

> differently, without the implicit or explicit
> intent of favoritism or discrimination on the
> part of the individual who holds the attitudes
> or practices the behavior.   (p. 378)

They indicated that inconsistent variable conceptualization and definition across studies makes comparisons difficult. The methodological concerns they raised included unrepresentative samples, inappropriate instruments, highly selective reviews of the literature, counselor social desirability, and over-reliance on analogue studies. They also emphasized that researcher values can have potentially biasing effects on the reporting of findings, on conclusions drawn from research findings and on reviews of the literature. They concluded that, in light of these factors, it is premature to draw conclusions about gender bias in clinicians' judgements.

In a recent review of the literature examining the influence of patient variables on clinical judgement, Lopez (1989) raised some additional concerns. Specifically, he proposed that the definition of bias be expanded to include underdiagnosis as well as overdiagnosis. That is, bias may not only be found in clinicians' overestimating the severity of presenting symptoms and necessary treatment, but bias may also be found in clinicians' neglect of some problem areas for a client. When he re-examined the results of 60 studies with the expanded definition (underdiagnosis and overdiagnosis), he found that the broader definition of bias resulted in twice as many cases indicating bias. His new results revealed that the data equally supported as well as rejected evidence of bias. Lopez (1987) also proposed that variables investigated may need to include some cognitive

processes utilized in clinical judgements such as
attributions, memory, recalling base rates and hypothesis-
testing. Lopez suggested that ambiguous case material may be
more amenable to identifying clinician gender biases. He
expressed concern about social desirability/ transparency in
analogue studies and proposed that this methodology be
improved rather than eliminated. However, it should be noted
that Lopez (1987) conducted his review for several patient
variables including gender, race, social class and many
others. So, gender effects were not separately analyzed but
were integrated into the overall results.

In summary, previous results on the presence of sex-
stereotyping in mental health standards suggest that this
bias does exist but in a matter of degrees. The results are
mixed and inconclusive as to whether and how clinicians sex-
role stereotyped beliefs may affect clinician judgements of
diagnosis, prognosis, and treatment recommendations. Some
methodological concerns about social desirability,
transparency and "manipulation checks" of analogue studies as
well as conceptual concerns of inconsistent definitions have
been raised.

Effect of Client Gender on Diagnosis

Some have proposed that the sex differences in
prevalence rates may reflect gender bias within the
diagnostic criteria and/or the clinicians' sex-stereotyped
use of the criteria (Kaplan, 1983; Warner, 1978, 1979).
Kaplan (1983) proposed that DSM-III diagnoses reflect sex
bias and promote more frequent diagnoses and treatment for
women. Williams & Spitzer (1983), however, stated that

Kaplan's criticism is unfounded, since men are over-
represented in some categories. *DSM-III* Axis II diagnoses
have been subjected to a general criticism of poor
reliability (Mellsop et al., 1982). For some of the Axis II
diagnoses there has been debate about the possibility that
certain diagnostic descriptors reflect caricatures of sex-
stereotyped behaviors (Chodoff, 1982; Lerner, 1974). In
particular, antisocial personality disorder and histrionic
personality disorder have been charged with this criticism
(Ford & Widiger, 1989; Hamilton, et al., 1986; Warner, 1978,
1979). However, the results of two studies have challenged
the caricature hypothesis (Slavney, 1984; Slavney & Chase,
1985). Also, for several personality disorders, including
borderline personality disorder and obsessive-compulsive
personality disorder, it has been argued that clinicians may
be influenced by sex-stereotypes when making diagnoses rather
than relying on a client's presenting symptomatology (Morey &
Ochoa, 1987). Hamilton, Rothbart, and Dawes (1986) suggested
that *DSM-III* diagnoses which rely on trait criteria
(primarily Axis II personality disorders) rather than
behaviorally-anchored criteria (Axis I diagnoses) are more
likely to be influenced by clinicians' gender-based
expectations. According to this hypothesis, when a client
presents with symptoms that are indicative of personality
traits rather than behaviorally-defined criteria, clinicians
may be more influenced by gender-based expectations (or base
rates) in making diagnoses.

Warner (1978) presented 175 clinicians with cases in
which client sex was varied, and the client presented with a

combination of antisocial personality features and hysterical personality features. Clinicians were then asked to choose between one of eight possible diagnoses. He found that the female case vignette was diagnosed hysterical in 76% of the time and antisocial 22%. For the male case vignette, 49% of the time the male was diagnosed hysterical and 41% as antisocial. There were no clinician sex differences. He proposed that, even when presented with identical symptoms, clinicians tended to view males as antisocial and females as hysterical.

Warner (1979) examined the possible effects of client race and sex on clinician diagnoses. He presented 173 therapists with hypothetical patients in which race (Chicano versus Caucasian) and sex were varied. In addition, the diagnostic symptoms were ambiguous and suggested antisocial or hysterical personality disorders. He concluded that the data found hysterical personality and antisocial personality to be "sex-biased diagnoses" (p. 303). Warner found that men were more likely to be diagnosed antisocial personality disorder and women were more likely to be diagnosed hysterical personality disorder even when the symptoms were the same. An alternative explanation to his proposal that the criteria are sex-biased is to suggest that when clinicians were presented with ambiguous symptomatology reflecting trait-based characteristics, gender influenced their decision more than presenting symptomatology.

Hamilton, Rothbart, and Dawes (1986) asked 65 psychologists to diagnose 18 case histories from ten possible DSM-III diagnoses. Two forms (varied by sex) of ten cases

were created which presented varying levels of combined antisocial personality and histrionic personality symptomatology. They found that the female case histories were more likely to be diagnosed histrionic than the male cases displaying the same symptoms. However, there was no client gender effect for the antisocial personality features. Clinician gender did not affect differences in diagnoses. They proposed that antisocial criteria are "behavioral" descriptors and histrionic criteria are more trait-based. These authors also suggested that vague descriptors may lead to sex bias in diagnosis.

Ford and Widiger (1989) suggested that base-rate effects should be less influential when a given case symptomatology is unambiguous for a certain diagnosis. They proposed that

> if sex differences in diagnosis are due to base rates, then the effect of sex should be more evident when the diagnosis is ambiguous than when the patient meets the criteria for the disorder. (p. 302)

However, their results found that, even with the least ambiguous case stimuli (in which male and female cases presented with symptoms of histrionic versus antisocial personality disorder), the sex of the patient influenced clinical decisions. Specifically, subjects diagnosed women as histrionic and not antisocial even when the symptoms were more clearly antisocial. There was also a tendency to do the reverse for the male, but the effect was more pronounced in the female cases. Thus, for these two diagnoses, Ford & Widiger (1989) found that client gender had a greater influence than ambiguity of case symptoms. So, this finding refutes the hypothesis that reliance on base rates is a

sufficient explanation for these diagnostic differences.
Client gender was an overriding factor even when base rates
were not necessary in light of all of the available
information.

With the exception of a study on somatization disorder
(Fernbach, 1984; Fernbach, Winstead & Derlega, 1989), no
analogue studies were found that attempted to investigate
whether a client's gender may influence therapeutic and
diagnostic decisions more than presenting complaints for
other Axis I diagnoses.  Perhaps, as proposed by Hamilton et
al. (1986), one explanation for the lack of attention to sex
ratio discrepancies in Axis I diagnoses is that they are
considered more objective, more specific, and less vulnerable
to the influence of clinician subjectivity.

Fernbach, Winstead and Derlega (1989, Fernbach, 1984)
presented case vignettes to 455 clinicians enrolled in the
Virginia State Board of Medicine's Roster of Practitioners of
Healing Arts, 1982-1983 and 49 clinicians listed in the
Maryland Psychological Association 1982 Membership Directory.
Analyses were run with a total of 119 completed
questionnaires.  This study investigated several aspects of
clinician judgement including diagnosis, recommendations for
treatment, and prognosis.  The clinicians were presented with
unambiguous stimuli of male and female clients with symptoms
for somatization disorder and antisocial personality
disorder.  They found that, when the case symptoms were
relatively unambiguous, the diagnosis of somatization
disorder was not significantly influenced by patient sex.
However, the case vignette with the diagnosis of antisocial

personality disorder was affected by gender. That is, when a male and a female client presented with the same symptoms of antisocial personality disorder, the male was more likely to be diagnosed antisocial. They proposed that the more specific and objective criteria for somatization disorder may account for the lack of a gender effect. They also suggested two hypotheses to explain the gender effect of antisocial personality disorder: (a) Clinicians may rely on base rates and diagnose it more frequently in men, and (b) clinicians are influenced by sex-role expectations of men to manifest problems behaviorally while women are expected to have "emotional problems." Thus, in this study, the case presented unambiguous symptoms that reflected more objective criteria (*DSM-III* Axis I somatization disorder) were not influenced by client gender, and base rates were not needed. However, for the disorder that utilized more subjective criteria (antisocial personality), gender-based expectancies (base rate or sex role) may have had a significant influence. Fernbach et al. (1989) also noted that "base rates and sex-stereotypes are not independent" (p. 248). They went on to state that base rates are determined from clinicians' diagnoses which are likely influenced by sex-role expectations. Thus, when sex-role stereotypes are equivalent to base rates, decisions based on this information may be rationalized as sound judgement rather than bias (Fernbach et al., 1989).

In summary, prior analogue research has focused on Axis II diagnoses in investigating possible reasons for the gender differences in diagnoses. However, despite specific and

unambiguous criteria, clinician sex-stereotyped expectations may influence clinician judgements (Ford & Widiger, 1989). Also, as suggested by Fernbach et al. (1989), base rates and sex-stereotyped decisions are interdependent for some diagnoses, so relying on a base rate explanation for sex differences in diagnoses is not necessarily unrelated to sex stereotypes. This position is supported by Locksley, Hepburn and Ortiz (1982) who stressed the similarity between social stereotypes and base rates from a cognitive processing perspective. They defined social stereotypes as "beliefs that various traits or actions are characteristics of particular social groups" (p. 23). Locksley et al. (1982) also proposed that social stereotypes may "behave like" base rate information in terms of individual judgements. Specifically, similar to base rates, stereotyped beliefs should be abandoned when presented with specific information about an individual (Locksley et al., 1982).

As discussed earlier, two Axis I diagnoses that have disproportionate sex ratios are major depression and alcohol dependence (American Psychiatric Association, 1987; Gomberg, 1979; Nolen-Hoeksema, 1987; Weissman & Klerman, 1977; Zucker, 1986). In addition, previous discussions have indicated that these disorders often coexist (Corrigan, 1980; Zucker, 1986). However, no studies were found that attempted to investigate the possible influence of client gender on therapists' interviewing priorities, diagnoses, or treatment planning with the diagnostic categories of depression and alcohol dependence. It is hypothesized that, consistent with sex-stereotyped expectations, when a clinician is presented with

ambiguous symptoms which reflect behaviorally-anchored criteria, clinicians rely on sex-stereotyped expectations rather than case specific information. That is, when a male and a female present with a combination of the same Axis I symptoms (depression and alcohol dependence), clinicians will rely on sex-stereotyped expectations and will underdiagnose depression in men while underdiagnosing alcohol dependence in women.

## Effect of Client Gender on Clinician Recall

In addition to investigating whether a client's biological sex is a primary factor in the final outcome of a clinician's diagnostic decision-making process, a few studies have attempted to explore whether client variables such as gender, ethnicity and sexual orientation influence a therapist's recall of client presenting information (Buzcek, 1981; Buzcek, 1986; Casas, Brady & Ponteratto, 1983; Wampold, Casas, & Atkinson, 1981). Few studies have investigated the possible influence of client sex on earlier stages of information-processing (before the final stage of the decision-making process where social desirability factors may be an influence.) Therefore, variables that need to be examined are clinician memory functions in retrieval of client information (recall) and storage of client information (recognition).

Only one study was found (Buzcek, 1981) which examined the potential effect of client gender on clinician recall of the client's presenting problems. Buzcek (1981) presented 89 internship-level trainees in clinical psychology with an audiotape of a bogus client presenting with symptoms of

depression, anxiety and loss of energy. During a mock initial interview, the client also presented 24 social facts, 24 vocational facts, and 72 general facts. The clinicians were then given guidelines and ten minutes to write down as many facts (not inferences) about the client as they could recall. In addition to the recall task, these therapists were involved in tasks of recognizing client information, evaluating the importance of background facts in treatment planning, generating additional questions, and generating hypotheses regarding the etiology of the client's problems. Raters coded the responses into one of three categories: general, social or vocational. In terms of recall, Buzcek found the results were contrary to the hypotheses. Specifically, clinicians correctly recalled more vocational information for the female than the male client. However, they tended to recall fewer concerns for the female client overall. A methodological concern in this study was the use of a female interviewer with both the male and female client presentations, and there were no comparable case presentations with a male interviewer. Thus, the possible influence of the interaction between interviewer sex and client sex could not be addressed.

Buzcek (1986) conducted a similar study with college undergraduates to determine whether her previous findings would hold true for a non-clinician population. She also corrected for the previous methodological concerns by developing two additional tapes using a male interviewer. Other than the addition of the two tapes, the procedure was identical to the previous study. Buzcek found similar

patterns of results between these undergraduates and the
counselors. That is, as with the previous studies, no
evidence suggested sex-role stereotyping of information
recalled by the students (i.e., more vocational for the male
clients and more social/domestic for the female). Consistent
with the results of the previous study, this study revealed a
significant difference in the overall recall. For male and
female therapists, fewer facts were recalled for the female
client as compared to the male. Interestingly, this study
found an interaction effect with more vocational facts being
recalled when the interviewer was female (which was the
procedure during the first study). This methodological
factor could account for the first study's findings of
greater recall for vocational concerns for the female client.
In this study, as with the counselor study, no significant
results were found for the recognition task, thus suggesting
that the recall task may be more sensitive to the influence
of client gender effects.

The scant research on the influence of client gender on
clinician recall suggested that no sex-stereotyped
categorical differences would be expected. However, these
data did indicate that it would be reasonable to hypothesize
that, overall, fewer concerns for the female client would be
recalled than for the male client. It is important to
continue investigating the influence of client gender on
clinicians' recall since this measure seems to be less
subject to social desirability influences and because recall
of fewer concerns for a client may lead to underdiagnosis
(Buzcek, 1986; Lopez, 1989).

## Effect of Client Gender on Attributions of Etiology

Another variable in clinical judgement that is potentially vulnerable to gender effects is a clinician's attribution of etiology. That is, when clients of both sexes present with similar concerns, clinicians may tend to make different attributions about the factors underlying their presenting symptoms. This aspect of clinical judgement and information processing would likely have wide ramifications in terms of influencing the questions generated during an initial interview as well as treatment planning.

Few studies have investigated the influence of client gender on clinicians' attributional hypotheses of etiology (American Psychological Association, 1975; Bowman, 1982; Fisher, 1989; Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice, 1978). Although they will not be reviewed extensively here, studies with non-clinicians have shown that gender may affect the types of attributions that are made in judging behaviors (Deaux, 1976; Deaux & Emswiller, 1974). Specifically, these studies have shown that when a male succeeds, his success is attributed to an internal and stable ability while a woman's success is attributed to unstable factors such as luck (Deaux, 1976). Also, both male and female observers tended to view men as being more responsible for positive outcomes while negative outcomes were attributed to situational factors, and the reverse was true for women (Deaux & Emswiller, 1974). The results of the few studies with clinicians were consistent with these results.

The Task Force on Sex Bias and Sex Role Stereotyping in

Psychotherapeutic Practice indicated that therapists may tend to attribute female clients' presenting problems to internal, psychodynamic factors more than to external factors (which is consistent with the results of studies with nonclinicians) (Deaux, 1976; Deaux & Emswiller, 1974). However, this survey was limited by the absence of a comparison sample of male clients.

Bowman (1982) presented clinicians with a male or female case history of a client who was career-oriented and had a high level of activity (stereotypically male characteristics). Clinicians attributed the male client's problems to an inability to deal with anger. However, the female client presenting with the same concerns was thought to have underlying conflicts of sexual identity and dominance in marriage.

Fisher (1989) investigated therapists' and their patients' causal explanations about the patients' presenting problems and the progress in therapy. Thirty-nine therapists of various disciplines and experience levels (19 women and 20 men) working at the Institute of Psychiatry at Northwestern Medical Center were included in the sample. They were asked to describe their beliefs about why their patients were having their specific problems, as well as to discuss any problems in developing a therapeutic alliance and their explanations of these difficulties. Raters coded the clinicians' responses according to a standardized approach, the CAVE technique (Content Analysis of Verbatim Explanations). This study found that during the initial session, therapists' causal explanations were not

significantly different for the male and female patients. However, they found trends suggesting that male and female therapists tended to perceive female clients' problems as persisting into the future (suggesting that their problems were not situational but were more stable and enduring).

In summary, there is limited research examining clinicians' causal attributions of client presenting problems. However, studies with nonclinicians suggested that observers often attributed males' success to internal, stable abilities and their failures to situational events and the reverse for women. The results of one study with clinicians revealed trends that were consistent with the nonclinician results. Another study also found client gender effects in clinicians' etiological attributions. Based on these findings and sex-stereotyped expectations, it is hypothesized that clinicians will judge the female client as having internal and stable factors underlying her presenting problems while the male client's problems will more likely be attributed to external and situational factors.

Effect of Client Gender on Question Generation

Related to the variable of clinicians' etiological attributions of client problems are the questions that a clinician generates during an initial interview. During an interview, there are many possible pathways that an interviewer can explore, and usually, a clinician chooses to explore one path over another based on hypotheses they generate about factors related to a client's presenting concerns. Similar to memory functions and causal attributions, the decision-making process involved in

question generation is often outside conscious awareness and may be subtly affected by client gender effects.

Buzcek (1981) found that male counselors asked the female client more questions related to interpersonal functioning and family relationships. This was found despite the fact that the case stimuli statements of social concerns were the same for both sexes.

Buzcek's study with nonclinicians (1986) found that both male and female undergraduates asked more questions of the social/domestic nature for the female client than the male client.

In conclusion, both of Buzcek's studies (with clinicians and nonclinicians) consistently revealed that more questions of an interpersonal/domestic concern were asked for the female client who presented the same concerns as a male client. This was true only for the male clinicians in the first study although it was true for subjects of both sexes in the second study. Based on these findings, it is hypothesized that when the case presentation includes identical background information for the male and female client, clinicians will ask more social/domestic-related questions of the female clients, and this finding will be greater for the male clinicians.

Effect of Client Gender on Judgement of Prognosis

Several studies have investigated whether a client's gender is a factor that influences clinicians' expectations for improvement and progress in treatment (Abramowitz, Roback, Schwartz, Yasuna, Abramowitz & Gomes, 1976; Feinblatt & Gold, 1976; Fernbach, 1984; Gomes & Abramowitz, 1976;

Hoffman & Noem, 1975; Miller, 1974; Schwartz & Abramowitz, 1975; Stack, Lannon & Miley, 1983; Stearns, Penner & Kimmel, 1980; Zygmond & Denton, 1988). In general, the results of these studies have failed to indicate that client gender consistently influences clinicians' prognostic decisions.

Miller (1974) presented therapists from various disciplines with a case history in which gender was varied, and the client presented with mild depressive symptoms. These clinicians judged the female case history as having a more positive prognosis as compared to the male case history.

Abramowitz, Roback, Schwartz, Yasuna, Abramowitz & Gomes (1976) presented a sample of clinicians from the American Group Psychotherapy Association with a case vignette of either a male or a female outpatient group therapy member. The client was presented as having concerns about sexual performance and with hostile-dependent interpersonal dynamics. The client was also described as tearful and silent during a typical therapy session. This study also found a slight difference in clinicians' ratings of the female patient as having a better prognosis than the male.

Feinblatt and Gold (1976) utilized a sample of graduate students in clinical and school psychology. These subjects read bogus case studies of a child with behavioral problems in which the gender was varied. In this study, the client's gender did not result in significant differences in prognostic judgments. However, the case in which the client presented with counter sex-stereotyped symptoms was judged as more impaired and having poorer prognosis regardless of the gender.

Gomes and Abramowitz (1976) sampled psychologists who were members of the American Psychological Association (APA) and presented them with clinical case histories that varied gender and sex-role "appropriateness" of the clients' traits. The responses of 99 male and 83 female therapists were analyzed. Gomes and Abramowitz found that female vignettes were judged by male clinicians as having a better prognosis than the male version. However, these gender differences did not hold true for the female therapists.

Interestingly, as noted by Fernbach (1984), in both Miller's (1974) and Abramowitz et al.'s (1976) studies, the clients who were judged more poorly in terms of prognosis were the male clients presenting with counter sex-stereotyped symptoms (e.g., depression, tearfulness, and hostile-dependency issues). This was also true for the Feinblatt and Gold (1976) results. This suggests that clients presenting with exclusively counter sex-stereotyped symptoms may be given poorer prognostic expectations by clinicians.

Schwartz and Abramowitz (1975) presented clinicians with case descriptions of clients who had difficulties with depression, somatic concerns, sexual conflicts, and perfectionism. These cases varied race as well as gender. They also analyzed for the clinician variables of traditionalism (as measured by the Traditional Beliefs Scale) and years of experience. No gender differences in prognosis were found. However, there was an interaction effect with more experienced clinicians reporting poorer prognoses for Caucasian women.

Stearns, Penner and Kimmel (1980) presented 86

clinicians with one of eight videotapes in which client sex, case history, occupation, and symptoms were varied. This study also failed to find significant differences in clinician judgements of treatment recommendations and prognosis based on client sex.

Stack, Lannon & Miley (1983) investigated therapists' expectations for rehospitalization for 269 patients (61% female 39% male) who were discharged from a state community mental health center. When the therapists' predicted relapse rates for two years were compared to the actual rates, the results failed to indicate a gender bias in clinicians' expectations.

Zygmond and Denton (1988) investigated the possible influence of patient gender bias in marital therapists' prognostic decisions. Two hundred clinicians who were members of the American Association for Marriage and Family Therapy and the American Association for Sex Educators, Counselors and Therapists were randomly selected. Sixty-four completed and returned the questionnaires. The subjects were presented with clinical profiles describing eight couples seeking couples therapy for inhibited sexual desire. The study found that gender of the identified patient did not influence the clinicians' prognostic decisions.

Fernbach et al. (1989) found that the female clients, regardless of diagnosis, received more favorable prognoses. However, they failed to find that the presenting counter-sex stereotyped symptoms influenced prognosis.

In conclusion, the results of studies investigating the influence of client gender on prognostic decisions are mixed.

In some cases, female clients were given better prognoses than the males when the male client case histories contained some "counter-sex stereotypical symptoms". In several studies where the counter-sex stereotypical nature of the client's presenting problems was not an issue, the results suggest that client gender does not have an effect. Only one study found that an interaction of several variables including race and clinician experience may lead to poorer prognosis for a Caucasian woman. Thus, these data are not consistent and hypotheses cannot be generated about the effect of client sex differences in prognosis.

Effect of Client Gender on Length of Treatment

Data from previous studies have indicated that more women than men are likely to be diagnosed as having a mental illness and that the origin of women's problems are likely to be perceived as enduring and internal while men's difficulties are often attributed to temporary and external factors (Fisher, 1989; Gove & Tudor, 1974; Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice, 1975). Thus, it would seem reasonable to propose that clinicians may anticipate that women will require longer periods of treatment than men. Two sources of data about gender differences in length of treatment included studies reporting actuarial data from clinic and hospital records, and those studies reporting clinicians' judgements and predictions.

Brown and Kosterlitz (1964) examined demographic, diagnostic and treatment variables for a sample of accepted applicants at an university medical school outpatient clinic.

They found that men stayed in therapy significantly longer than women (52% of the men came for five or more sessions as compared to 35% of the women).

Lowinger and Dobie (1968) examined the relationship between client characteristics (e.g., sex, race, marital status, religion and social class) and the number of sessions in therapy at an outpatient clinic primarily staffed by psychiatric residents. They found that women had significantly more visits than men.

Consistent with Brown and Kosterlitz, Safer (cited in Marecek & Johnson, 1980) found that male clients stayed in therapy longer. However, the inferences from this finding were limited since there were significant and complex interactions between client sex, length of stay, clinician gender and frequency of sessions.

Abramowitz, Abramowitz, Roback, Corney and McKee (1976) evaluated demographic and treatment data for clients seen at two clinics, one psychologically-oriented and one psychiatric -oriented, affiliated with a university. The therapists were from varied disciplines including predoctoral psychologists, Ph.D. level psychologists, psychiatric residents, and social workers. This study found that female clients being seen by male clinicians (both predoctoral psychologists and psychiatric residents) stayed in therapy significantly longer than their male clients. However, there were no significant differences between the length of treatment for clients of either gender who were seen by female clinicians at both facilities. Therefore, the results of this study were mixed and reflected complex therapist-client interactions.

Doherty (1976) examined the length of stay for admissions to a psychoanalytically-oriented private general hospital unit. His study included data from the admissions of 32 men and 23 women. He found that there was a very small gender difference in length of stay with men averaging 51 days and women averaging 48. Doherty did not report the statistical significance of his findings.

Stein et al. (1976) compared the treatment provided to a sample of males and females diagnosed as neurotic depressive. This study followed their outpatient treatment over a six month period. They found a significant difference between the male and female samples with the women receiving an average of 10.80 individual therapy sessions while the men's average was 7.85.

Faden and Taube (cited in Kirshner & Johnston, 1983) investigated data from nonpublic hospitals and again found a small gender difference in length of stay. Interestingly, their results were in the opposite direction from Doherty's. Specifically, Faden and Taube found that women's median length of stay was 13.8 days as compared to 13.3 days for men. However, no information was provided about the statistical significance of this finding.

In a study that investigated gender differences in inpatient hospitalization variables, Hoffman and Noem (1975) did not find significant differences between their samples of male and female alcoholics treated at a state hospital alcohol treatment program in terms of length of stay.

Kirshner and Johnston (1983) examined gender differences on variables related to inpatient psychiatric

hospitalization. This study was conducted at a university affiliated hospital and included 244 psychiatric admissions (174 women and 70 men). The variables examined included the following: a) "admission factors" such as route of entry to treatment, demographics, history of hospitalization and level of functioning (as measured by the Global Assessment Scale, GAS); "discharge factors" such as type of discharge, disposition, level of functioning and length of stay; c) responsiveness to treatment; d) gender interactions with other demographics (i.e., age, marital status, insurance, previous history, medical and psychiatric diagnosis). The results of this study found no significant gender differences in length of stay.

Fernbach et al. (1989) assessed clinician judgements about the recommended length of treatment for written vignettes of male and female cases who presented symptoms reflecting antisocial personality disorder or somatization disorder. This study found that the recommended length of treatment for the female cases were significantly longer than those for males, and the effect was larger for the female case presenting with antisocial personality disorder. Fernbach et al. interpreted this finding as being consistent with their hypothesis that cases presenting with counter-sex stereotyped symptoms as more disturbed.

In summary, the results of studies investigating the influence of client gender on length of treatment are mixed and inconclusive. Although several studies suggested that women may be more likely to be in treatment longer (Lowinger & Dobie, 1968; Stein et al., 1976), there were also several

studies suggesting that men stay in treatment longer (Brown &
Kosterlitz, 1964; Safer, cited in Marecek & Johnson, 1980).
In addition, a few studies found no significant sex
differences (Abramowitz et al., 1976; Doherty, 1976; Faden &
Taube, 1977; Kirshner & Johnston, 1983). Only one study was
found that directly investigated the effect of clinicians'
sex on recommendations for length of treatment; the results
did reveal a significant gender effect suggesting women are
recommended for longer treatment (Fernbach et al., 1989).
Nonetheless, based on the inconclusive results from previous
research, it would not be reasonable to develop hypotheses
about clinicians' recommendations for length of treatment.
Effect of Client Gender on Recommendation for Medication

An important aspect of treatment recommendation that has
been examined is the influence of client gender on
therapists' recommendations for psychotropic drug
prescription. Clinicians may rely on sex-stereotyped
expectations and anticipate that women will present with more
emotional concerns. Consistent with previous studies, they
may be more likely to see women as being overemotional
(Fabrikant, 1974). Thus, they may look to medications more
often as a method to help women modulate their feelings
(Fernbach, 1984).

Schwartz and Abramowitz (1975) investigated the
influence of client sex and race on psychiatrists'
judgements. They found that, in this sample, the more
experienced psychiatrists perceived the female client as
being a better candidate for chemotherapy. However, this did
not hold true for the less experienced therapists.

Stein, Del Gaudio, and Ansley (1976) compared the treatment provided to males and females diagnosed as neurotic depressive at an outpatient, university, community mental health clinic. No gender differences were found for demographics including age, race, marital status or education in the sample (30 females and 14 males). However, a statistically significant gender difference was found for the percentages of men and women prescribed anti-depressants (37% of the women and 7.7% of the men). Interestingly, when males and females presented the same symptoms, more women were likely to be given anti-depressants.

Fernbach et al. (1989) investigated the influence of patient gender on clinician recommendations for medication when the client presented with symptoms of somatization disorder or antisocial personality disorder. They did not find any significant gender differences in recommendations for medication although the results suggested a trend consistent with the hypothesis that women would be recommended for medications more than men. One possible explanation for the lack of significant results is that the stimulus diagnoses were not considered amenable to treatment through psychotropic medications.

Cafferta and Meyers (1990) reported results from the National Medical Care Expenditure Survey for 1977 which collected information on sociodemographics for a national U.S. sample of citizens. The survey gathered information about the citizens' reported health status and patterns of utilizing health care organizations. This survey was investigating possible explanations for women's preponderance

in prescription drug use. They concluded that, rather than being related to an effect of physician-client interactions, these differences can be explained by women's increased likelihood of perceiving themselves as ill, particularly with mental illness and musculoskeletal illnesses. According to this survey, these disorders account for approximately half of all psychotropic drug prescriptions. However, an individual's likelihood of being prescribed drugs was mediated by employment status (i.e., employed men and women had a decreased chance of being prescribed drugs). Divorced, separated or widowed women had an increased likelihood of obtaining psychotropic drugs, particularly for mental illness, and they had an increased frequency of visiting clinicians (which may also contribute to the differences). These authors concluded that women's increased likelihood of identifying themselves as sick and seeking help for mental and musculoskeletal problems can account for the preponderance of their prescription drug use. However, these hypotheses are not sufficient and do not really address the following question: When men and women present with the same symptoms, are physicians equally likely to prescribe psychotropic medications? Although this study did not address that question, it supported data from previous studies indicating that women are more likely to have mental illness and receive medical treatment for these difficulties (Gove, 1974). This study also emphasized that various diagnoses may require different treatment, thus placing people with one diagnosis at greater risk for being prescribed medications. That is, these differences seem to

be based on diagnosis rather than gender.

Hohmann (1989) analyzed the 1985 National Ambulatory Medical Care Survey data which collected data on a stratified sample in which information from random patients' visits were examined. The actual data were collected by participating physicians and office staff. Disorders were coded according to the *Ninth Revision of the International Classification of Diseases (ICD-9)* (World Health Organization, 1977). These results indicated that women were more likely to receive prescriptions for anxiolytics and antidepressants but not hypnotics/ barbiturates and antipsychotics. They found that, even when patients had identical sociodemographic backgrounds, symptoms, diagnoses, and health service utilization, women were 37% more likely than men to receive an anxiolytic. When similar factors were controlled, women were 87% more likely than men to receive antidepressants. However, these gender differences were not evident for the other psychotropic drugs including hypnotics/ barbiturates and antipsychotics. This author maintained that true prevalence rates could not account for this difference unless physicians were underreporting and underdiagnosing psychiatric disorders in women. She proposed three possible explanations: (a) Women have greater access and opportunity for physician contact; (b) women are better at asking for prescriptions, and/or men are better at refusing them; and (c) physicians may be susceptible to client gender effects. However, when she controlled for frequency of visits to test the first hypothesis, she found that women's greater opportunity did not account for the difference. Thus, the

other two explanations, which involve client-physician interactions, are viable and need to be explored. In addition, an alternative explanation is that men are more frequently employed in occupations that would prohibit the use of psychotropic drugs.

In conclusion, these data suggest than women are more likely to be prescribed medications than men, even when they have the same symptoms and when they make equal numbers of visits to physicians. In addition, one study found that even when males and females presented with similar depressive symptoms, women were more likely to be prescribed anti-depressants. It is hypothesized that when a clinician perceives a male or a female client as depressed and when the clients are presenting equivalent depressive symptoms, the female will be more likely to be recommended for medication. No hypothesis is generated about the alcohol dependent symptoms since, currently, this disorder is not considered appropriate for psychotropic medication.

Effect of Client Gender on Recommendation for Therapeutic Modality

There has been concern about the effect of client gender on therapists' recommendations for therapeutic modality. Specifically, Maracek and Kravetz (1977) have suggested that group therapy, which puts less emphasis on the therapist's powerful status, may be more beneficial for women while individual therapy, which places the emphasis of power on one authority figure and may reinforce women's oppressed status. Since the sex-stereotyped view of women includes passivity and dependence, it is possible that clinicians may

inadvertently foster dependence in women by recommending them for individual therapy as opposed to the relatively more empowering group therapy and vice versa for male clients (Fabrikant, 1974).

Brody and Detre (1972) investigated whether clinicians are influenced by a patient's gender in making recommendations for individual versus group therapy. This study was conducted at a college counseling center with one female and eight male clinicians who did intake evaluations. The results of this study indicated that the clinicians referred significantly more women than men for individual therapy as opposed to group therapy. However, two limitations of this study include the extremely small sample and the disproportionate sex ratio in the sample.

Consistent with Brody and Detre's (1972) hypotheses, Fernbach et al. (1989) found that clinicians recommended males more frequently for group therapy regardless of their diagnosis. However, Fernbach failed to find significant gender differences in recommendations for individual therapy.

Following these previous findings, it seems reasonable to propose that, regardless of diagnosis, male clients will be recommended for group therapy more often than female clients. However, since past results are inconclusive as to whether clinicians disproportionately recommend female clients for individual therapy, no hypothesis can be generated about gender effects on recommendations for individual therapy.

Effect of Client Gender on Recommendation for Therapeutic Style

Women are stereotypically viewed as being more emotionally expressive and talkative while men are considered more action-oriented (Fabrikant, 1974; Gibbs, 1984; Noel-Hoeksema, 1987). Non-directive and insight-oriented therapy emphasizes verbally expressing feelings while directive and cognitive-behavioral approaches encourage activity and problem-solving. Thus, it seems that women would be considered more appropriate for non-directive and insight-oriented therapies while men would be considered good candidates for directive and cognitive-behavioral approaches (Gibbs, 1984).

Schwartz and Abramowitz (1975) found that more traditionally-oriented psychotherapists recommended insight therapy more frequently for female than male clients. However, the opposite was true for psychologists with less traditional orientations. Thus, the clinicians with less traditional orientations recommended insight-oriented therapy less often for women. Bowman (1982) found that insight-oriented therapy was recommended more for female clients, and couples therapy (which tends to be more problem-focused and action-oriented) was recommended more for male clients.

Fernbach (1984) found that regardless of diagnosis, female case vignettes were recommended more frequently for nondirective therapy. This study also revealed that female vignettes with primarily antisocial personality features were recommended more frequently for insight-oriented therapy.

In terms of directive versus nondirective approaches, Parker (1967) examined audio-recordings of therapy interactions of 16 male therapists who were treating a male

and a female client. This study found that these therapists made more nondirective responses to clients that were female than male. However, there was no significant difference in the frequency of directive responses made to male or female clients. A primary limitation of this study is the lack of female therapists.

Fischer, Dulany, Fazio, Hudak and Zivotofsky (1976) assessed 135 social workers' (79 female and 56 male) judgements of client case histories. These case presentations were varied by sex and the dimensions of aggressivity-passivity. Their results revealed no evidence of a bias in a negative direction toward female clients. However, female clients were judged more appropriate for nondirective therapy.

In summary, based on the results of these studies a few hypotheses were generated. It is predicted that clinicians will recommend insight-oriented and nondirective therapeutic approaches more for the female client than the male client presenting with symptoms of alcohol dependence and depression. Likewise, it is expected that the male client will be recommended more for directive and problem-focused, cognitive/behavioral.

Effect of Client Gender on Recommendation for Vocational Counseling

Sex-stereotyped views would propose that men's vocational concerns are prominent and that for women, emotional and interpersonal problems are most prominent. Since clinicians are not immune to the influence of culturally influenced stereotypes, it seems reasonable that

they might also hold these conceptions.

Buzcek's (1981) results were indirectly related to the issue of vocational recommendations and provide partial support for the above hypotheses. Specifically, she found that there was no tendency for counselors of either sex to differentially recall or emphasize vocational concerns for male or female clients. However, male clinicians tended to ask more questions of female clients about social/domestic concerns. Thus, there is some evidence to suggest that vocational versus interpersonal issues may influence male clinicians during the initial interviewing process and may influence their later recall. The following studies are more directly related to the issue of vocational recommendations.

Pietrofesa and Schlossberg (1970, cited in Schlossberg & Pietrofesa, 1973) presented counseling doctoral trainees (16 male and 13 female) with the task of interviewing a bogus female client. This client presented with concerns about deciding between a career in teaching or in engineering. These interviews were rated by independent judges for statements of bias reflecting the clinicians' preference for the female client's career choice. The results found that 81.3% of the biased statements were against the client entering engineering and 18.7% were biased for that decision.

Thomas and Stewart (1971) investigated high school counselors' perceptions of a female client presenting with vocational concerns and their recommendations for a female client. They presented 62 counselors with an audiotape of a bogus female high school student. One audiotape presented a client with ambivalence about a traditional career choice

(home economist), and in the other, the client presented ambivalence about a nontraditional career (engineering). These counselors perceived the traditional career as more appropriate and recommended therapy significantly more for the woman who had nontraditional career interests.

Hoffman and Noem (1975) investigated demographics, therapeutic progress and aftercare information collected on all alcoholics admitted to a state hospital between 1971 and 1973. They found that female alcoholics were significantly less often referred to employment than male alcoholics. Significant differences existed for demographics between the males and the females. However, no significant gender differences were found in rates of completion, length of stay or prognosis.

Hill, Tanney, Leonard and Reiss (1977) presented 38 therapists with videotapes of a female client with concerns about anxiety, fear of rape and indecision about a traditional (social work) versus nontraditional (engineer) career interest. These clinicians judged the severity of the problem, the length of therapy required, and the anticipated benefits of therapy. The results found no differences across these variables for the two clients. However, the interpersonal concerns were rated as more important than the vocational concerns. Again, the lack of comparable video-tapes of a male client is an important limitation of this study.

Fernbach (1984) failed to find client gender differences in therapists' recommendations for vocational counseling.

In summary, the results of previous studies on the

effect of client gender on vocational recommendations were mixed and inconclusive. Some studies did suggest that sex-stereotypes may influence a counselor when a female client presents with nontraditional career choices. However, when only gender effects (and not counter-sex stereotyped career choices) were examined, three of the four studies did not find gender differences. Thus, no hypotheses about the effect of client gender on vocational recommendations can be generated.

## Effect of Clinician Gender on Clinical Judgement

In addition to concerns about the effect of client gender on clinical judgements, the influence of clinician sex and the interactions between clinician and client gender have been explored. The following discussion is primarily limited to studies that have investigated the influence of clinician gender on clinical judgements rather than on the process of psychotherapy. Several studies, some discussed previously in this paper, have examined the possible influence of clinician gender on clinical judgement and did not find significant differences (Feinblatt & Gold, 1976; Fischer et al., 1976; Hamilton, et al., 1986; Hill et al., 1977; Sterns et al., 1980; Warner, 1978, and 1979). Abramowitz and Dokecki (1977) reviewed studies specifically addressing clinical judgements and concluded that therapists of both sexes have been shown to be equal in sex-role stereotyping. However, some studies revealed that male therapists may be more stern than female therapists, and other studies suggested that female counselors make more positive responses to female clients.

Smith (1980) reviewed 15 studies (14 analogue and one

naturalistic) and concluded that "effects related to the gender of the counselor or therapist were contradictory and average to nothing..." (p. 405). She concluded that no evidence suggested that male counselors are less effective than female counselors or that same gender pairings are less vulnerable to bias. However, Smith's review was not limited to studies on clinical judgement but also included studies on the process aspects of therapy.

However, a few studies have found clinician gender differences in some variables of clinical judgement (Buzcek, 1980; Fernbach, 1984; Shapiro, 1977; Wright, Meadows, Abramowitz & Davidson, 1980; Zygmond & Denton, 1989). Shapiro (1977) found that female counselors were more reinforcing and less punishing than the male therapist with female clients who presented in a typical or an atypical role. In terms of sex stereotypes, some evidence suggested that female counselors evaluated atypical clients more favorably. Wright et al. (1980) found that female therapists were less likely than male therapists to give the diagnosis of psychosis to female outpatients. However, this difference was not found for the male clients. Thus, consistent with the results of Abramowitz and Dokecki (1977), female therapists may be more positive in interactions with female clients.

Buzcek (1981) found that female counselors recalled more information about both sexes than their male counterparts. Also, she found that male clinicians were more likely to ask the female client more social/domestic-related questions. The amount of information recalled and type of questions

asked could have an effect on the data available to clinicians when making diagnoses and recommendations.

Fernbach et al. (1989) found one clinician gender effect. Female therapists tended to endorse cognitive-behavior therapy more than male therapists, and this difference could not be explained by therapist theoretical orientation differences. However, these authors suggest the results could have been spurious in light of the high number of analyses conducted. In addition, these findings contradict a somewhat related finding by Abramowitz et al. (1976) who found that female therapists were more likely than male clinicians to choose an indirectly controlling response to a hypothetical, outpatient-group client.

Zygmond and Denton (1988) examined clinician gender in prognostic judgements of couples with one member of the couple identified as having sexual problems. In this study, therapist gender strongly affected what information clinicians used in making prognostic decisions. Specifically, female therapists emphasized the seriousness of the presenting problems, the partner's feelings about the sexual relationship, and the spouse's frequency of desire for intercourse. Male therapists, instead, relied on the wife's desire for sexual intercourse and the husband's sexual satisfaction.

In summary, these mixed results suggest that clinician gender does not consistently influence clinical judgement. However, recall seems to be one factor indirectly related to clinical judgement and treatment planning that may be influenced by clinician gender. Consistent with the data on

therapist recall, it is hypothesized that female clinicians will be likely to recall more information overall.

Conclusions

Although much controversy exists around the issue of clinician sex-stereotyping, the evidence generally suggests that it does occur. However, the data also indicated that the prevalence of sex-stereotyping may be decreasing, and it may occur to a relative degree rather than being displayed as blatantly as in the past.

With respect to the effect of client gender on diagnosis, analogue investigations have primarily involved Axis II diagnoses which depend more on subjective and trait-based criteria rather than specific and behavioral-based criteria. Ford and Widiger's (1987) study utilizing borderline and antisocial personality disorders found that regardless of the degree of ambiguity of the case symptoms, client gender influenced clinicians' judgements. Fernbach et al. (1989) had similar findings with their case presentation of the antisocial personality disorder but not for the somatization disorder case presentation. With the exception of Fernbach et al. (1989), no analogue studies were found that examined the effect of client gender on clinical judgements when presented with behaviorally-anchored Axis I symptoms. In addition, few consistent clinician gender effects on clinical judgements were revealed.

Several reviewers identified methodological concerns in previous studies addressing client gender effects on clinical judgements. Specifically, there was often no validation of the effectiveness or transparency of the experimental

manipulation. The potential influence of social desirability on clinicians' final judgements was also emphasized.

Also, recent research on gender effects has been expanded to include the early decision-making processes of memory, attributions of etiology, and question generation, which may be less vulnerable to social desirability factors. In fact, data from the few studies addressing these three variables have found client gender effects.

The literature has revealed evidence of gender effects in the following areas of treatment recommendations: therapeutic modality (group); therapeutic style (nondirective/insight-oriented or directive/cognitive behavioral); and medication evaluation. However, no consistent evidence of client gender effects was found for prognosis or recommendations of length of treatment.

Consistent with Barak and Fisher's (1989) definition, the current study investigated "gender effects" by studying gender differences in clinician decision-making processes without implying sex-biased intent on the part of the therapist. The current study presented therapists with a case showing a combination of symptoms from the frequently coexisting Axis I diagnoses of depression and alcohol dependence and then examined the influence of client gender on clinician diagnosis, recall, attribution, question generation, prognosis and treatment recommendations. In addition, an item was developed to assess the transparency of the experimental manipulation. In particular, the present study attempted to determine whether gender would be an overriding influence in clinical judgements when therapists

were presented with the same ambiguous, but relatively objective and behaviorally-anchored, symptoms by either a male or a female client. The following research question was at issue: Do clinicians attend to all of the relatively objective diagnostic criteria equally, or are they influenced by client gender and related sex-stereotyped expectations?

Hypotheses

In light of the previous discussion, the following hypotheses were developed:

1. Clinicians are less likely to diagnose depression than alcohol dependence in the male client and less likely to diagnose alcohol dependence than depression in the female client.

2. Clinicians will recall less overall information about the female client than the male.

3. Female clinicians will recall more information overall than the male clinicians.

4. Clinicians will ask more questions related to social/domestic concerns of the female client as compared to the male client.

5. Clinicians will be more likely to attribute the female client's problems to internal and stable factors.

6. Clinicians will attribute the male client's problems to external and situational factors.

7. The female client will be recommended more for medication, nondirective, and insight-oriented therapy.

8. Group therapy, directive, and cognitive-behavioral therapy will be recommended more for the male client.

## Method

### Overview of Design

Male and female clinicians heard one of four audiotapes in which a client presented initial problems including a combination of major depressive and alcohol dependence symptoms. In two audiotapes, the client was male and in the other two, the client was female. The study was a 2 x 2 x 2 (Gender of Client x Gender of Clinician x Version of Tape) factorial design. In addition, the cell sizes of the independent variables ranged from ten to 13 cases.

### Subjects

The subjects were 88 clinicians from varied disciplines (master's and doctoral level clinical psychology, master's and doctoral level social work, master's and doctoral level counseling education, master's degree in nursing, and medical degree). These clinicians were employed in a variety of settings including the following: Veteran's Administration Medical Center, military hospital, private hospital, community mental health center, private practice, and university counseling center).

### Materials

Tapes. Four audiotapes were constructed in which two male clients and two female clients describe identical presenting complaints and background information (see Appendix A). The only difference in the content of these presentations was that the work supervisor discussed in the script was the same gender as the client. This change was made in order to eliminate any possible client-supervisor gender interactions which could have affected the clinicians'

perceptions of the client's concerns.

Every effort was made to insure a high degree of similarity between the tapes. Generally, the tapes were produced by a process involving rehearsal and feedback from listeners. Specifically, two actors (one male and one female) rehearsed the script together and then, each made a tape separately. Two listeners evaluated the tapes for several characteristics including authenticity, affect and similarity. These actors were given specific feedback from the listeners regarding intonation, affective display, authenticity and similarity. This process was repeated until the listeners were satisfied that significant differences had been minimized. Two additional actors (one male and one female) listened repeatedly to the first two tapes and attempted to replicate the first actors' presentations as closely as possible. Again, the same two listeners evaluated these tapes, and the actors were given feedback regarding necessary changes. After these two listeners were satisfied that the differences between the four tapes were minimized, two additional listeners heard excerpts from the four tapes and again, revisions of the tapes were made, when recommended.

The tapes consisted of a mock client's monologue, initial presentation (approximately seven minutes long) of concerns, problems, and reasons for seeking therapy. The scripts used to make the tapes included a combination of symptoms consisting of an equal number of symptoms related to major depression and alcohol dependence. The depressive symptoms included the following: (a) a lack of interest in

activities, (b) fatigue or loss of energy, (c) insomnia and
(d) an inability to concentrate. The client described the
following concerns related to alcohol use: (a) social or
recreational activities given-up or reduced because of
alcohol consumption, (b) a preoccupation with alcohol use,
(c) persistent social conflicts due to alcohol use, and (d)
increased tolerance for alcohol. Also, the client presented
other background information consisting of 24
interpersonal/domestic facts and an equal number of
vocational facts as well as ten general facts. No attempt at
counterbalancing of the items was made in order to enhance
the realism of the presentations. In addition, the two
different conditions of tape version were created by grouping
the tapes based on the process by which they were made.
Therefore, Tape Version 1 consisted of the tapes constructed
by the first male and female actors while Tape Version 2
consisted of the tapes constructed by the second pair of
actors.

Measures

Recall. Subjects were asked to spend five minutes
writing all the facts that they could recall about the case
(see Appendix C for an example of the questionnaire). These
facts were coded into one of five categories:
social/domestic, employment/vocational, general, symptoms-
depression, symptoms-alcohol dependence. The social/
domestic category included facts related to the client's
spouse, the relationship with their spouse or their family of
origin (parents, siblings etc.). The employment category
consisted of any facts related to boss, job, academic

history, and future career plans. The general category included any personal facts that were not in the employment and social/domestic categories, such as relationships with co-workers, situational issues, material possessions, and friendship concerns. Any statements related to the specific symptoms of depression (i.e., poor concentration, low energy, sleep problems and anhedonia) were coded in the depression-symptom category. Also, the alcohol dependence category consisted of statements related to alcohol use that were stated in the script and/or were symptoms of alcohol dependence (i.e., decrease in social activities due to alcohol use, preoccupation with alcohol, social conflict due to use, and increased tolerance). In addition to specific coding instructions, coders used coding sheets in which the specific statements from the script were itemized according to the category for which they were intended to represent (see Appendix D and E).

Three raters, who were blind to the purpose of the study and the gender of the subject, independently rated the questionnaires. Interrater reliability correlations were calculated for all the subjects included in the analyses. The mean reliability coefficients for the three raters on the recall categories ranged from .54 to .87. However, the range for effective reliability of the means of these three raters, as calculated by the Spearman-Brown formula, falls between .77 and .95 and places the effective mean ratings within acceptable limits (Rosenthal, 1973).

Question Generation. Subjects were asked to spend five minutes, listing in any order, questions that they would like

to have asked if they were going to be continuing the interview.  These responses were also coded into the five categories of social/domestic, employment/vocational, general, symptoms-depression, and symptoms-alcohol dependence.  Questions about their relationship with their spouse, marital history, marital plans, relationship with their parents, relationship with their siblings, and their role in their family of origin were coded social/domestic. The employment category included questions related to their boss, job history, academic history, and employment goals and plans.  The general category consisted of questions about personal issues that do not fit the two categories of social/domestic and employment, such as relationships with friends, co-workers or situational concerns, past counseling, reasons for seeking therapy, goals for therapy, substance use other than alcohol, and other affective symptoms unrelated to depression.  Questions about the specifics of their alcohol use (when, how much, etc.), consequences of their drinking (legal consequences), other symptoms of alcohol abuse (blackouts, shakes etc.), own history of alcohol abuse, and family history of alcoholism were coded under alcohol dependence.  The depression-symptoms category included questions about their personal history of depressive symptoms (how long, episodes, precipitating events), other symptoms of depression (suicidal ideation and loss of appetite) and family background of affective disorders.  Mean interrater reliability coefficients were calculated between the same three raters who coded the recall data using the data from those same subjects, and these correlations ranged from .74

to .83. However, as with the recall data, the range for effective reliability of the means of these three raters, as calculated by the Spearman-Brown formula, would be .87 to .93; thus, placing the effective mean ratings within acceptable limits (Rosenthal, 1973).

Diagnosis. The clinicians were given a list of 10 possible diagnoses, including Axis I (i.e., adjustment disorder, alcohol abuse, alcohol dependence, dysthymia, generalized anxiety, and major depression) and Axis II diagnoses (i.e., borderline personality disorder, histrionic personality disorder, obsessive-compulsive disorder and paranoid personality disorder). They were asked to rate, on a seven-point Likert scale, the degree to which they believed a particular diagnosis was appropriate for the client they had just heard. The scale anchors were '1 = not appropriate' to '7 = very appropriate'. Also, the clinicians were asked to list, in rank order, the two diagnoses from the list of Likert scales which they believed to be most appropriate for the client they had just heard.

Attributions of Etiology. A list of ten possible underlying etiological factors, including the following: external stressors, personal traits, physical illness, traumatic experience, normative developmental crisis, chronic interpersonal problems, biological predisposition, vocational stressors, marital stressors, and dysfunctional family of origin were rated. For each factor, clinicians were asked to indicate on a seven-point Likert scale the degree of likelihood that a particular factor may be underlying the client's concerns. The anchors for these scales were '1 = not

likely to recommend' and '7 = very likely to recommend'.

Therapeutic Modality. A list of nine possible treatment recommendations were presented with a seven-point Likert scale. These included: individual therapy, group therapy, medication evaluation, physical evaluation, inpatient treatment, marital therapy, vocational counseling and no therapy. Clinicians were asked to rate their likelihood of recommending a particular therapeutic modality. They were also asked to list, in rank order, the two therapeutic modalities from the previous list, that they believed to be most appropriate for the client.

Therapeutic Style. Clinicians were presented with a list of four possible therapeutic styles: insight-oriented, directive, cognitive-behavioral, and nondirective. They were asked to rate each item on a seven-point Likert scale based on the likelihood that they would recommend that particular style.

Prognosis. One seven-point Likert scale was presented to clinicians with instructions to rate their belief about the client's prognosis with the anchors being '1 = very poor' and '7 = excellent'.

Length of Treatment. There were two open-ended questions asking about recommended length of treatment. The clinicians were asked to indicate the expected number of sessions needed for outpatient treatment, if they recommended outpatient therapy, and/or the anticipated number of days hospitalized, if inpatient treatment was thought to be required.

Manipulation Validation. In order to assess the

effectiveness of the experimental manipulation, an open-ended question asked clinicians to write a brief statement reflecting their thoughts about the purpose of the study.

Procedure

Subjects were recruited by calling and/or writing to several directors of various mental health services in Virginia and Maryland and requesting permission to recruit subjects and to collect data. Individual clinicians practicing in the Hampton Roads area were also solicited for participation through phone calls and letters. Depending upon how the subjects were recruited and the setting in which they worked, administration of the experiment was to groups of clinicians or to an individual clinician. However, the procedure was the same regardless of the number of subjects participating.

During the phone calls and in the letters used to solicit participants, the clinicians were given a brief explanation of the study. In addition, prior to every administration of the experiment, the same brief verbal description of the study was presented. During group and individual administrations, clinicians were reassured that participation was voluntary and that they may choose to stop participation at any time during the procedure.

The brief explanation of the study stated that the task involved listening to an audiotape, approximately seven minutes long, of a mock client giving initial concerns and problems. They were told that, after listening to the tape, they would be asked to perform tasks similar to those conducted after an initial interview. Clinicians were also

informed that one task on the questionnaire involved listing questions that they would like to ask if they were continuing the interview. Those clinicians who chose to participate were asked to complete an informed consent form which also contained a brief written description of the experiment (see Appendix B).

Initially in data collection, one of the four tapes was randomly chosen for an individual clinician or group of clinicians to hear. However, toward the end of the data collection, as the cells were being filled, every effort was made to gather equal numbers of male and female clinicians for each tape. Therefore, in some cases, a tape was chosen to be played based on the gender ratio of a particular group of clinicians or an individual clinician's gender.

Before the clinicians listened to the tape, they were presented with a questionnaire packet which included the following: (a) a background information sheet that asked clinicians to answer questions about gender, years of experience, most recently earned professional degree, primary employment setting, and primary theoretical orientation; (b) an explanation of instructions for listing all the facts that they can recall about the client (similar to Buzcek's (1981) instructions differentiating "facts" from "inferences"); (c) two mostly blank pages on which clinicians were asked to list recalled facts and proposed questions; (d) a questionnaire that asked the clinician to rate, on seven-point Likert scales the appropriateness of various Axis I and Axis II diagnoses, the likelihood that a particular etiological factor may be underlying the client's problems,

the likelihood of recommending various treatment approaches and a prediction of prognosis; (e) an open-ended question that asked for the clinicians' recommendations for the length of treatment, and f) an open-ended question that also asked for the clinician's thoughts about the purpose of the study (refer to Appendix C).

The subjects were instructed that they should not turn any pages in the packet until instructed to do so. They were given an opportunity to ask questions and, then, asked to complete the first page. Prior to playing the tape, the subjects were asked to engage in the upcoming tasks with the understanding that the client is a general outpatient rather than the specific type of client that they might see in their particular setting. They were also asked to refrain from writing any notes while listening to the tape. Then, the tape was played. After listening to the tape, written and verbal instructions were given about the timed recall and question generation tasks.

Specifically, it was explained to the clinicians that they had five minutes to list all of the facts that they could recall about the client that they just heard. They were also asked to take some time to read the written instructions, including the example, which explained the difference between 'fact' and 'inference' and stressed the importance of only writing facts. Then, they were informed when timing had begun and ended.

When the time had expired for the recall task, they were told that they would be given five minutes to list any additional questions that they would have asked if they were

continuing the interview. Similar to the procedure for Buczek (1981), clinicians were told that they could ask as many or as few questions as they liked and did not necessarily have to use the entire five minutes. They were then told when the timing had begun and ended. After time had expired for the question generation task, or when the clinicians had finished their list, they were instructed to go on to the next section of the questionnaire.

At this time, clinicians were asked to read the written instructions before each of the remaining sections and to work at their own pace on each of the tasks. They were also urged to ask questions if they were confused by an item or did not understand any instructions. Therefore, they worked independently on the tasks related to attributions of etiology, diagnosis, treatment recommendations, prognosis, recommended length of treatment, and the question about the purpose of the study.

After the subjects completed the questionnaire, there was a debriefing session in which subjects were told that the purpose of the study was to investigate gender effects in therapy by comparing clinicians' responses to male and female clients for each of the dependent variables. Again an opportunity was provided for the subjects to ask questions.

<u>Results</u>

<u>Demographic Description of Subjects</u>

A total of 108 subjects volunteered to participate in the study. However, the data from 20 subjects were excluded for the following reasons: a) three subjects suspected the purpose of the study; b) four subjects spent 50% or greater of their clinical practice working in the field of substance abuse; c) 13 subjects failed to respond to some aspect of the questionnaire or did not have an advanced clinical degree (i.e., master's level or higher). The final sample consisted of 88 clinicians.

<u>Clinician Gender.</u> The final sample of 88 clinicians consisted of 44 female clinicians and 44 male clinicians. A one-way analysis of variance (ANOVA) revealed a significant difference between male and female clinicians for age. Male clinicians were significantly older ($\underline{M}$ = 41.8) than the female clinicians ($\underline{M}$ = 37.2), $\underline{F}(1,85)$ = 10.0, $\underline{p}$ <.01 (see Table 1). An ANOVA revealed that there was also a significant difference between male and female clinicians for years of experience. Again, the male clinicians had significantly more years of clinical experience ($\underline{M}$ = 9.3) than the female clinicians ($\underline{M}$ = 6.0), $\underline{F}(1,86)$ = 6.64, $\underline{p}$ <.05 (see Table 2).

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Insert Tables 1 and 2 about here

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<u>Client Gender Condition.</u> An ANOVA revealed no significant difference in age distribution between the clinicians in the different client gender conditions, $\underline{F}(1,85)$

= .025, ns. In addition, an ANOVA indicated no significant difference between the clinicians in the different client gender condition for years of experience, $F(1,86)$ = 2.49, ns.

Tape Version. An ANOVA revealed no significant difference in the mean age between the clinicians in the different conditions of tape version, $F(1,86)$ = 1.75, ns. In addition, an ANOVA revealed no significant differences between the clinicians in the different tape version conditions for years of experience, $F(1,86)$ = .230, ns.

In general, these results revealed that the male clinicians tend to be older than female clinicians and to have more years of clinical experience. However, there were no significant differences between the clinicians who heard the male versus the female tapes or those who heard Tape Version 1 and Tape Version 2 in terms of age or years of experience.

Theoretical orientation. Clinicians were asked to indicate their primary theoretical orientation from seven choices (psychodynamic, behavioral, cognitive-behavioral, existential/phenomenological/humanistic, family systems, eclectic and other). These choices were coded into three categories consisting of the following: psychodynamic, behavioral/cognitive-behavioral, and eclectic/other. A 2 x 3 (Clinician Gender x Theoretical Orientation) chi-square analysis using these recoded variables also failed to reach significance, $X^2(3, N = 88)$ = .76, ns. A 2 X 3 chi-square analysis between these three categories of theoretical orientation and gender of client revealed no significant differences between the clinicians who were in the different

client gender conditions, $\underline{X}^2$(3, $\underline{N}$ = 88) = 1.48, ns. In addition, 2 x 3 (Tape Version x Theoretical Orientation) chi-square analysis indicated that there were no significant differences between the clinicians in the different tape version conditions, $\underline{X}^2$(3, $\underline{N}$ = 88) = 3.04, ns.

Clinical Setting. Clinicians were asked to indicate the percentage of time spent in various employment settings (refer to Appendix C). Their responses were coded according to the clinical setting in which they spent 50% or greater of their time. These percentages were coded into the following three categories: inpatient, outpatient and administration/other. A 2 x 3 (Clinician Gender x Clinical Setting) chi-square analysis revealed no significant difference between male and female clinicians, $\underline{X}^2$(2, $\underline{N}$ = 88) = .16, ns. When clinical work setting was compared across the clinicians who were in the different client gender conditions, a 2 x 3 chi-square analysis (Client Gender x Clinical Setting) revealed no significant difference, $\underline{X}^2$(2, $\underline{N}$ = 88) = 1.27, ns. Also, a 2 X 3 chi-square analysis of Tape Version x Clinical Setting did not reach statistical significance, $\underline{X}^2$(2, $\underline{N}$ = 88) = 2.11, ns.

Clinical Degree. Clinicians also reported their most recently earned professional degree. This sample consisted of clinicians falling into the following professional degree categories: a) doctoral level psychologists (Psy.D. and Ph.D. = 44.3%); b) master's level psychologists (M.A. and M.S. = 20.5%); c) master's level social workers and licensed clinical social workers (M.S.W. and L.C.S.W. = 15.9%); d) doctoral level social workers (D.S.W.= 2.3%); e) doctoral

level counselors in education (Ed.D. = 8.0%); f) master's
level counselors in education (M.Ed. = 6.8%); g) master's
level nursing degree (M.N. = 1.1%); and h) psychiatrist (M.D.
= 1.1%). These were recoded into the following four
categories: a) Psychology (Psy.D., Ph.D., M.A., M.S.); b)
Social Work (M.S.W., L.C.S.W., and D.S.W.); c) Counseling
(Ed.D., M.Ed.) and d) Medical/other (M.N. and M.D.). A 2 x 4
chi-square analysis (Clinician Gender x Professional Degree)
revealed no significant differences between male and female
clinicians by professional degree, $\underline{X}^2$(3, $\underline{N}$ = 88) = .85, ns.
A 2 x 4 chi-square analysis (Tape Version x Professional
Degree) also failed to reveal a significant difference in
professional degree between the clinicians assigned to the
tape version conditions, $\underline{X}^2$(3, $\underline{N}$ = 88) = 3.03, ns. When a 2
x 4 (Client Gender x Professional Degree) chi-square analysis
compared percentages of clinicians with various professional
degrees across the client gender conditions, there was not a
significant difference, $\underline{X}^2$(3, $\underline{N}$ = 88) = 5.75, ns.

Results for Diagnosis

The questionnaire presented the clinicians with ten
possible diagnoses and asked them to rate their belief about
the appropriateness of each diagnosis on a seven-point Likert
scale (see Appendix C). Hypothesis 1 predicted that
clinicians would be more likely to consider the diagnosis of
major depression appropriate for the female clients and the
diagnosis of alcohol dependence appropriate for the male
clients. A 2 x 2 x 2 (Clinician Gender x Client Gender x
Tape Version) multivariate analysis of variance (MANOVA) was
conducted with the following diagnostic scales: adjustment

disorder with anxiety features, alcohol abuse, alcohol dependence, dysthymia, generalized anxiety, major depression, borderline personality disorder, histrionic personality disorder, obsessive-compulsive personality disorder, paranoid personality disorder. Multivariate $F$ ratios were significant for the clinician gender by tape version interaction, $F(10,71) = 2.32$, $p < .05$, and the main effect of client gender, $F(10,71) = 2.06$, $p < .05$ (see Table 3).

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Insert Table 3 about here

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For the clinician gender by tape version interaction, there was a significant univariate result for dysthymia, $F(1,80) = 10.20$, $p < .05$. However, post-hoc analyses of the simple effects were not significant. Specifically, female clinicians ($M = 5.26$) gave only relatively higher ratings than the male clinicians ($M = 4.80$) for dysthymia to the clients in Tape Version 1, $t(44) = .85$, ns. In addition, male clinicians ($M = 5.42$) gave ratings which were only relatively higher than the female clinicians ($M = 4.51$) for dysthymia to the clients in Tape Version 2 which were not significantly different, $t(44) = -2.07$, ns.

The only significant univariate ANOVA client gender main effect was for alcohol abuse, $F(1,80) = 5.07$, $p < .05$ (see Table 4). This result indicated that clinicians were more likely to give higher ratings on the appropriateness of the diagnosis of alcohol abuse for the female clients than the male clients. There were no hypotheses specifically related to the diagnosis of alcohol abuse; however, since it is

considered a less severe disorder on a continuum with alcohol dependence, this result indirectly opposes what was predicted by Hypothesis 1.

There were no other significant client gender main effects for the dependent variables which were specified in the hypotheses (see Table 4). In general, there was a lack of support for Hypothesis 1 which predicted that clinicians would be significantly more likely to consider the diagnosis of major depression appropriate for the female clients than the male clients. Also, these results do not support the component of Hypothesis 1 which anticipated that clinicians would more likely consider the diagnosis of alcohol dependence appropriate for the male clients than the female clients.

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Insert Table 4 about here

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Clinicians were also asked to choose, in rank order, the two diagnoses from those ten listed on the Likert scales, which they believed to be most appropriate. In order to test Hypothesis 1, the diagnoses chosen by each clinician were coded into one of three categories: a) alcohol-related (alcohol abuse or alcohol dependence; b) depression-related (major depression or dysthymia); and c) 'other' (any of the other six diagnoses). Again, it follows from the predictions of Hypothesis 1 that clinicians would give the female clients a depression-related diagnosis as the first or second rank diagnosis more frequently than the male clients. Likewise, Hypothesis 1 anticipated that male clients would be assigned

the alcohol-related diagnoses as first or second rank diagnoses more often than the female clients.

Two 2 x 3 chi-square analyses (one for each choice), with client gender as one variable and diagnostic category (with three levels) as the other variable, were conducted to test this hypothesis. There were no significant differences between the male and female clients in the percentages of first rank diagnoses, $X^2$(2, $N$ = 88) = .69, ns (see Table 5). Clinicians were equally likely to give the male (62.2%) and female clients (65.1%) depression-related diagnoses as the first rank diagnosis.

Although the differences in percentages of the second rank diagnoses between the female and male clients were not statistically significant, they did approach significance, $X^2$(2, $N$ = 88) = 5.06, $p$ <.10 (see Table 6). For the second rank diagnosis, clinicians were most often likely to assign the alcohol-related diagnoses for the male clients (55.6%) and the female clients (62.8%). There was a relatively higher frequency of 'other' second rank diagnoses for the male clients (11.1%) than the female clients (0.0%). This trend suggested that clinicians would assign an alternative 'other' diagnosis more to the male clients than the female clients for a second rank diagnosis. When the 'other' diagnostic category was broken down into specific diagnoses, the most frequent diagnoses given the male clients (80%) were anxiety-related (generalized anxiety disorder and adjustment disorder with anxiety).

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Insert Tables 5 and 6 about here

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An additional 2 x 4 chi-square (Client Gender x
Diagnosis) analysis was conducted in which the first and
second rank diagnostic choices were combined. These
diagnoses were recoded into the following categories: a)
depression-related and alcohol-related, b) depression-related
and 'other' (i.e., not depression or alcohol-related), c)
alcohol-related and 'other' (i.e., not depression or alcohol-
related), c) 'other' (i.e., not depression or alcohol-
related) and 'other' (i.e., not depression or alcohol-
related). This analysis did not reach significance and
revealed that clinicians were equally likely to give the male
(46.7%) and female (53.5%) clients depression-related and
alcohol-related as the first and second rank diagnoses, $\underline{X}^2$(3,
$\underline{N}$ = 88) = 1.33, ns (see Table 7). In addition, there were no
differences in the percentages of clinicians who gave both
the male and the female clients first and second rank
diagnoses which fell into the following categories: a)
depression-related and 'other', b) alcohol-related and
'other' and c) 'other' and 'other' (see Table 7).

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Insert Table 7 about here

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These results suggest that clinicians were equally
likely to believe that the diagnoses related to alcohol use
or depression would be appropriate for the male and the
female clients for first and second rank diagnoses. However,

clinicians were relatively more likely to believe that an alternative 'other' diagnosis reflecting anxiety problems (generalized anxiety disorder and adjustment disorder with anxiety features) would be appropriate for a second rank diagnosis for the male clients. Again, there was no support for the Hypothesis 1 prediction that there would be different percentages of male and female clients assigned the diagnoses related to alcohol use and depression.

Results for Recall of Information

Clinicians were asked to spend five minutes listing, in any order, the facts that they could recall about the information that the client in the tape had presented. Three raters coded each subject's responses into one of five categories: a) social/domestic; b) employment; c) general; d) symptom-depression; e) symptom-alcohol dependence (see Appendices D and E). A subject's score for each category was calculated as the mean of the three scores given by the three raters. The data for one subject was incomplete; therefore, these analyses are based on the responses of 87 subjects. A 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) MANOVA was conducted with each of the five categories listed above as dependent variables. In addition, none of the multivariate three-way, two-way or main effect $F$ ratios were significant (see Table 8). Also, none of the univariate client gender effects were significant for the dependent variables (see Table 9).

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Insert Tables 8 and 9 about here

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Hypothesis 2 predicted that clinicians would recall less information, overall, for the female clients than the male clients. In addition, Hypothesis 3 anticipated that female clinicians would recall more overall information than the male clinicians. In order to test these hypotheses, a separate three-way 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) ANOVA was conducted for the total number of facts recalled by clinicians. This analysis did not result in a significant client gender main effect; therefore, Hypothesis 2 was not supported (see Table 10). That is, there were no differences in the amount of information that clinicians recalled for the female clients versus the male clients. Also, there was no significant clinician gender main effect, which failed to support Hypothesis 3. Specifically, there were no significant differences in the amount of information recalled by male and female clinicians.

However, there was a significant interaction for client gender by tape version, $F(1,86) = 4.10$, $p < .05$ (see Table 10). Post-hoc analyses for the simple effects of this interaction did not reach significance. Although not anticipated, this result revealed that clinicians recalled relatively more information for the male client from Tape Version 1 ($M = 15.43$) than Tape Version 2 ($M = 14.02$), $t(43) = -.91$, ns. In addition, these clinicians remembered relatively more information about the female client of Tape Version 2 ($M = 16.26$) than Tape Version 1 ($M = 14.19$), $t(44) = .20$, ns.

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Insert Table 10 about here
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## Results for Question Generation

Clinicians were asked to spend five minutes listing, in any order, questions that they would like to have asked if they had been continuing the interview. Three raters coded each subject's responses into one of five categories: a) social/domestic; b) employment; c) general; d) symptom-depression; e) symptom-alcohol dependence (see Appendices D and E). The score for each subject in each category was calculated as the mean of the three scores given by the raters. The data for one subject was incomplete; therefore, these analyses are based on the responses of 87 subjects. It was predicted in Hypothesis 4 that clinicians would ask more questions related to social/domestic issues of the female than the male clients. A 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) MANOVA was conducted with each of the five categories listed above as dependent variables. The resulting three-way, two-way and main effect MANOVA $F$ ratios were not significant. Although, the MANOVA $F$ ratio for clinician gender did reveal a trend toward significance, $F(6,74) = 2.12$, $p < .10$ (see Table 11).

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Insert Table 11 about here
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For the main effect of clinician gender, the univariate ANOVA for general questions revealed that male clinicians ($M$ = 5.73) asked the clients more questions about issues that

fell in the general category than the female clinicians ($\underline{M}$ = 4.41), $\underline{F}(1,79)$ = 5.58, $\underline{p}$ <.05.

Although the multivariate $\underline{F}$ ratio was not significant, two univariate ANOVAs for client gender also showed a trend toward significance. In general, clinicians were more likely to ask the female clients questions about presenting symptoms than the male clients, $\underline{F}(1,79)$ = 2.93, $\underline{p}$ <.10 (see Table 12). More specifically, there was a trend for clinicians to ask more questions related to depressive symptoms for the female clients than the male clients, $\underline{F}(1,79)$ = 3.92, $\underline{p}$ <.06 (see Table 12). However, the univariate ANOVA did not result in a significant client gender main effect for social/domestic questions (see Table 12). Therefore, these results did not support Hypothesis 4.

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Insert Table 12 about here

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Results for Attributions of Etiology

Clinicians were asked to rate, on a seven-point Likert scale, the likelihood that each of ten etiological factors may contribute to the client's problems. A 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) MANOVA was conducted with these ten scales: physical illness, external stressors, traumatic experience, normative developmental transition, chronic interpersonal problems, biological predisposition, vocational stressors, marital conflict, dysfunctional family of origin, personal traits and 'other'. In order to test Hypotheses 5 and 6, two scales, external stressors and personal traits were included as items to

represent external-situational etiological factors and internal-stable etiological factors, respectively. Multivariate $F$ ratios for three-way, two-way and main effect analyses were not significant. However, the MANOVA $F$ ratio for the main effect of client gender did approach significance, $F(11,70) = 1.68$, $p < .10$ (see Table 13).

There was a trend indicating that clinicians were more likely to attribute the female clients' problems to a traumatic experience than the male clients' problems, $F(1,80) = 3.64$, $p < .10$ (see Table 14). There were no significant univariate ANOVA interactions or main effects for the variables external stressors and personal traits (see Table 14). Clinicians were equally likely to attribute the presenting problems of the male and female clients to external stressors and personal traits; therefore, Hypotheses 5 and 6 were not supported.

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Insert Tables 13 and 14 about here

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Results for Treatment Recommendations

Therapeutic Modality. To test components of Hypotheses 7 and 8, a 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) MANOVA was conducted with the eight scales related to treatment recommendations as dependent variables (i.e., individual therapy, group therapy, medication evaluation, physical evaluation, inpatient treatment, marital therapy, vocational counseling, no therapy). Specifically, Hypothesis 7 predicted that the female clients would be given higher ratings on recommendations for medication evaluation. In

addition, Hypothesis 8 predicted that the male clients would be given higher ratings on recommendations for group therapy. Multivariate $F$ ratios were not significant for three-way and two-way interactions or main effects (see Table 15). Furthermore, univariate ANOVA testing of the variables specified in the hypotheses were not significant (see Table 16).

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Insert Tables 15 and 16 about here

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The clinicians were also asked to choose, in rank order, the two most appropriate recommendations from the previous list of seven treatment modalities. Two chi-square analyses (one for each choice) were conducted. The first chi-square analysis was a 2 x 4 (Client Gender x Treatment Modality, with four levels: individual therapy, group therapy, medication evaluation and marital therapy, $X^2(3, N = 88) = 9.04$, $p < .05$) (see Table 17). Although this result was significant, these findings should be interpreted with caution due to the low expectancy value (below five) of some cells. The therapeutic recommendation category had four levels because all the clinicians' responses fell into one of the four categories mentioned above. For the first rank therapeutic recommendation, clinicians most frequently recommended individual therapy for both the female (67.4%) and male clients (66.7%) (see Table 17). There were differences in the percentages of male and female clients recommended for group therapy, medication evaluation and marital therapy. Specifically, consistent with Hypothesis 8,

for a first choice recommendation, male clients (20%) were more likely to be recommended for group therapy than female clients (2.3%). Of those few clinicians who recommended a medication evaluation as their first choice, more of them recommended the female clients (7.0%) than the male clients (2.2%), which gives some support to Hypothesis 8. Although not predicted, female clients (23.3%) were more likely to be given a first choice recommendation for marital therapy than male clients (11.1%).

For the second rank recommendation, clinicians' responses included six different recommendation choices (i.e., individual therapy, group therapy, medication evaluation, physical evaluation, marital therapy, and vocational counseling); therefore, a 2 x 6 chi-square analysis for the second choice recommendations was conducted (see Table 18). The expected frequencies for the cells of this analysis were also below the recommended value of five which suggests that these findings should be interpreted with caution. This analysis revealed no significant differences for male and female clients on the six treatment modalities, $X^2$(5, $N$ = 88) = 2.88, ns (see Table 18). However, the most frequently ranked second recommendation of treatment modality for both the female clients (39.5%) and the male clients (48.9%) was marital therapy.

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Insert Tables 17 and 18 about here

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Therapeutic Style. Clinicians were asked to rate

on a seven-point Likert scale the likelihood that they would recommend each of the four therapeutic styles (i.e., insight-oriented, cognitive-behavioral, directive, nondirective). Hypothesis 7 predicted that clinicians would be more likely to recommend nondirective therapy and insight-oriented therapy for the female clients. Also, Hypothesis 8 anticipated that clinicians would recommend cognitive/behavioral therapy and directive therapy for the male clients. To investigate these hypotheses, a 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) MANOVA was conducted with the four scales related to therapeutic style as dependent variables. The only multivariate $F$ ratio to reach significance was the clinician gender by client gender two-way interaction, $F(4,77) = 2.63$, $p < .05$ (see Table 19). However, the client gender by tape version two-way interaction demonstrated a trend toward significance, $F(4,77) = 2.11$, $p < .10$) (see Table 19).

Clinician gender by client gender univariate ANOVAs were significant for directive therapy, $F(1,80) = 4.47$, $p < .05$) and nondirective therapy, $F(1,80) = 8.44$, $p = <.01$. Specifically, for directive therapy, clinicians gave higher ratings for clients of the opposite sex, but simple effect post-hoc analyses revealed that these were not significant differences. That is, female clinicians gave relatively higher ratings to the male clients ($M = 4.48$) than the female clients ($M = 3.95$), $t(44) = -.91$, ns; and male clinicians gave relatively higher ratings to the female clients ($M = 4.90$) than the male clients ($M = 3.95$), $t(44) = 2.02$, ns. However, the opposite trend was found for

nondirective therapy, and these post-hoc analyses of simple effects also failed to reach significance. That is, female clinicians gave relatively higher ratings to female clients ($M$ = 3.35) than the male clients ($M$ = 2.13), $t(44)$ = 2.30, ns. Similarly, the male clinicians gave relatively higher ratings to the male clients ($M$ = 3.65) than the female clients ($M$ = 2.63), $t(44)$ = -1.91, ns.

For the client gender by tape version interaction, only the univariate ANOVA for cognitive-behavioral therapy was significant, $F(1,80)$ = 5.41, $p$ <.05. However, post-hoc analyses of these simple effects were not significant. That is, clinicians were relatively more likely to recommend the female client of Tape Version 1 ($M$ = 5.52) for cognitive-behavioral therapy than the female client of Tape Version 2 ($M$ = 4.91), $t(44)$ = 1.85, ns. However, the clinicians were relatively more likely to recommend the male client of Tape Version 2 ($M$ = 5.45) for cognitive-behavioral therapy than the male client of Tape Version 1 ($M$ = 4.52), $t(44)$ = -1.67, ns.

There were no significant univariate ANOVA client gender main effects for the dependent variables that were specified in the hypotheses (see Table 20). These data failed to provide support for these components of Hypotheses 7 and 8.

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Insert Tables 19 and 20 about here

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Results for Prognosis

Clinicians were asked to rate, on a seven-point Likert scale, their expectations about the client's prognosis. No

hypotheses were generated about this variable. A three-factor ANOVA 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) that was conducted for the scale addressing prognostic judgements revealed no significant interaction or main effect results (see Tables 21 and 22).

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Insert Tables 21 and 22 about here

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## Results for Length of Treatment

Clinicians were asked to indicate the number of outpatient sessions recommended, if they recommended outpatient therapy. If they recommended inpatient treatment, they were also asked to indicate the number of inpatient days recommended. No hypotheses were generated involving the length of treatment (i.e., number of outpatient sessions or number of inpatient days).

One three-factor ANOVA 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) was conducted for the clinicians' estimated length of outpatient treatment in terms of number of sessions and did not reveal any significant results (see Tables 23 and 24).

Clinicians were also asked to indicate the number of inpatient days recommended, if they believed that inpatient treatment was appropriate. Since very few clinicians recommended any inpatient treatment (11.4%), these responses were recoded into nominal variables indicating whether or not inpatient treatment was recommended. A 2 x 2 chi-square analysis was conducted (Inpatient Recommendation x Client Gender) and resulted in no significant difference between the

percentages of clinicians who recommended inpatient treatment for the male and female clients, $\underline{X}^2$(1, $\underline{N}$ = 88) = .005, ns (see Table 25). In addition, only analyses directly related to the main hypothesis of client gender differences were pursued; therefore, a t-test was conducted on the responses from the ten clinicians who recommended any inpatient treatment. This analysis also failed to reach significance, $\underline{t}$(8) = .06, ns (see Table 26).

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Insert Tables 23 through 26 about here

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## Manipulation Validation

The clinicians' responses to the question about the purpose of the study was analyzed for content. Three clinicians indicated that they suspected that the purpose of the study was to investigate client gender issues, and the data from these subjects were excluded from analyses.

## Discussion

This study investigated the influence of client gender on several aspects of clinicians' decision-making processes and clinical judgements. Hypotheses were generated about client gender influences on clinicians' recall, question generation, diagnostic impressions, treatment recommendations and prognostic judgements. Of these hypotheses, only those which predicted client gender differences in the types of therapeutic modalities recommended by clinicians were clearly supported by the results of this study. Before the specific hypotheses and their related findings are discussed in more depth, various methodological issues which could have contributed to the absence of results supporting the hypotheses will be addressed.

Previous research investigating gender issues in clinical judgements has relied primarily on written vignettes (Fernbach et al., 1989; Ford & Widiger, 1989; Hamilton et al., 1986; Warner, 1978; Warner, 1979). Similar to Buzcek's (1981) investigation, this study attempted to increase the realism of the analogue stimuli by using actors who were simulating a client's description of presenting problems. In addition, an effort was made to maximize the similarity between the male and female tapes for characteristics such as emotional display and intonation. It may be that this effort to control for potentially confounding differences between the male and female presentations resulted in a suppression of typical vocal and emotional differences displayed by males and females. Therefore, this experimentally induced similarity between the

male and female presentations may have actually diminished the authenticity of the tapes in terms of gender-specific characteristics. Consequently, gender-typical vocal cues to which clinicians respond may have been distorted thus minimizing the influence of client gender on the relevant variables.

In addition to the efforts to enhance the similarity between the male and female tapes, there was an attempt to maximize the similarity between all four tapes on the characteristics mentioned previously. However, some significant differences for clinician gender by tape version and client gender by tape version interactions were found, suggesting that differences in subtle, vocal characteristics among the four tapes existed. That is, despite the fact that all four tapes contained identical content (which was presented with relatively similar affect and tone of voice) clinicians occasionally responded differently to each of the actors in terms of clinical judgements and treatment recommendations. The process of enhancing the similarity between the tapes was difficult and, evidently, not completely successful. These findings suggest that, in the absence of visual information, individual prosodic vocal characteristics (such as rhythm, pitch, and inflection) play a role in clinical impressions. Although it is beyond the scope of this discussion to explore what those subtle, vocal differences might be and how they manifest themselves, these factors are worthy of future investigation.

In addition, obtaining an acceptable range of interrater reliability on the coding of the recall and question

generation data was more difficult than had been anticipated. Unlike Buzcek (1986), who reported an extremely high interrater agreement ranging from 91% to 97%, the correlation coefficients for the raters in this study were relatively lower. However, the means of three raters' data were used in the analyses for recall and question generation, so an acceptable degree of effective interrater reliability was achieved suggesting this was not a relevant methodological issue.

It could be argued that the lack of significant findings in the current study was due to the fact that a new cohort of clinicians was being investigated than in past studies. However, the sample of clinicians in the current study consisted of two cohorts, older male clinicians and younger female clinicians. Post-hoc analyses were conducted to determine if clinician age had a significant effect on the results of this study, and no significant effects were found. Therefore, it does not seem that cohort effects can account for the lack of significant gender effects in this study.

Diagnosis

With the exception of Fernbach et al.'s (1989) investigation addressing somatization disorder, most analogue studies investigating client gender effects on diagnostic decisions have focused on Axis II personality disorder diagnoses with disproportionate sex ratios (Ford & Widiger, 1989; Hamilton et al., 1986; Warner, 1978; Warner, 1979). Only Fernbach et al.'s (1989) analogue study included an exploration of possible client gender effects for an Axis I diagnosis with disproportionate sex ratios. The present

study investigated possible client gender effects in clinicians' diagnostic decisions for two Axis I diagnoses, major depression and alcohol dependence, which are noted for unequal percentages of males and females (American Psychiatric Association, 1987).

These results did not support Hypothesis 1, which predicted that clinicians would be less likely to consider the diagnosis of major depression appropriate for the male clients and less likely to consider the diagnosis of alcohol dependence appropriate for the female clients. That is, there were no client gender main effects for these two diagnoses.

However, there was an unanticipated client gender main effect for the diagnosis of alcohol abuse. These results revealed that clinicians considered the diagnosis of alcohol abuse more appropriate for the female clients than for the male clients. Although this diagnosis was not directly included in Hypothesis 1, it is considered a less severe form of problem-drinking than alcohol dependence (American Psychiatric Association, 1987). This result could be interpreted as indirectly contradicting the predictions of Hypothesis 1. Despite the fact that the male and female clients presented with equally severe alcohol dependence symptoms, clinicians were more likely to consider the diagnosis of alcohol abuse more appropriate for the female than the male clients. One speculation is that since alcohol-use problems in women contradict traditional sex-stereotyped expectations, when these difficulties are presented by a female client, clinicians may consider them

more of a concern. In addition, society's increased attention to substance abuse problems may have sensitized clinicians to the possibility of alcohol abuse problems in women as well as men. Since clinicians gave relatively equal ratings for the diagnosis of alcohol dependence, this interpretation seems plausible.

Although not predicted, there was a significant interaction (Clinician Gender x Tape Version) for the diagnosis of dysthymia. These findings revealed that female clinicians were more likely to consider a diagnosis of dysthymia appropriate for the clients of Tape Version 1. At the same time, male clinicians gave higher ratings for the diagnosis of dysthymia to the clients of Tape Version 2. Although every effort was made to minimize significant differences between the four tapes, some evidently remained. It seems that clinicians responded to prosodic vocal differences between the actors which affected their diagnostic impressions. These results highlight the complexity and influence of subtle, vocal factors which may affect a clinician's reaction to a client.

When forced to rank order the two most appropriate diagnoses, clinicians were equally likely to assign the depression-related diagnoses (major depression and dysthymia) and the alcohol dependence-related diagnoses (alcohol dependence and alcohol abuse) to both the male (46.7%) and the female clients (53.5%). Importantly, these clinicians accurately recognized the combination of depressive and alcohol-dependent symptoms that the clients presented and subsequently made the most appropriate diagnoses.

A number of possible explanations can be posited for the lack of findings to support Hypothesis 1. As mentioned previously, any subtle, vocal gender differences between the male and female client tapes, which may have affected clinicians' diagnostic impressions, may have been suppressed by the homogenization of the tapes. In addition, since the diagnostic criteria of major depression and alcohol dependence are considered more objective and have a demonstrated high interrater reliability, these diagnostic categories may be less vulnerable to gender influences (Hamilton et al., 1986; Spitzer et al., 1979). The script used in the tapes consisted of statements related to an equal number of symptoms for major depression and alcohol dependence. Although the case presentation was ambiguous in that it did not completely meet the criteria for either diagnosis, the criteria for these two diagnoses are relatively objective (Hamilton et al., 1986). As proposed by Hamilton et al. (1986), Axis I diagnostic criteria that are objective and behaviorally-anchored may not be as vulnerable to client gender effects as the more trait-based Axis II diagnostic categories. In fact, these results support the hypothesis that a client's gender does not override a clinician's consideration of the presenting symptoms when the diagnostic criteria are objective and behaviorally-anchored.

There was a trend for clinicians to give the male clients a second rank diagnosis related to anxiety disorders relatively more frequently than the female clients. This finding is not related to the hypotheses and is difficult to explain. A possibility is that these clinicians perceived

the male clients' affective symptoms as reflecting anxiety rather than depression. It seems that the clinicians were equally sensitive to the affective symptoms for both the male and female clients, but they may have more readily labeled such symptoms 'anxiety' in the male clients than the female clients.

Recall

Based on prior results reported by Buczek (1981, 1986), Hypothesis 2 predicted that clinicians would recall fewer facts for the female clients than the male clients. The findings from this study did not support this hypothesis and fail to support Buzcek's (1981) previous findings. That is, there were no differences in the total amount of information recalled for the female versus the male clients. In addition, there were no client gender main effects for recall in any of the recall categories including the following: social/domestic, employment, general, symptom-alcohol dependence, or symptom-depression. These findings suggest that, as with diagnosis, client gender was not a dominating factor that influenced the clinicians' recall of presenting information. In sum, a client's gender did not predominate over other factors in the clinicians' information-retrieval.

Also building on data from Buczek (1981), Hypothesis 3 proposed that female clinicians would remember more information than male clinicians. In addition to Buzcek's (1981) data, it is consistent with sex-role stereotypes to expect women to be more relationship and 'other-oriented' in their interactions, and therefore, they may be more attentive to the content presented by others. However, the data from

this study failed to support Hypothesis 3. Specifically, there were no differences in the amount of information recalled by female and male clinicians.

However, the data did reveal an unanticipated interaction in which clinicians recalled more information for the male client of Tape Version 1 than Tape Version 2. In addition, they were more likely to recall information for the female client of Tape Version 2 than the female of Tape Version 1. These findings also suggest that individual differences in vocal qualities have a notable impact on clinicians and warrant further investigation.

Question Generation

Consistent with previous research and sex-stereotyped expectations, Hypothesis 4 predicted that clinicians would ask more questions related to social/domestic concerns for the female client than the male client, regardless of presenting symptoms (Buczek 1981, 1986). However, these results failed to support that hypothesis. There was no significant difference between the percentages of social/domestic questions that clinicians asked the male clients versus the female clients. Similar to the findings with the recall data, these results suggest that a client's gender is not a primary factor in clinicians' information-gathering processes about familial and relationship concerns.

However, these analyses did result in two unanticipated near-significant trends for clinicians to ask female clients relatively more questions about presenting symptoms, in general, and depressive symptoms, specifically. These findings suggest that when clinicians were inquiring about

presenting psychiatric symptoms, gender did have an influence. Two possible explanations for the first trend are that the clinicians were more concerned about the female clients' symptoms than the male clients' symptoms or that, for some reason, the clinicians were reluctant to pursue specific concerns about symptoms with male clients. In addition, despite the fact that the male and female clients presented identical symptoms of alcohol dependence and depression, clinicians were relatively more likely to address concerns about depression for the female clients. This finding indirectly supports Hypothesis 1 in that there was a tendency for clinicians to investigate depressive symptoms more for female clients than for male clients.

Also, there was an interesting tendency for male clinicians to emphasize general therapeutic questions in their inquiries more than the female clinicians. This finding suggests that male clinicians were more willing to explore issues outside of the presenting information than female clinicians. However, this finding is difficult to fully explain due to the broad range of topics that were included in the general category (e.g., relationships with friends, past therapeutic experiences, therapeutic goals, and unrelated symptoms).

Etiological Factors

Previous clinical research investigating gender effects in clinicians' attributions of underlying etiological factors of clients' problems has been scant. However, Hypotheses 5 and 6 were developed based on data which suggested that females' problems are more likely to be attributed to

internal and stable factors while external-situational factors are more likely to be perceived as underlying males' problems (Deaux, 1976; Deaux & Emswiller, 1974; Fisher, 1989). Two seven-point Likert scales labeled external stressors and personal traits were included in a list of other possible etiological factors to represent the concepts of external-situational and internal-stable, respectively. Analyses on these scales, in particular, and seven other dependent variables related to etiology revealed no client gender main effects. That is, clinicians did not generate different hypotheses for the male and female clients in terms of these underlying etiological factors including external stressors and personal traits. It is possible that the external-situational and internal-stable concepts are more complex than these scales were able to represent.

However, there was a trend for clinicians to consider traumatic experience an underlying etiological factor more for the female clients than the male clients. This finding is interesting since the clients in the tapes gave no direct indication of past or current abuse. One speculation is that clinicians may believe that there is a higher prevalence of sexual and physical abuse for women than men, and therefore, they may rely on this base-rate information to anticipate that their female clients' have been or are being abused. In light of the limited research on etiological factors, it would be beneficial for future investigations to develop more specific operationalized definitions of etiological concepts when investigating variables that affect clinical judgement.

Treatment Recommendations

Therapeutic Modality. Based on previous research,
Hypothesis 7 had predicted that female clients would be
recommended more for medication, and Hypothesis 8 anticipated
that male clients would be recommended more frequently for
group therapy (Fernbach et al., 1989; Hohman, 1989; Stein et
al., 1976). These data revealed that when clinicians were
asked to rate their likelihood of recommending a particular
treatment modality, no client gender differences emerged.
However, when clinicians were forced to choose their first
choice therapeutic recommendation, there were some
significant differences for client gender. These findings
indicated that individual therapy was the first choice
treatment recommendation by most clinicians for both the male
(67.4%) and the female (66.7%) clients. However, those
clinicians who did not recommend individual therapy for the
male client were most likely to recommend group therapy,
which is consistent with the prediction of Hypothesis 8. In
addition, the clinicians who did not recommend individual
therapy for the female clients were most likely to recommend
marital therapy. Although not anticipated, this suggests
that clinicians may consider changes in the marital
relationship to be more important for the female clients, who
present with depression and alcohol dependent problems, than
male clients with similar problems. Of the few clinicians
who recommended a medication evaluation as their first
choice, there was a trend for them to recommend this
intervention more frequently for the female clients than the
male clients, which gives some support to Hypothesis 7.
However, these findings should be interpreted with caution

due to the small number of cases in these analyses.

Although this study's finding that males are more likely to be recommended for group therapy was supported by previous research, it is difficult to explain (Fernbach et al., 1989). It could be that clinicians expect males to be more resistant to interventions and need consensual validation or to be intimidated by the therapeutic relationship. One important focus for future research is to further investigate the factors that contribute to clinicians' apparent tendency to consider males more appropriate than females for group therapy.

Although the finding of this study regarding gender differences in recommendations for medication evaluations was slight, it did provide some support for previous studies that have suggested that females are more likely to be recommended for psychotropic medications than males, even when they present with equally severe symptoms (Hohman, 1989; Schwartz & Abramowitz, 1975; Stein et al., 1976). One concern that stems from this body of research is that males and females with depressive symptoms may be receiving inadequate or inappropriate treatment.

These findings are similar to Ford and Widiger's (1989) findings in which the process by which clinicians evaluated presenting symptoms was not influenced by client gender while the overall diagnostic outcome did reveal client gender effects. That is, Ford and Widiger (1989) found that the actual process of making clinical judgements based on specific criteria was not affected by the client's gender. However, when the clinicians were asked to make a global

judgement, client gender had a significant influence. In the present study, the processes involved in the clinicians' recall of information, generation of interview questions, and relatively objective, diagnostic decision-making did not seem to be greatly influenced by client gender. However, clinicians' global outcome treatment recommendations revealed that client gender was influential.

Speculation leads one to wonder if these gender differences for the outcome of treatment recommendations could be due to some underlying diagnostic gender effect. That is, if a woman is perceived as depressed, regardless of other coexisting symptoms, she is referred for marital therapy or a medication evaluation. Likewise, if a male presents with symptoms of alcohol dependence, regardless of the other coexisting symptoms, he is referred for group therapy. It seems that males and females are not necessarily getting worse treatment but different treatments reflecting a difference in therapeutic emphasis. In addition, these results suggest that when clients present with combined symptoms of depression and alcohol dependence, treatment planning may focus on one aspect of the symptomatic picture more than another.

Therapeutic Style. Consistent with Fernbach et al.'s (1989) findings, Hypothesis 7 and 8 anticipated that males would be recommended more for directive and cognitive-behavioral therapy while females would be seen as more appropriate for nondirective and insight-oriented therapy. However, these hypotheses were not supported by this study.

There were two clinician gender by client gender

interactions which approached significance. It seems that clinicians were more likely to recommend a directive therapeutic style when working with opposite-sex clients. However, when working with a client of the same sex, clinicians were more likely to recommend a nondirective style. These findings suggest that when clinicians are working with clients of the opposite sex, they prefer being more active and promoting more structure in the therapeutic interactions. Yet, when working with same-sex clients, the clinicians were willing to be less active and to have minimal structure in therapeutic interactions. It may be that clinicians are less comfortable and/or have more anxiety about conducting therapy with clients of the opposite sex.

There was a significant client gender by tape version interaction for cognitive-behavioral therapy in which the female client of Tape Version 1 was given higher ratings than the female of Tape Version 2. Conversely, the male client of Tape Version 2 was given higher ratings than the male client of Tape Version 1. These results also highlight the significant influence of individual vocal characteristics on the clinicians' judgements.

Nonetheless, it seems that client gender, alone, was not a significant factor in determining the particular therapeutic style that a clinician recommended. Intuitively, it would seem that a clinician's identified theoretical orientation, in combination with the client's presenting problems, would be strong determinants of a recommended therapeutic style.

Prognosis

Due to mixed and inconclusive results in the literature, there were no hypotheses generated about clinicians' prognostic judgements (Miller, 1974; Schwartz & Abramowitz, 1975; Stack et al., 1983; Stearns et al., 1980; Zygmond & Denton, 1988). In fact, no client gender or clinician gender effects were found for a clinician's prognostic rating.

## Length of Treatment

Also due to mixed results from previous data, no hypotheses were generated about clinicians' recommendations for length of treatment (Abramowitz et al., 1976; Brown & Kosterlitz, 1964; Hoffman & Noem, 1975; Kirshner & Johnston, 1983). The findings from this study support results from previous studies which indicated that client gender does not affect clinicians' recommendations for treatment duration (inpatient or outpatient) (Kirshner & Johnston, 1983; Stein et al., 1976).

## Conclusion

In summary, this study failed to find client gender differences in clinicians' recall, question generation, and diagnoses. These findings suggest that client gender is not an overriding factor for these aspects of clinical judgment. Interestingly, clinicians' global treatment recommendations did demonstrate client gender differences even in the absence of diagnostic differences between the male and female clients. Specifically, the female clients were referred more often for marital therapy and medication while the male clients were more likely to be referred for group therapy. Although these inconsistent findings are not easily explained, it may be that the information-retrieval,

information-gathering and diagnostic decision-making
processes are not susceptible to gender effects while the
global decision regarding a preferred therapeutic
intervention is vulnerable to sex-stereotyped expectations.
In addition, the presence of significant differences between
the individual tapes was evident and highlighted the
influence of subtle, vocal factors on clinical impressions.

One notable limitation of this study, as with most
analogue studies, was that it fell short of accurately
simulating the clinical situation. When clinicians are
conducting intake assessments, they have access to nonverbal
information that was not available by listening to a voice on
an audiotape. Also, the tape consisted of a monologue
presentation; consequently, clinicians did not have the
opportunity to observe the clients interacting with another
person or to gather additional information from the clients.
Therefore, these findings have only limited generalizability
to actual clinical phenomena.

It would be worthwhile for future studies to investigate
the prosodic, vocal factors displayed in audiotapes and the
mechanisms by which they affect clinical judgement. In
addition, the growing body of literature which suggests that
clinicians are more likely to recommend males for group
therapy and females for marital therapy and medication,
despite identical symptoms, deserves more investigation.
Also, despite the lack of significant results related to
client gender effects in attributions of etiology, this
aspect of the clinical process has been neglected by research
and deserves more focused investigation.

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Table 1

Age Distribution of Male and Female Clinicians

| Therapist Age | Females % | Males % |
|---|---|---|
| 20-29 | 18.6 | 4.5 |
| 30-39 | 34.9 | 36.5 |
| 40-49 | 46.5 | 47.7 |
| 50-59 | 0.0 | 11.4 |

Table 2

Years of Experience distribution of Male and

Female Clinicians

| Years of Experience | Females % | Males % |
|---|---|---|
| 1-5 | 45.5 | 29.5 |
| 6-10 | 25.0 | 18.2 |
| 11-15 | 22.7 | 29.5 |
| 16-20 | 6.8 | 9.1 |
| 21-over | 0.0 | 13.7 |

Table 3

## 2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) MANOVA for Diagnoses

| Effect/ Interaction | $F(10,71)$ | $p$ |
|---|---|---|
| T | 1.78 | .08 |
| C | 2.32 | .02 |
| V | 1.17 | .33 |
| TC | .67 | .75 |
| TV | 2.06 | .04 |
| CV | 1.44 | .18 |
| TCV | .69 | .72 |

Note. T = Therapist gender ; C = Client gender; V = Version of tape.

Table 4

Univariate Analysis of Variance for Client Gender Effects

for Diagnoses

| Diagnosis | Means | | | |
|---|---|---|---|---|
| | Female | Male | $F(1,80)$ | p |
| Adjustment Disorder w/ Anxiety | 3.76 | 3.70 | .00 | .96 |
| Alcohol Abuse | 5.65 | 5.21 | 4.84 | .03 |
| Alcohol Dependence | 4.63 | 4.95 | 1.67 | .20 |
| Dysthymia | 5.15 | 4.95 | .39 | .53 |
| Generalized Anxiety Disorder | 3.08 | 3.40 | 1.36 | .25 |
| Major Depression | 5.06 | 5.10 | .13 | .72 |
| Borderline Personality Disorder | 2.82 | 2.55 | 1.96 | .17 |
| Histrionic Personality Disorder | 2.50 | 2.30 | .31 | .58 |
| Obsessive- Compulsive Personality Disorder | 2.61 | 2.85 | 1.75 | .19 |
| Paranoid Personality Disorder | 2.10 | 2.46 | 2.38 | .13 |

Table 5

Distribution of First Rank Diagnosis by Client Gender

|  | Depression/ Dysthymia | | Alcohol Abuse/ Dependence | | Other | |
|---|---|---|---|---|---|---|
|  | n | % | n | % | n | % |
| Female client | 28 | (65.1) | 10 | (23.3) | 5 | (11.6) |
| Male client | 28 | (62.2) | 9 | (20.0) | 8 | (17.8) |

$X2(2) = .699$    $p$ = ns

Table 6

Distribution of Second Rank Diagnosis by Client Gender

|  | Depression/ Dysthymia | | Alcohol Abuse/ Dependence | | Other | |
| --- | --- | --- | --- | --- | --- | --- |
|  | n | % | n | % | n | % |
| Female client | 16 | (37.2) | 27 | (62.8) | 0 | (0.0) |
| Male client | 15 | (33.3) | 25 | (55.6) | 5 | (11.1) |

$X2(2) = 5.06$    $p = <.10$

Table 7

Distribution of Combined Diagnoses by Client Gender

|  | Alcohol Dep./ Depression | | Depression/ Other | | Alcohol Dep./ Other | | Other/ Other | |
|---|---|---|---|---|---|---|---|---|
|  | n | % | n | % | n | % | n | % |
| Female client | 23 | (53.5) | 6 | (14.0) | 14 | (32.6) | 0 | (0.0) |
| Male client | 21 | (46.7) | 6 | (13.3) | 17 | (37.8) | 1 | (2.2) |

$X2(3) = 1.33$    $p = ns$

Table 8

2 x 2 x 2 (Clinician Gender x Client Gender x Tape
Version) MANOVA for Recall Categories

| Effect/<br>Interaction | $F(6,74)$ | $p$ |
|---|---|---|
| T | .67 | .68 |
| C | .36 | .90 |
| V | .50 | .80 |
| TC | .91 | .49 |
| TV | .71 | .65 |
| CV | 1.05 | .40 |
| TCV | .39 | .88 |

Note. T = Therapist gender ; C = Client gender; V =
Version of tape.

Table 9

Univariate Analysis of Variance for Client Gender Effects

for Recall Categories

| Category | Means | | | |
| | Female | Male | $F(1,79)$ | $p$ |
| --- | --- | --- | --- | --- |
| Social/ Domestic | 5.92 | 5.56 | .59 | .44 |
| Employment | 4.51 | 4.54 | .00 | .96 |
| General | 1.65 | 1.55 | .20 | .66 |
| Symptom Total | 3.16 | 3.14 | .01 | .90 |
| Symptoms of Depression | 1.90 | 1.83 | .09 | .75 |
| Symptoms of Alcohol Dependence | 1.26 | 1.31 | .02 | .87 |

Table 10

2 x 2 x 2 (Clinician Gender x Client Gender x Tape
Version) Analysis of Variance for Total Amount Recalled

| Source of Variation | Mean Squares | $F(1,79)$ | $p$ |
|---|---|---|---|
| T | 8.93 | .56 | .46 |
| C | 5.45 | .34 | .56 |
| V | 2.32 | .15 | .70 |
| TC | 20.21 | 1.27 | .26 |
| TV | .42 | .03 | .87 |
| CV | 65.34 | 4.10 | .04 |
| TCV | 4.94 | .31 | .58 |
| Error | 15.93 | | |

Note. T = Therapist gender ; C = Client gender; V =
Version of tape.

Table 11

2 x 2 x 2 (Clinician Gender x Client Gender x Tape
Version) MANOVA for Question Categories

| Effect/<br>Interaction | $F(6,74)$ | $p$ |
|---|---|---|
| T | 2.12 | .06 |
| C | 1.58 | .17 |
| V | .99 | .44 |
| TC | .87 | .52 |
| TV | 1.85 | .10 |
| CV | .68 | .67 |
| TCV | .55 | .77 |

Note. T = Therapist gender ; C = Client gender; V =
Version of tape.

Table 12

Univariate Analysis of Variance for Client Gender Effects

for Question Categories

| Category | Means | | | |
|---|---|---|---|---|
| | Female | Male | F(1,80) | p |
| Social/ Domestic | 4.07 | 3.58 | 1.00 | .32 |
| Employment | 1.08 | 1.10 | .00 | .98 |
| General | 4.68 | 5.41 | 2.05 | .16 |
| Questions Symptom Total | 6.78 | 5.52 | 2.93 | .09 |
| Questions Depression | 3.95 | 2.91 | 3.92 | .05 |
| Questions Alcohol Dependence | 2.83 | 2.61 | .27 | .61 |

Table 13

2 x 2 x 2 (Clinician Gender x Client Gender x Tape Version) MANOVA for Etiological Factors

| Effect/ Interaction | $F(11,70)$ | $p$ |
|---|---|---|
| T | .69 | .74 |
| C | 1.68 | .09 |
| V | .93 | .52 |
| TC | .60 | .82 |
| TV | 1.06 | .40 |
| CV | 1.43 | .17 |
| TCV | 1.47 | .16 |

Note. T = Therapist gender ; C = Client gender; V = Version of tape.

Table 14

Univariate Analysis of Variance for Client Gender Effects

for Etiological Variables

| Underlying Etiological Factors | Means | | | |
|---|---|---|---|---|
| | Female | Male | F(1,80) | p |
| External Stressors | 6.00 | 6.04 | .05 | .82 |
| Personal Traits | 5.19 | 5.10 | .54 | .46 |
| Physical Illness | 3.23 | 2.87 | .28 | .60 |
| Traumatic Experience | 3.82 | 3.34 | 3.64 | .06 |
| Normative Developmental Transition | 4.58 | 4.55 | .02 | .89 |
| Chronic Interpersonal Problems | 4.54 | 5.04 | 1.38 | .24 |
| Biological Predisposition | 3.96 | 4.04 | .05 | .81 |
| Vocational Stressors | 5.29 | 5.64 | 1.73 | .19 |
| Marital Conflict | 5.93 | 5.79 | .48 | .49 |
| Dysfunctional Family of Origin | 5.28 | 5.40 | .01 | .91 |
| Other | .95 | 1.48 | .93 | .34 |

Table 15

2 x 2 x 2 (Clinician Gender x Client Gender x Tape
Version) MANOVA Therapeutic Modality Recommendations

| Effect/<br>Interaction | $\underline{F}(8,73)$ | $\underline{p}$ |
|---|---|---|
| T | .79 | .61 |
| C | 1.35 | .23 |
| V | 1.15 | .34 |
| TC | .54 | .82 |
| TV | .57 | .79 |
| CV | .45 | .89 |
| TCV | .56 | .81 |

Note. T = Therapist gender ; C = Client gender; V =
Version of tape.

Table 16

Univariate Analysis of Variance for Client Gender Effects
for Recommendations of Therapeutic Modality

| Treatment Modaility | Means | | | |
|---|---|---|---|---|
| | Female | Male | $F(1,80)$ | $p$ |
| Group Therapy | 4.06 | 4.70 | 1.66 | .20 |
| Medication Evaluation | 4.91 | 4.83 | .16 | .69 |
| Individual Therapy | 6.26 | 6.12 | .01 | .91 |
| Physical Evaluation | 4.97 | 4.48 | 1.66 | .20 |
| Inpatient Treatment | 1.69 | 2.04 | 2.71 | .10 |
| Marital Therapy | 5.86 | 5.51 | 2.71 | .10 |
| Vocational Counseling | 3.30 | 3.31 | .01 | .89 |
| No Therapy | 1.15 | 1.17 | .04 | .84 |

Table 17

Distribution of First Rank Therapuetic Recommendation by

Client Gender

| | Individual | | Group | | Medication Evaluation | | Marital | |
|---|---|---|---|---|---|---|---|---|
| | $\underline{n}$ | $\underline{\%}$ | $\underline{n}$ | $\underline{\%}$ | $\underline{n}$ | $\underline{\%}$ | $\underline{n}$ | $\underline{\%}$ |
| Female client | 29 | (67.4) | 1 | (2.3) | 3 | (7.0) | 10 | (23.3) |
| Male client | 30 | (66.7) | 9 | (20.0) | 1 | (2.2) | 5 | (11.1) |

$\underline{X}2(3) = 9.04$     $\underline{p} = <.05$

Table 18

Distribution of Second Rank Therapuetic Recommendation by
Client Gender

| | Individual | Group | Medic. Eval. | Marital | Phys. Eval. | Vocat. Couns. |
|---|---|---|---|---|---|---|
| | n % | n % | n % | n % | n % | n % |
| Female client | 7(16.3) | 5(11.6) | 11(25.6) | 17(39.5) | 2(4.7) | 1(2.3) |
| Male client | 5(11.1) | 2(4.4) | 11(24.4) | 22(48.9) | 4(8.9) | 1(2.2) |

$X2(5)$ = 2.88     $p$ = ns

Note. Individual = Individual Therapy; Group = Group

Therapy; Medic. Eval. = Medication Evaluation; Marital =

Marital Therapy; Phys. Eval. = Physical Evaluation; Vocat.

Couns. = Vocational Counseling.

Table 19

2 X 2 X 2 (Clinician Gender X Client Gender X Tape Version) MANOVA for Therapeutic Style

| Effect/ Interaction | $\underline{F}(4,77)$ | $\underline{p}$ |
|---|---|---|
| T | 1.43 | .23 |
| C | .38 | .82 |
| V | 1.56 | .19 |
| TC | 2.63 | .04 |
| TV | .81 | .52 |
| CV | 2.11 | .09 |
| TCV | 1.84 | .13 |

Note. T = Therapist gender ; C = Client gender; V = Version of tape.

Table 20

Univariate Analysis of Variance for Client Gender Effects

for Recommended Therapeutic Style

| Therapeutic Style | Means | | | |
| --- | --- | --- | --- | --- |
| | Female | Male | $F(1,80)$ | p |
| Insight-Oriented | 5.50 | 5.13 | .48 | .49 |
| Cognitive-Behavioral | 5.21 | 5.00 | .52 | .47 |
| Directive | 4.50 | 4.25 | .35 | .55 |
| Nondirective | 2.97 | 2.89 | .01 | .90 |

Table 21

2 x 2 x 2 (Clinician Gender x Client Gender x Tape
Version) Analysis of Variance for Rating of Prognosis

| Source of Variation | Mean Squares | $\underline{F}(1,80)$ | $\underline{p}$ |
|---|---|---|---|
| T | .09 | .10 | .75 |
| C | 1.08 | 1.25 | .27 |
| V | .94 | 1.09 | .30 |
| TC | .20 | .23 | .64 |
| TV | .32 | .37 | .55 |
| CV | .07 | .08 | .78 |
| TCV | .20 | .23 | .63 |
| Error | .86 | | |

Note. T = Therapist Gender, C = Client Gender, V = Version of Tape.

Table 22

Analysis of Variance for Prognosis by Client Gender

| Means | | $F_{(1,80)}$ | $p$ |
|---|---|---|---|
| Female | Male | | |
| 5.34 | 5.12 | 1.25 | .27 |

Table 23

2 x 2 x 2 (Clinician Gender x Client Gender x Tape
Version) Analysis of Variance for Number of Outpatient
Sessions Recommended

| Source of Variation | Mean Squares | $F(1,80)$ | $p$ |
|---|---|---|---|
| T | 430.02 | 1.21 | .28 |
| C | 3.37 | .01 | .92 |
| V | .81 | .00 | .96 |
| TC | 29.12 | .08 | .77 |
| TV | .01 | .00 | .99 |
| CV | 1140.05 | 3.20 | .07 |
| TCV | 7.34 | .02 | .89 |
| Error | 356.23 | | |

Note. T = Therapist gender ; C = Client gender; V =
Version of tape.

Table 24

Analysis of Variance for Outpatient Sessions by Client Gender

| | Means | | $F(1,80)$ | $p$ |
|---|---|---|---|---|
| | Female | Male | | |
| | 22.58 | 22.82 | .01 | .92 |

Table 25

Distribution of Recommendation of Inpatient Treatment by
Client Gender

| | Recommend Inpatient | | Not Recommend Inpatient | |
|---|---|---|---|---|
| | $\underline{n}$ | $\underline{\%}$ | $\underline{n}$ | $\underline{\%}$ |
| Female client | 5 | (11.6) | 38 | (88.4) |
| Male client | 5 | (11.1) | 40 | (88.9) |

$\underline{X}2(1) = .005$    $\underline{p} = ns$

Table 26

T-test for Inpatient Days Recommended by Client Gender

| Means | | $t(8)$ | $p$ |
|---|---|---|---|
| Female | Male | | |
| 17.00 | 16.60 | .06 | .95 |

## Appendix A

### Examples of Female and Male Scripts

Female Script:

Client's response to the Dr.'s question "Tell me what brought you in here today?"

Well, I guess things haven't been going very well lately. And it seems to be getting worse no matter what I do. A lot of things in my life have been bothering me, and I just don't know how to deal with it anymore. Part of it's my job....

I work for this communications company. And, I really used to <u>like</u> my job. You see, I work with computers, and I <u>like</u> that. But, it's my boss. You see, it's this woman that I work for. It's like she just always *demands* so much extra time and work from me. There just doesn't seem to be enough time in the day to it all done and still get home at a reasonable hour.

And even when I *do* get everything done, and <u>I</u> think I've done a good job. It's that she never says anything good. But, if there's a mis<u>take</u>. I sure do hear about <u>that</u>. It just doesn't seem fair to me. And then whenever...if I start to bring it up. I mean these concerns I have or any other problems I may be having. She always seems to get really angry, and I'm just afraid of what she's gonna do if I ever make her <u>too</u> angry. And, so, I don't feel like I can do anything about it.

And... I don't know... I'm really worried because I want to get this raise. I'm up for a raise, a merit raise and ...I'm really not sure <u>how</u> that's gonna go. But it's not just <u>her</u>. It's other things too. It seems that with these

projects that I've been working on...well they're pretty important, and I just seem to have trouble concentrating on them. And, well, there are times when I come in <u>late</u> in the mornings and I don't know if she picks up on that stuff or what. I'm just not sure, and I don't know, I've just been worrying a lot about my job. I really have been.

Well, one reason I'm late all the time is that I'm having so much trouble sleeping. I wake up early in the morning, before I need to be up, and I have trouble going back to sleep. And it seems like getting out of bed in the morning is one of the <u>hardest</u> things to do. Then, well, I <u>am</u> really afraid she's picking up on these things. And I have got to have that raise...normally I wouldn't care so much, but it's really important to me right now to get that raise.

You see, my husband and I have been having these financial problems lately. And well, we bought this new house a few months ago and money has gotten <u>very</u> tight. It hasn't <u>always</u> been this way. We've been married just over two years and things were going pretty well. But, over these past few months....with this money crunch....Well, things have just gotten <u>so</u> much worse. Before, we'd come home from work and share a couple of drinks and talk about how our days had gone...But <u>now</u> we come home and share our drinks in front of the <u>TV</u> instead of talking. But it's just <u>not</u> the same. And, well, it seems like that after dinner we get into these arguments. At first we start off talking about finances but then we always seem to get off onto other things....It seems like after I've had a few drinks I always end up saying things that I really <u>don't</u> mean.....I don't know...Like I was

saying, our arguments always seem to get out of hand. We always fight about so many different things.

One thing we argue about is starting a family... *He thinks* ....well...he seems to be bringing that up <u>often</u> lately. But, with the financial problems we're having and, the way we haven't been getting <u>along</u>...<u>I'm</u> not sure. I know some people say that having children can bring people closer together, but ...you know....I'm just afraid that with all the stress we're under, with money and all, a baby may drive us further apart. I just don't know what to do ...Things are just going <u>really</u> badly right now.

And as if our personal problems aren't bad enough, my husband *always* brings my parents up too. You see...my husband thinks my parents are too hard on me. I have this brother who is a <u>doctor</u> and of course he makes a lot of money. Basically, in my parents' eyes he can't do any wrong. Well, my sister, she married a lawyer and just had a baby. And then there's me....The other side of the story is that my parents have never approved of my husband.... Anyway, my husband and my parents have <u>never</u> really gotten along.

You know, when I was in college, well I went to this <u>really</u> good school, and I made all A's and B's. Well, <u>now</u> I don't feel like I'm making as much money as I should be with my degree. My parents throw it up in my face that they paid <u>so</u> much money for me to get that diploma and that I haven't used it very well. I <u>have</u> been thinking about going back to school and getting more training....But with money so tight right now, well, we really can't afford for one of us to quit our job or do anything like that.

And besides the fact that we don't have much money, I'm just not _motivated_ like I used to be. I just don't have much energy. I seem to feel tired a lot of the time. And when I'm at work, I think about money, I think about the problems with my husband....It used to be that a drink would help me unwind and forget about some of this stuff. And I used to look _forward_ to having some drinks after work. They really helped take the edge off....Sometimes, I find that during the middle of the day I start thinking about what it's gonna be like to get home in the evening and just relax with a drink. I really look forward to that...But you know... It seems like one or two doesn't help me forget my day like they used to. It's just not the same.

I just don't enjoy anything like I used to. You know, I used to enjoy watching movies...And now, I can't seem to sit through an entire one without losing interest. And I got this bicycle that I had _really_ wanted. It was really a splurge in terms of money. And now that I've got it... It just seems like too much trouble to even get it out....

I'm just not sure what to do... Well, I really don't have anyone to talk to about these problems.

You know, I used to have some friends at work. There were some people there that I used to get along with. Well, the other day I overheard somebody saying that, well, that I'm moody. You know, _that_ _really_ bothered me. I _thought_ we got along...._These_ days I haven't been up for much of _anything_...But I _don't_ think that means I'm _moody_...I just really hope you can help me with these problems. I just don't know what to do anymore....

Male Script:

Client's response to the Dr.'s question "Tell me what brought you in here today?"

Well, I guess things haven't been going very well lately. And it seems to be getting worse no matter what I do. A lot of things in my life have been bothering me and I just don't know how to deal with it anymore. Part of it's my job....

I work for this communications company. And, I really used to <u>like</u> my job. You see, I work with computers, and I <u>like</u> that. But, it's my boss. You see, it's this man that I work for. It's like he just always *demands* so much extra time and work from me. There just doesn't seem to *be* enough time in the day to it all done and still get home at a reasonable hour.

And even when I *do* get everything done, and <u>I</u> think I've done a good job. It's that he never says anything good. But, if there's a mis<u>take</u>. I sure do hear about <u>that</u>. It just doesn't seem fair to me. And then whenever...if I start to bring it up. I mean these concerns I have or any other problems I may be having. He always seems to get really angry, and I'm just afraid of what he's gonna do if I ever make him <u>too</u> angry. And, so, I don't feel like I can do anything about it.

And... I don't know... it's like, I'm really worried because I want to get this raise. I'm up for a raise, a merit raise and ...I'm really not sure <u>how</u> that's gonna go. But it's not just <u>him</u>. It's other things too. It seems that with these projects that I've been working on...well, they're pretty important, and, I just seem to have trouble

concentrating on them. And, well, there are times when I come in <u>late</u> in the mornings and I don't know if he picks up on that stuff or what. I'm just not sure, and I don't know, I've just been worrying a lot about my job. I really have been.

Well, one reason I'm late all the time is that I'm having so much trouble sleeping. I wake up early in the morning, before I need to be up, and I have trouble going back to sleep. And it seems like getting out of bed in the morning is one of the <u>hardest</u> things to do. Then, well, I <u>am</u> really afraid he's picking up on these things. And I have got to have that raise...normally I wouldn't care so much, but it's really important to me right now to get that raise.

You see, my wife and I have been having these financial problems lately. And well, we bought this new house a few months ago and money has gotten <u>very</u> tight. It hasn't <u>always</u> been this way. We've been married just over two years and things were going pretty well. But, over these past few months....with this money crunch....Well, things have just gotten <u>so</u> much worse. Before, we'd come home from work and share a couple of drinks and talk about how our days had gone...But <u>now</u> we come home and share our drinks in front of the <u>TV</u> instead of talking. But it's just <u>not</u> the same. And, well, it seems like that after dinner we get into these arguments. At first we start off talking about finances but then we always seem to get off onto other things....It seems like after I've had a few drinks I always end up saying things that I really <u>don't</u> mean....I don't know...Like I was saying, our arguments always seem to get out of hand. We

always fight about so many different things.

Another thing we argue about is starting a family...
*She thinks* ....well...she seems to be bringing that up <u>often</u>
lately. But, with the financial problems we're having and,
the way we haven't been getting <u>along</u>...<u>I'm</u> not sure. I know
some people say that having a *baby* can *bring people closer*
together, but ...you know....I'm just afraid that with all
the stress we're under, with money and all, a baby may drive
us further apart. I just don't know what to do ...Things are
just going <u>really</u> badly right now.

And as if our personal problems aren't bad enough, she
*always* brings my parents up too....you see.. my wife thinks
my parents are too hard on me. I have this brother who is a
<u>doctor</u> and of course he makes a lot of money. Basically, in
my parents' eyes he can't do any wrong. Well, my sister, she
married a lawyer and just had a baby. And then there's
me.... The other side of the story is that my parents have
never approved of my wife.... Anyway, my wife and my parents
have <u>never</u> really gotten along.

You know, when I was in college, well I went to this
<u>really</u> good school, and I made all A's and B's. Well, now I
don't feel like I'm making as much money as I should be with
my degree. My parents throw it up in my face that they paid
<u>so</u> much money for me to get that diploma and that I haven't
used it very well. I <u>have</u> been thinking about going back to
school and getting more training....But with money so tight
right now, well, we really can't afford for one of us to quit
our job or do anything like that.

And, besides the fact that we don't have much money, I'm

just not <u>motivated</u> like I used to be. I just don't have much energy. I seem to feel tired a lot of the time. And when I'm at work, I think about money, I think about the problems with my wife....It used to be that a drink would help me unwind and forget about some of this stuff. And I used to look <u>forward</u> to having some drinks after work. They really helped take the edge off....Sometimes, I find that during the middle of the day I start thinking about what it's gonna be like to get home in the evening and just relax with a drink. I really look forward to that.. But you know... It seems like one or two doesn't help me forget my day like they used to. It's just not the same.

I just don't enjoy anything like I used to. You know, I used to enjoy watching movies...And now, I can't seem to sit through an entire one without losing interest. And I got this bicycle that I had <u>really</u> wanted. It was really a splurge in terms of money. And now that I've got it... It just seems like too much trouble to even get it out....

I'm just not sure <u>what</u> to do...Well, I really don't have anybody to <u>talk</u> to about these problems...

You know, I used to have some friends at work. There were some people there that I used to get along with. Well, the other day I overheard somebody saying that, well, that I'm moody. You know, <u>that</u> <u>really</u> bothered me. I <u>thought we</u> got along....<u>These days</u> I haven't been up for much of <u>anything</u>...But I <u>don't</u> think that means I'm <u>moody</u>...I just really hope you can help me with these problems. I just don't know what to do anymore....

Appendix B

Informed Consent Form

Project Name: Empathy

Investigator(s): Jodi French and Barbara Winstead, Ph.D.
Date:_____.

By signing this form I,_____ am
agreeing to participate as a volunteer in the following
study. I am aware that this study is a part of the
educational and research program of Old Dominion University
and is supervised by Barbara Winstead, Ph.D.

I understand that I will listen to an audiotape of a person
who is presenting specific concerns. I also agree to
complete written tasks and to answer questions similar to
those performed during an initial interview.
I understand that all data and information I provide will be
kept confidential in terms of my identity.
I have been given an opportunity to ask questions and am
satisfied with the answers.

I am aware that I have the choice to withhold any answer to
specific items or questions in the questionnaires.

I acknowledge that I can withdraw my consent and end
participation at any time, without any negative consequences.

I understand that the exact purpose of the study will be
explained to me during a debriefing at the end of the study.

I understand that I have the right to contact the Psychology
Department Committee for the Protection of Human Subjects
and/or the University Committee should I wish to express any
opinions regarding the conduct of this study.


Date:_____.     Signature:_____.

Date of Birth:_____.

Appendix C

## Sample of Questionnaire

Dear Clinician:

The following information is confidential, so please do not write your name on the questionnaire.

Age:_____.

Sex:_____.

Years of experience as a clinician (post-degree):_____.

Professional degree_____.

Please indicate what percentage of your time is spent in the following employment settings: (please base this on 100% total)

1) Inpatient (Acute)                                    _____

2) Inpatient specialized  (specify_____.)
   (behavioral medicine, eating
   disorders, substance abuse, etc.)             _____

3) Inpatient (intermediate/long-term)      _____

4) Outpatient (public)                             _____

5) Outpatient (private practice)              _____

6) Outpatient (university
   counseling center)                              _____

7) Outpatient specialized (specify_____.)
   (behavioral medicine, eating disorders,
    substance abuse, etc.)                        _____

8) Administration                                   _____

9) Academic/Research                           _____

10) Other_____.  _____

Please choose from the list below your primary theoretical orientation: (Circle the number).

1) Psychodynamic/Object Relations    2) Behavioral

3) Cognitive/Behavioral                      4)
Existential/Humanistic/

                                                       Phenomenological

5) Gestalt                                           6) Family Systems

7) Eclectic                                          8) Other_____.

You will be asked to spend five minutes listing (in any order) all the facts that the client stated in the case you just heard. This study is only interested in the actual facts you can recall about the case rather than any inferences that you may have made. In order to aid you in deciding what would be considered actual information, an example differentiating acceptable fact from inference will be provided.

Ex. John and Susan were going to meet at seven o'clock in front of the library. Both had an upcoming exam for which they needed to prepare. Susan finished early and went home.

| Fact | Inference |
|---|---|
| 1) John and Susan had made plans to meet at seven o'clock. | 1) John asked Susan to meet him in front of the library. |
| 2) John and Susan each had an upcoming exam. | 2) John and Susan had an exam in the same course. |
| 3) When Susan finished, she went home. | 3) Susan finished before John. |

Please be sure to limit your statements to actual information provided in the case rather than inferences you may have made. Use the space below and the next page if necessary.

Now you are being asked to spend five minutes listing
questions that you consider important in treatment planning
if you were going to continue the intake interview.  Please
do not begin until instructed to do so.  Use the space below
and the next page if needed.

Please rate the degree to which you feel each of the following Axis I and Axis II diagnoses would be appropriate. In light of the limited case information, you are asked to choose a point on the seven point scale which corresponds to the appropriateness of that diagnosis. You are not being asked to choose only one, but to indicate the degree of appropriateness, based on the limited information of each diagnosis.

Adjustment Disorder with Anxiety Features
```
-----------------------------------------------------------------
   1         2         3         4         5         6         7
not appropriate           neither appropriate               very
                          nor inappropriate          appropriate
```

Alcohol Abuse
```
-----------------------------------------------------------------
   1         2         3         4         5         6         7
not appropriate           neither appropriate               very
                          nor inappropriate          appropriate
```

Alcohol Dependence
```
-----------------------------------------------------------------
   1         2         3         4         5         6         7
not appropriate           neither appropriate               very
                          nor inappropriate          appropriate
```

Dysthymia
```
-----------------------------------------------------------------
   1         2         3         4         5         6         7
not appropriate           neither appropriate               very
                          nor inappropriate          appropriate
```

Generalized Anxiety
```
-----------------------------------------------------------------
   1         2         3         4         5         6         7
not appropriate           neither appropriate               very
                          nor inappropriate          appropriate
```

Major Depression
```
-----------------------------------------------------------------
   1         2         3         4         5         6         7
not appropriate           neither appropriate               very
                          nor inappropriate          appropriate
```

Borderline Personality Disorder
```
-----------------------------------------------------------------
   1         2         3         4         5         6         7
not appropriate           neither appropriate               very
                          nor inappropriate          appropriate
```

Histrionic Personality Disorder
```
    1        2        3        4        5        6        7
not appropriate              neither appropriate          very
                             nor inappropriate        appropriate
```

Obsessive-Compulsive Personality Disorder
```
    1        2        3        4        5        6        7
not appropriate              neither appropriate          very
                             nor inappropriate        appropriate
```

Paranoid Personality Disorder
```
    1        2        3        4        5        6        7
not appropriate              neither appropriate          very
                             nor inappropriate        appropriate
```

Please list below, in rank order, the two diagnoses from the
list above that you believe are most appropriate.

1._____.

2._____.

_____
_____

Listed below are possible factors that could be involved in
the etiology of the client's presenting problems. Under each
item is a seven point scale. For each item, please indicate
the degree of likelihood that the factor may be underlying
the client's concerns.

Physical Illness
```
    1        2        3        4        5        6        7
not a likely                 neither likely              a very
  factor                     nor unlikely          likely factor
```

External stressors
```
    1        2        3        4        5        6        7
not a likely                 neither likely              a very
  factor                     nor unlikely          likely factor
```

Traumatic experience

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not a likely | | | neither likely | | | a very |
| factor | | | nor unlikely | | likely | factor |


Normative developmental transition

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not a likely | | | neither likely | | | a very |
| factor | | | nor unlikely | | likely | factor |


Chronic interpersonal problems

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not a likely | | | neither likely | | | a very |
| factor | | | nor unlikely | | likely | factor |


Biological predisposition

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not a likely | | | neither likely | | | a very |
| factor | | | nor unlikely | | likely | factor |


Vocational stressors

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not a likely | | | neither likely | | | a very |
| factor | | | nor unlikely | | likely | factor |


Marital conflict

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not a likely | | | neither likely | | | a very |
| factor | | | nor unlikely | | likely | factor |


Dysfunctional Family of Origin

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not a likely | | | neither likely | | | a very |
| factor | | | nor unlikely | | likely | factor |

Personal Traits

```
  1         2         3         4         5         6         7
not a likely                 neither likely              a very
  factor                     nor unlikely          likely factor
```

Other_____.

```
  1         2         3         4         5         6         7
not a likely                 neither likely              a very
  factor                     nor unlikely          likely factor
```

Listed below are several possible treatment recommendations. On the seven point scale listed below each item, please circle the number which corresponds to the probability that you would recommend that approach for the client previously presented. Do this for each item.

Individual therapy

```
  1         2         3         4         5         6         7
not likely to                neither likely         very likely
recommend                    nor unlikely          to recommend
```

Group therapy

```
  1         2         3         4         5         6         7
not likely to                neither likely         very likely
recommend                    nor unlikely          to recommend
```

Medication evaluation

```
  1         2         3         4         5         6         7
not likely to                neither likely         very likely
recommend                    nor unlikely          to recommend
```

Physical evaluation

```
  1         2         3         4         5         6         7
not likely to                neither likely         very likely
recommend                    nor unlikely          to recommend
```

Inpatient treatment

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not likely to recommend | | | neither likely nor unlikely | | very likely to recommend | |

Marital therapy

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not likely to recommend | | | neither likely nor unlikely | | very likely to recommend | |

Vocational counseling

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not likely to recommend | | | neither likely nor unlikely | | very likely to recommend | |

No therapy

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not likely to recommend | | | neither likely nor unlikely | | very likely to recommend | |

Please list below, in rank order, the two approaches from the
list above that you believe would be most effective.

1._____.

2._____.

_____

Listed below are several therapeutic styles. Assuming that
therapy is appropriate for the client previously presented,
choose a point on the seven point scale below each item which
corresponds to the probability that you would recommend that
particular style.

Insight-oriented

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not likely to recommend | | | neither likely nor unlikely | | very likely to recommend | |

Directive

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not likely to recommend | | | neither likely nor unlikely | | very likely to recommend | |

Cognitive/Behavioral

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not likely to recommend | | | neither likely nor unlikely | | very likely to recommend | |

Nondirective

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not likely to recommend | | | neither likely nor unlikely | | very likely to recommend | |

On the following seven point scale, please rate your expectations about this client's prognosis.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| very poor | poor | guarded | fair | good | very good | excellent |

If outpatient was recommended, please indicate the number of outpatient sessions recommended:

_____ .

If inpatient was recommended, please indicate the number of days recommended:

_____ .

In the space below, please write a sentence about your thoughts as to the purpose of this study.

Thank you for your time and effort!

## Appendix D

## Sample of Recall and Question Data Coding Instructions

### I. Instructions for Recall Coding

A. The following is a brief description of the different categories:

1) Employment: Anything related to boss, job, academic history, future career plans.

2) Social/Domestic: Any facts related to their spouse, their relationship with spouse or family of origin (parents, siblings etc.).

3) General: Anything personal that is not in the two other categories such as relationship with co-workers, situational issues, material possessions, friendship concerns.

4) Depression: Anything related to the specific symptoms of depression mentioned in script such as poor concentration, low energy, sleep problems and concentration problems.

5) Alcohol Dependence: Same as above except for alcohol use and symptoms listed on the coding sheet ( decrease in social activities due to alcohol use, preoccupation with alcohol, social conflict due to use, and increased tolerance).

B. Use the "Script Coding" sheets and attempt to match statements that are written with those that are on the coding sheet. The coding sheet statements were taken from the script for the male client so, don't be thrown when the sheets are referring to a female client. The gender of spouse is reversed as is the gender of the boss.

C. However, there are sometimes when this is not as easy at it may sound, so I am going to attempt to predict some potential issues and give you some guidelines.

1) Watch out for INFERENCES and CONFABULATIONS (i.e. write something that is not in the script):
Example A: "Client is sometimes moody" would not be coded because it is an inference. The script did not include a statement "I think I'm moody".

Example B: "Client's sister is held up as an example in the family" Like wise, this is not stated in the script.

Example C: " Client feels his/her parents compare him/her unfavorably to brother and sister". Or "Brother and sister are held up as more "successful" than client. Although this is implied in the script, it is not stated directly.
2) Relatively often one statement may be coded into two categories. That is, you may find that two different ideas have been combined into one statement so be sure to break the statement down into separate components of a phrase or

sentence that the subject has written.

Example A: "Client and spouse have begun to have fights at night after having had a few drinks." This would be coded in both Social item "#8" and Alcohol Dependence item "c)".

Example B: "Client and spouse bought a new house (General item "#3)") and are now having financial problems with money being tight (Social item "#1").

Example C: "Client and spouse used to talk together after work but now they have their drinks in front of the TV (Social item # 7 and Alcohol Dependence item "a")"

3) Sometimes one statement will match two different items in the same category. Again, you may need to break one statement written into different components that may be coded in separate items.

Example A: "Client has considered returning to school but feels finances make that unlikely" (Employment items # 23 and # 24).

Example B: "Arguments between client and spouse start off about finances (Social items # 9) and expand from there (Social item # 10) clients says things that doesn't mean.

Example C: "Client used to get good grades" (Employment item # 21) in college (Employment item # 20).

4) Following the above statements, be sure to continue looking through all of the categories and all the items within a category even if you have already found one "match" for one part of a written sentence.

5) Be on the look out for repeated statements of the same item. That is, you may find that the same thing is stated two different ways. You can only count an item once even though it has been referred to twice.

Example A: "Client has decreased motivation" and "Client reported decreased energy" would both be matched with Depression item "c".

Example B: "Client usually has a few drinks after work at home" and "Client lately finds that they have thoughts about drinking in the evening while they are at work" would both be coded Alcohol Dependence item "b".

6) BE CONSISTENT! Refer to past coding decisions to help decision-making in terms of being consistent.

7) Try to code everything, if appropriate.

8) Tally totals and transfer them to Coding Sheet Summary.

9) DON'T FORGET TO PUT THE ID # ON THE CODING SHEET AND SUMMARY SHEET

II. Coding Question lists

A) Here are some general definitions of categories to keep in mind:

   1) <u>Employment</u>: Any questions related to their boss, job history, academic history, employment goals and plans.

Example A: How long at job?

Example B: Have you had similar problems at work before?

Example C: Was boss always demanding?

   2) <u>Social/Domestic</u>: This category includes any questions about their relationship with their spouse, marital history, marital plans. This section also includes questions related to their relationship with their parents, relationship with siblings and role in their family. Also, questions about spouses family background.

Example A: Personal and family history?

Example B: Tell me about your husband's family history?

Example c: How much does husband drink?

   3) <u>General</u>: This category includes anything that is personal and not found in the two categories mentioned above. Also, relationships with friends, co-workers or situational concerns. In this category you would also include questions about past counselling, why they came to therapy, what they hope to get out of therapy, their goals or etc. Any questions related to substance abuse or dependence other than alcohol use would be coded in this category. This would hold true for any inquiry about other affective symptoms such as mania or etc.

Example A: Have you ever felt before as do now and what helped then?

Example B: Level of use of other drugs?

Example C: Prior treatment?

Example D: Medication ?

Example E: History of trauma or abuse?

   4) <u>Alcohol Dependence</u>: This category would include questions about the specifics of their alcohol use (when, how much etc.), consequences of their drinking (DWI's, other legal problems), other symptoms of alcohol abuse (blackouts, shakes etc.), own history of alcohol abuse. Also, any questions about family history of alcoholism. See handout of alcohol dependance and abuse symptoms for questions.
Example A: Explore need for alcohol.

Example B: Drink at times that didn't plan to?

Example C: Details of drinking history.

5) <u>Depression</u>:  Any questions about history of depressive symptomatology (how long, episodes, precipitating events) and inquiries about other symptoms (such as suicidal ideation, appetite).  Also, any questions related to family background of affective disorders.  See handout of depression and dysthymia symptoms.

Example A: Vegetative symptoms?

Example B: Onset of depression related symptoms?

Example C: What does client feel is basis of depression?

Example D: Explore feelings of inferiority.

B. Occasionally, one question may be coded into two categories.  That is, you may find that two different ideas have been combined into one question so be sure to break the question down into separate components of a phrase or sentence that the subject has written.

Example: In a list of questions about client's alcohol use which would be coded "alcohol use" (i.e.  how much, how often, own history of use), there may also be questions about husband's drinking, which would be coded as "social".

C. Be on the look out for repeated questions of the same issue.  That is, you may find that the same thing is stated two different ways.  You can only count an issue once even though it has been referred to twice.

Example:  "Explore client's wishes for future" and "explore what client would like to be different in future" would both the coded "General" and since they are related to the same issue of future goals, only one point is given.
D. BE CONSISTENT!  Refer to past coding decisions to help decision-making in terms of being consistent.

E. Try to code everything, if appropriate.

F.  When coding, indicate beside each item what code you gave them (i.e. E=Employment; S=Social/Domestic; G=General; A=Alcohol use; D=Depression.  Then just tally, on the same sheet, the number that fell into each category.  Then, transfer these totals to Coding Sheet Summary.

G. DON'T FORGET TO PUT THE ID # ON THE CODING SHEET AND SUMMARY SHEET

Appendix E

Sample of Recall and Question Data Coding Sheets

ID#:_____

Script Coding Summary

RECALL        QUESTION

I. Social/Domestic

Total:_____        _____:Total

II. Employment

Total:_____        _____:Total

III. General

Total:_____        _____:Total

IV. Symptoms

A) Depression-

Subtotal:_____        _____:Subtotal

B) Alcohol Dependence

Subtotal:_____        _____:Subtotal

C) Overall

Sum of Subtotals=

Total:_____        _____:Total

V. Grand Total

Sum of all Totals=

TOTAL:_____        _____:TOTAL

Script Coding Sheets                ID#:_____

A. Social

_____    1. You see, my wife and I have been having these
            financial problems lately.

_____    2. Relationship has changed> It hasn't always been
            this way.
            >But it's just not the same.

_____    3. We've been married just over two years

_____    4. Relationship was good>  and things were going
            pretty well.

_____    5. Relationship has gotten worse> But, over these
            past few months....with this money crunch....Well,
            things have just gotten so much worse.
            >I just don't know what to do about it...Things
            are just going really badly right now.

_____    6. Before, we'd come home from work and share a
            couple of drinks and talk about how our days had
            gone...

_____    7. But now....Now we come home and share our drinks
            in front of the TV instead of talking.

_____    8. And, well, it seems like that after dinner we get
            into these arguments.

_____    9. Arguments begin over money> At first we start off
            talking about finances but then...

_____   10. Arguments get chaotic>  then we always seem to get
            off onto other things....
            >....I don't know...Like I was saying, our
            arguments always seem to get out of hand.
            >We always fight about so many different things.

_____ 11. Another thing we argue about is starting a
family...

_____ 12. She thinks....well...she seems to be bringing
that up often lately.

_____ 13. Husband not sure about having family> But, with
the financial problems we're having and, the way
we haven't been getting along...I'm not sure. ...

_____ 14. you know....I'm just afraid that all the stress
we're under, with money and all, may drive us
further apart.

_____ 15. As if our personal problems aren't enough, she
always brings up my parents too....

_____ 16. you see.. my wife thinks my parents are too hard
on me.

_____ 17. I have this brother who is a doctor and

_____ 18. of course he makes a lot of money.

_____ 19. Basically, in my parents' eyes he can't do any
wrong.

_____ 20. Well, my sister, she married a lawyer

_____ 21. and just had a baby.

_____ 22. The other side of the story is that my parents
have never approved of my husband....

_____ 23. Anyway, my wife and my parents have never really
gotten along.

_____ 24. My parents throw it up in my face that they paid
so much money for me to get that diploma and that
I haven't used it very well.

_____ :Total

B. <u>Employment</u>

_____    1. I work for this communications company.

_____    2. And, I really used to <u>like</u> my job. > and I <u>like</u> that.

_____    3. You see, I work with computers,

_____    4. But, it's my boss. You see, it's this man that I work for.

_____    5. It's like he just always demands so much extra time and work from me.

_____    6. There just doesn't seem to be enough time in the day to it all done and still get home at a reasonable hour.

_____    7. Boss never gives compliments >And even when I do get everything done, and <u>I</u> think I've done a good job. It's that he never says anything good.

_____    8. But, if there's a mis<u>take</u>. I sure do hear about <u>that</u>.

_____    9. It just doesn't seem fair to me.

_____    10. Afraid to bring up concerns because boss might get mad >And then whenever I...if I start to bring it up. I mean these concerns I have or any other problems I may be having. He always seems to get really angry,

_____    11. Afraid of consequences of making boss angry> and I'm just afraid of what he's going to do if I ever make him <u>too</u> angry.

_____    12. And, so, I don't feel like I can do anything about it.

_____ 13. Wants a raise> And... I don't know... it's like,
I'm really worried because I want to get this
raise.
>And I have got to have that raise..normally I
wouldn't care so much...but it's really important
to me right now to get that raise.

_____ 14. Wants a merit raise> I'm up for a raise, a merit
raise and I'm...I'm really not sure <u>how</u> that's
going to go.

_____ 15. Working on important projects> It's other things
too.  It seems that with these projects that I've
been working on...well they're pretty important,

_____ 16. Poor concentration at work> and well, I just seem
to have trouble concentrating on them.  I just
can't seem to think things through as well as I
used to be able to.

_____ 17. And I... Well, there are times when I come in <u>late</u>
in the mornings

_____ 18. Not sure if boss is aware of problems at work> and
I don't know if he picks up on that stuff or what.
I'm just not sure...and ...
>Then, well, I <u>am</u> really afraid he's picking up on
these things.

_____ 19. Job is a major stressor/concern> I don't know, I've
just been worrying a lot about my job.  I really
have been.
>Part of its my job

_____ 20. You know, when I was in college, well I went to
this <u>really</u> good school,

_____ 21. and I made all A's and B's.

_____ 22. Now, well, <u>now</u> I don't feel like I'm making as much money as I should be with my degree.

_____ 23. I <u>have</u> been thinking about going back to school and getting more training....

_____ 24. But with money so tight right now, well...we really can't afford for one of us to quit our job or do anything like that.

_____:Total

C. <u>General</u>

_____ 1. Well, I guess things haven't been going very well lately.

Alot of things in my life have been bothering me,

_____ 2. and I just don't know how to deal with it anymore. >And it seems to be getting worse no matter what I do.

_____ 3. And well, we bought this new house a few months ago and money has gotten <u>very</u> tight.

_____ 4. I know some people say that having children can bring people together, but

_____ 5. You know, I used to enjoy watching movies...

_____ 6. And I got this bicycle that I had <u>really</u> wanted.

_____ 7. >You know, I used to have some friends at work. There were some people there that I used to get along with.

>I <u>thought</u> we got along....

_____ 8. Well, the other day I overheard somebody saying that, well, that I'm moody.

_____ 9. You know, <u>that</u> really bothered me. But I don't

think that means I'm <u>moody</u>...

_____ 10. I just...I just really hope you can help me with

these problems. I just wonder where to start or how

to get out of this. I'm just really feeling

down....

_____: Total

D. <u>Symptoms</u>

   1. Depression:

_____ a) [<u>concentration problems</u>] >and well, I just seem to

have trouble concentrating on them.

>When I'm at work I find I think about money, I

think about the problems with my wife

_____ b) [<u>sleeping difficulties</u>] >Well, one reason I'm late

all the time is that....I'm having so much trouble

sleeping. I wake up early in the morning, before I

need to be up, and I have trouble going back to

sleep. But I still don't feel like getting out of

bed.

_____ c) [<u>fatigue, low energy</u>] >And...besides the fact that

we don't have much money, I'm just not <u>motivated</u>

like I used to be. I just don't have much energy.

I seem to feel tired a lot of the time.

>And now that I've got it... It just seems like too

much trouble to even get it out....

_____ d) [<u>anhedonia, not enjoying things</u>] >I just don't enjoy

anything like I used to.

>And now, I can't seem to sit through an entire one

without losing interest.

>These days I haven't been up for much of anything

_____:Subtotal


2. Alochol Dependence

____ a) [social or recreational activities are given up or reduced because of alcohol consumption] But now....Now we come home and share our drinks in front of the TV instead of talking.

____ b) [a preoccupation with alcohol use] And I used to look forward to having some rinks after work. They really helped take the edge off....Sometimes, I find that during the middle of the day I start thinking about what it's going to be like to get home in the evening and just relax with a drink. I really look forward to that...well...

____ c) [a persistent social conflict due to alcohol use] >It seems like after I've had a few drinks I always end up saying things that I really don't mean

____ d) [increased tolerance for alcohol] >But you know, it seems like one or two doesn't help me forget my day like they used to.
>It used to be that a drink would help me unwind and forget about some of this stuff. Its just not the same.

_____:Subtotal

_____:Total (Symptoms)

## AUTOBIOGRAPHICAL STATEMENT

Jodi Lenoir French was born in Pulaski, Virginia, on August 15, 1965. She attended the University of Virginia from 1984 to 1987 and graduated with a Bachelor of Arts degree in psychology. Jodi began pursuing a doctorate in clinical psychology at the Virginia Consortium for Professional Psychology in 1987. She completed a predoctoral internship at Perry Point Veterans Administration Medical Center in August, 1990. Her clinical interests include psychotherapy issues with women, substance abuse, and adolescent development. Jodi received a graduate fellowship from the College of William and Mary in 1987.