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# PSYCHOSOCIAL SUPPORT AND GENDER PERSPECTIVE. IMAGE OF A WOMAN AND A MAN AMONG THOSE INVOLVED IN PROFESSIONAL PSYCHOSOCIAL SUPPORT AND THE IMPACT OF THIS IMAGE ON PROFESSIONAL ACTIVITIES[1]

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**gender bias, clinician assessment and diagnosis, psychosocial helping**

*The authors, on the basis of the study, show the impact of the patient's and therapist's gender on the clinical activities which have been taken. The paper can carry practical implications which can suggest including gender bias issues during therapists' training and in clinical specialties.*

**Summary.** Aim. The aim of this paper is to reveal ideas about health and disease shared by specialists working as professional helpers (including psychotherapists). The study implies that patients' behaviors are seen as more healthy when they reflect androcentric model of health. Method. Empirical case study: depending on experimental condition, the same clinical case was presented as a case of female or male patient. Afterwards, several questions addressing severity of patient's problems and therapeutic recommendations were asked. Moderators: Ambivalent sexism and right-wing authoritarianism (RWA). Experimental design: Between-subjects ANOVA in 2 (gender of specialist) x 2 (gender of patient) design. **Results.** N 74 (44F and 30M), participants were professionals in psychological help. Female professionals similarly evaluated patients of both sexes, whereas male therapists revealed systematic error - gender bias: despite the same symptoms, they evaluated psychological malfunctioning of a female patient as significantly worse than the male patient, and recommend more intense treatment for the former. The above interactions were not moderated by the ambivalent sexism or right-wing authoritarianism.

**Conclusions.** 1. Professionals of both sexes share androcentric (agentic) model of mental health; 2. Male professionals may tend to perceive similar symptoms of psychological malfunctioning as less serious in men; 3. The fact that the discussed gender bias in clinical judgment was found only among male professionals may indicate an existence of ingroup bias. Perhaps, male professionals tend to infer highly positive agentic traits in male patients, because male professionals and male patients belong to the same gender category.
key words: gender bias, clinician assessment and diagnosis, psychosocial helping

*… although now we all confirm that gender is an important dimension,*
*there is no general agreement why, how it happens,*
*how to think about it and how to move it into practice.*
Judith Myers Avis [1]

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## Introduction

Criteria for the clinical diagnosis of disorders (DSM — Diagnostic and Statistical Manual of Mental Disorders; ICD — International Classification of Diseases) function as scripts used by researchers and clinicians in the area of mental health for better and easier communication, also between specialists from different countries. These are tools of great power, aimed at sharing information, helping in the organization of health services due to the nature of patients, harmonizing indicators of patients' problems, helping clinicians in predicting symptoms and allowing scientists to carry out research based on the same guidelines [2]. On the other hand, many researchers highlight the dangers of careless application of clinical diagnoses, e.g. np. Caplan and Cosgrove [3], Kamens [4]. Theories dealing with the labeling and stigmatization of people with mental disorders, such as modified labeling theory of mental illness [5] suggest that cultural beliefs about mental disorders contain an element of stigmatization. These beliefs are individually internalized and affect specialized diagnoses made by specific individuals, thereby adversely affecting the estimation of the patient's difficulties. Some even argue that international classifications of mental disorders (DSM, ICD) are a mechanism of social control, because they do not distinguish between the actual mental disorder and nonconformist behavior, although the apparent deviant is psychologically healthy [5], which seems to be rather far-reaching conclusion.

The area of psychopathology has been particularly rated as troublesome because of the relationships of diagnosis, psychotherapy and gender issues [6, 7]. Feminists point out that some diagnoses like nymphomania, hysteria or masochism serve to reinforce the conformist behavior in women, because otherwise they risk to be labeled as dysfunctional [6]. Disorders, which are often attributed to women, include depression and anxiety disorders [6]. Some researchers believe that it is in fact the result of an underestimation of depression and anxiety range in men because the expression of these difficulties is different from the criteria symptoms — especially taking into account the specifics of women — included in the international classifications of mental disorders (Good, Thomson, Brathwaite [8]). Researchers say that people generally cope with anxiety and panic, they avoid stimuli and/or associations affiliated with these phobias. Since experiencing these feelings is aversive, in order to relieve these conditions, men usually abuse alcohol, drugs and/or move to impulsive behavior, which is socially accepted to a greater extend [8]. Diagnostic systems can involuntarily maintain characteristic of wider systems — political, social — beliefs supporting divisions between the sexes, the so-called gender distinctions, as in Webb-Woodard [9]. For example, when a boy hears the slogan "boys do not cry", he is automatically instructed by a social system in which he lives, that showing affection and weaknesses is not the appropriate style of interaction, and that "only girls cry" [8].

Most gender stereotypes present in many cultures are based on the division into two main aspects of human existence: the one of community and the one of agency, what Wojciszke has written about [10].

Community, and therefore focus on maintaining and developing positive relationships with other people, is highly correlated with the aspect of femininity. On the other hand, agency, connected with the focus on achievements, developing our own skills and exercise our control over the implementation of the objectives, is highly correlated with the aspect of manhood [10]. Male and female researchers involved in the feminist revision of the clinical issues believe that these categories are automatically imposed on what behavioral acts are evaluated as healthy or disturbed [11]. The problem arises when the therapist constructs a model of a healthy person, referring to a causative man with a characteristic for such a stereotype pattern of behavior, relationship-building and the Self image. Behavior and interaction styles preferred by women may, in this case, be labeled as dysfunctional [12, 13]. Most of these features and abilities, which traditionally are closer to womanhood, are not valued as highly as the ones closer to masculinity, such as individualism and rationality. All the things that are associated with emotionality, intuition, responding to the needs of others, searching for approval, sacrificing in the name of feelings, little interpersonal distance may be perceived as not coping with emotions or immaturity, not as another form of experiencing oneself and the world [13].

All authors of feminist movements claim that the division of gender is not only dichotomous but also hierarchical, where the masculine element occupies a higher position than the female one [7]. So the opposite of the above "soft" traits is a "healthy" ideal of a strong Self, which is closer to the pattern of masculinity. In our culture, to a relatively high extend, the following traits are highly valued: assertiveness, endeavoring to fulfill your goals, following the reasons and logic, independence, having clear views. Following strong emotions, feelings and needs of a relationship — stereotypically feminine traits — are quite commonly considered as a sign of weakness [14].

The analysis of the most recent literature on the interpenetration of culture, social change, and the language with the concepts of clinical theory and therapeutic practice shows the effect of different categories/social identities, including the therapist's and patient's sex, on taking actions in the process of diagnosis and therapy.

Researchers [15] show overrepresentation of the diagnosed borderline disorder among women from a population of people who have committed criminal behavior. It is as if the same anti-social behavior was treated as less clinically pathological among men. According to the researchers, this could ultimately lead to unauthorized imposing repressive and remedial measures on women stigmatizing them as disturbed and reducing the likelihood of rehabilitation and returning them to the normative order.

Kelly et al. [16] traced diagnostic recognitions among 1,445 US veterans who served in the military operations in Afghanistan and Iraq. They found out that race/ethnicity and gender were associated with the diagnosis of mental disorders. Veterans of Asian, American Indian origin, Alaska residents and women were diagnosed at a faster rate than white men. Therefore, the authors postulate that studies are needed to identify the factors contributing to the difference in speed of diagnosis based on race/ethnicity and gender.

So how do these processes of interaction between gender of the person seeking professional help and gender of the person who gives this help can look in our Polish conditions? What is closer to the ideal of health to our domestic professionals offering help?

## Material

In the current study we formulated the supposition that — especially in traditional cultures (which undoubtedly is still Polish culture [17]) — the concepts of health and disease reflect the male standards of identity and relationships: it is the so-called androcentric model of mental health [6]. The primary objective of the study was to determine whether this implicit assumption is shared by professionals dealing with helping others on a daily basis, and if so — whether it affects, among others, the process of diagnosing disorders (their severity and depth), assessment of self-dealing with problems, a kind of recommendations for patients of both genders formulated by an expert. An important research question was also whether these assumptions are shared by specialists of both genders, or whether they occur, as might be assumed, with much greater intensity in male professionals.

## Method

We have examined 74 Polish experts — therapists of both sexes: 44 women and 30 men, professionals dealing with helping others, with 20 of them saying that they work as psychotherapists. The most numerous groups according to their professional education were psychologists (38) and pedagogues (29), 7 people completed other courses of study (sociologists, a doctor, a theologian, etc.). The respondents had an average of 13.77 years of experience in their profession, with an average age of 39.71 years. Most people worked in private practice (28), in a psychiatric hospital in the neuroses department (18) and dispensary mental health (17), and the indications concerning the types of patients they work with most often are: personality disorders (53), depression (42), addictions (39) and neuroses (38). All respondents confirmed that they are regularly supervised.

Our study was based on a well known in the literature method of a case study [18] where each participant — the therapist — read the detailed description of the clinical case and was asked for its assessment. The male/female character (hero or heroine) of the story was not diagnostically unequivocal and contained a mix of symptoms of the various categories of disorders: anxiety, depression, alcohol abuse, personality disorder. This procedure was designed to create a description that does not imply any sex so it could be the most universal. Depending on the experimental conditions, the same case was presented as a man or a woman. Table 1 shows the number of individual test conditions.

Table 1. **The numbers of subgroups for conditions: the respondent's sex and the character's sex**

| | | Sex of the respondent | |
|---|---|---|---|
| | | **Female therapist** | **Male therapist** |
| **Sex of story character** | **Female patient** | 22 | 14 |
| | **Male patient** | 22 | 16 |

After describing the case, the respondents were given a set of 10 questions of a clinical nature. For the purposes of this study, its volume and the clarity of conclusion, we are presenting four of them.

1. To what extent — intensity is a disorder, that you suggested for Mrs. Marta, present?

a. slight

b. medium

c. strong

d. very strong

2. Below are the most common general recommendations proposed in the work of psychotherapy or counseling. We ask you to describe how these instructions are accurate in the case of Mrs. Marta.

(5 items, 5-items scale, Cronbach's alpha = 0.67).

Examples of items for the primary control:

*She believed in herself, she got to know her strengths.*

*She used the situation to prove she can do things she cares about.*

Examples of items for the secondary control:

She *was more adapting to her role and adjusting expectations to possibilities.*

*She did not forget about others, she cared about the closest people (family, neighbors, and workmates) who can be her support.*

3. Now we would like to ask about the possible sources of problems of Mrs. Marta. What do you think, to what extent Mrs. Marta's problems result from the three following causes of problems — internal, external, biological.

4. Assuming that Mrs. Marta will not be subject to any specialized therapeutic interactions, what do you think, would she be in a position to cope with problems on her own? Mark on the scale from 1 to 7, where 1 means that she will definitely not cope, and 7 means definitely yes, she will cope.

After questions concerning running the therapy, the subjects had to fill in two scales, which we treated as moderators of dependent variables: the scale of Ambivalent Sexism [19] and the scale of the Right-Wing Authoritarianism [20].

The following hypotheses have been agreed:

**H 1:** Professionals will attribute greater severity of occurring disorders to women than men and this trend is stronger among male therapists than female therapists.

**H 2:** We expected that women will be recommended to undergo a secondary control, so the suggestion to learn to adapt to the circumstances. In contrast, men are more likely to be recommended strategies of domination and primary control suggesting the need for greater independence from the environment.

**H 3:** Assigning the patent's source of problems will depend on gender and not on the actual circumstances. When it comes to women, internal attributions of their problems will be made more often and in the case of men — external and this trend will be stronger for male respondents.

**H 4:** We presumed that in the professionals' opinion women will be less likely to deal with their problems on their own if they do not subject to therapeutic help.

**H 5:** The effects predicted in the above hypotheses will be stronger with increasing levels of Ambivalent Sexism and RWA — The Right-Wing Authoritarianism (moderators of the effect).

## Results

To examine the effects of a gender of the respondent and the character of the story, we first conducted multivariate analysis of variance (MANOVA).

Dependent variables:

I. DIAGNOSIS:

a) The severity of the disorder.

b) What are the reasons - the source of problems of the male/female patient?

- Internal
- External
- Biological

II. THERAPY

Recommendations for applying the primary vs. secondary control.

III.RESILIENCE

What is the ability of self-steering — self-coping with the problems of a male/female patient without using professional help?

Independent variables were as follows:

a) the respondent's (participant's sex)

b) character's — patient's sex

c) the interaction between these variables

Two significant main effects have been obtained: 1 — character: $\lambda$ (Wilks' lambda) = 0.69; $F$ (11, 60) = 2.04, $p$ = 0.043; 2 — respondent's sex: $\lambda$ = 0.62, $F$ (11, 60) = 2.83, $p$ = 0.006) and the interaction of both variables ($\lambda$ = 0.59, $F$ (11, 60) = 3.12, $p$ = 0.003). This indicates that in our study what was the initial

diagnosis depended on the patient's and therapist's sex, and to be more specific — on the fact whether the assessed person was of the same sex or the other.

To better understand these results we should examine how the gender of the character and the patient differentiate individual indicators used in the study.

Hypothesis 1: *The severity of disorder*

The value of the variable describing the perceived degree of severity of the disorder (Figure 1) is differentiated by the respondent's sex ($F$ (1, 65) = 4.50, $p$ = 0.038) and at the tendency level by the character's sex ($F$ (1, 65) = 3.50, $p$ = 0.066), but there is a significant interaction: $F$ (1, 65) = 5.90, $p$ = 0.012). The same pattern can be observed: men define the disorder as more severe when it relates to a woman than when it relates to a man.

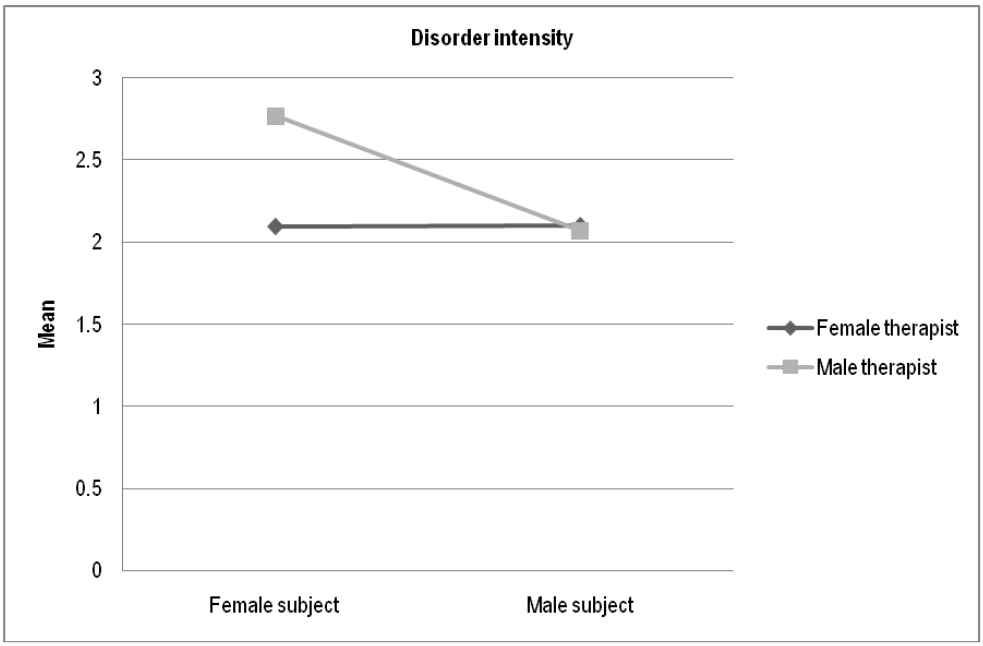


Figure 1. **Assessment of the severity of the disorder**

Hypothesis 2: *Recommendations for the use of primary control*

Rothbaum [In: Heeps 21] extended the traditional concept of control by two control processes: primary control and secondary control. Primary control is a setting where people develop a sense of personal control by influencing the objective conditions of the environment and customizing them to their needs. Alternatively, the secondary control is based on maximizing adjusting to the existing environment.

Therapists were asked to assess how much they agree with these treatment guidelines for the case of a woman or a man.

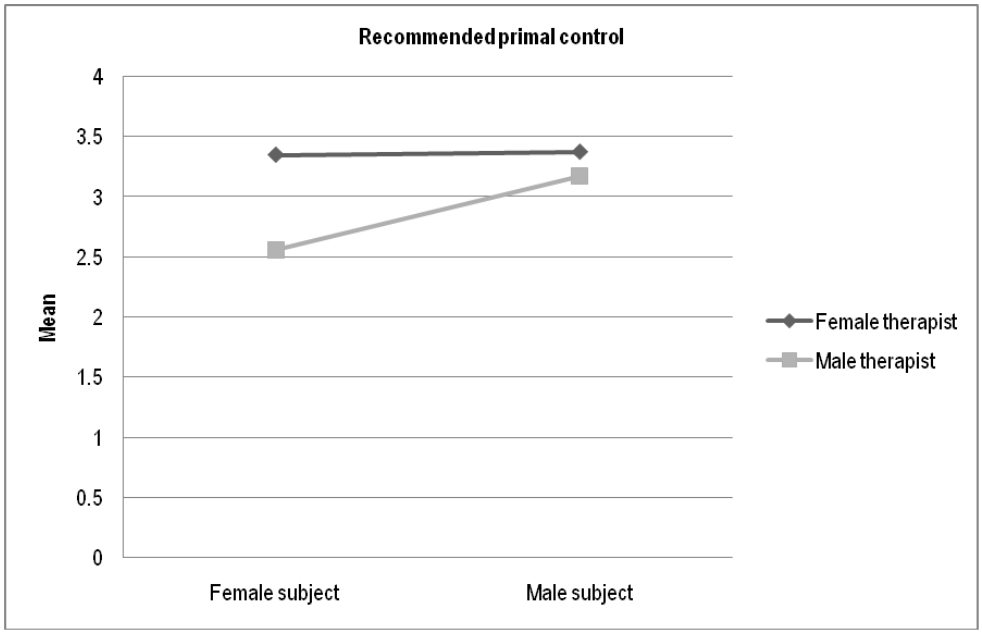


Figure 2. **Recommended primary control**

For the recommended primary control (Figure 2), the main effect of the respondent's gender is significant ($F$ (1, 70) = 8.61, $p$ = 0.005), insignificant — the main effect of the character's gender ($F$ (1, 70) = 2.38, $p$ = 0.127), interaction at the tendency level is significant ($F$ (1, 70) = 3.25, $p$ = 0.076). This means that men-therapists have a tendency to recommend the subjects of our case study strategies based on primary control so they believe less in their abilities to influence the environment, and more in the need to adapt to changes.

Hypothesis 3: *Sources of patient's problems*

After describing the case, the respondents received a series of questions, among others, three questions (scale 1—5) about the causes of the patient's problems — internal (personality), external (circumstances), biological (somatic illnesses).

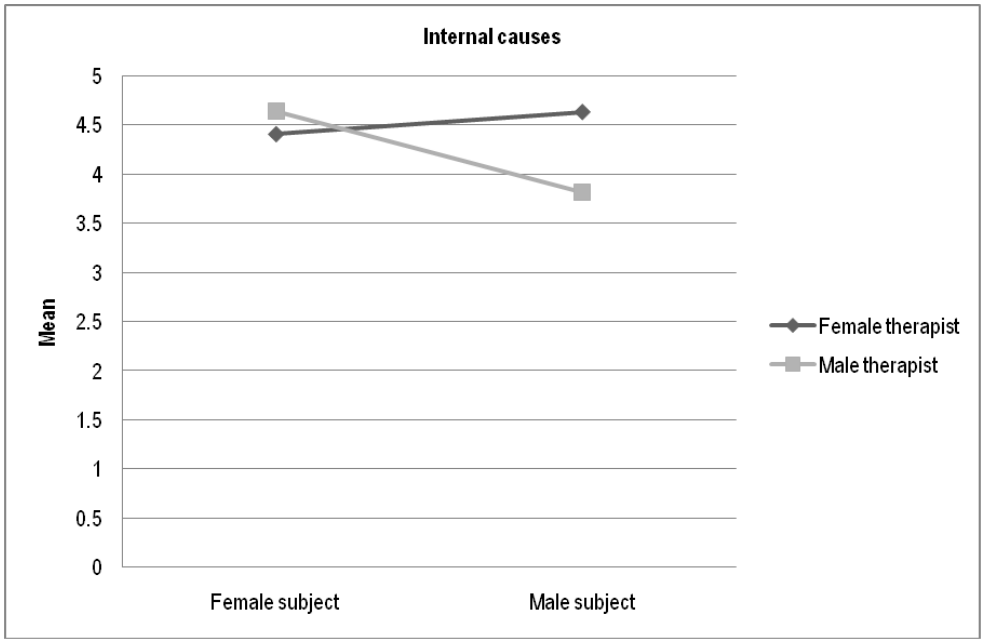


Figure 3. **Internal — personality causes of the patient's problems**

In the case of internal sources of problems, a significant main effect of the examined person's gender ($F$ (1, 70) = 5.18, $p$ = 0.026) and a significant interaction ($F$ (1, 70) = 14.47, $p$ <0.001) have been shown, the main effect of the character's gender is insignificant ($F$ (1, 70) = 2.38, $p$ = 0.127. Figure 3 shows what the shape of these relationships is: in fact, men-therapists perceive women-patients as perpetrators of their problems by assigning them internal sources of their difficulties.

Hypothesis 4*: Projected self-dealing*

Another question was whether, if the male/female patient was not subject to any specialized therapeutic interactions, they would be able to independently cope with the problems (scale 1—7). In this case, we received a significant interaction ($F$ (1, 70) = 4.66, $p$ = 0.034), the main effects of the character are insignificant: $F$ (1, 70) = 1.35, $p$ = 0.249; and of the respondent: $F$ (1, 70) = 262, $p$ = 0.610). Men-therapists believe that men who were assessed by them will cope better without professional help than women (Figure 4).

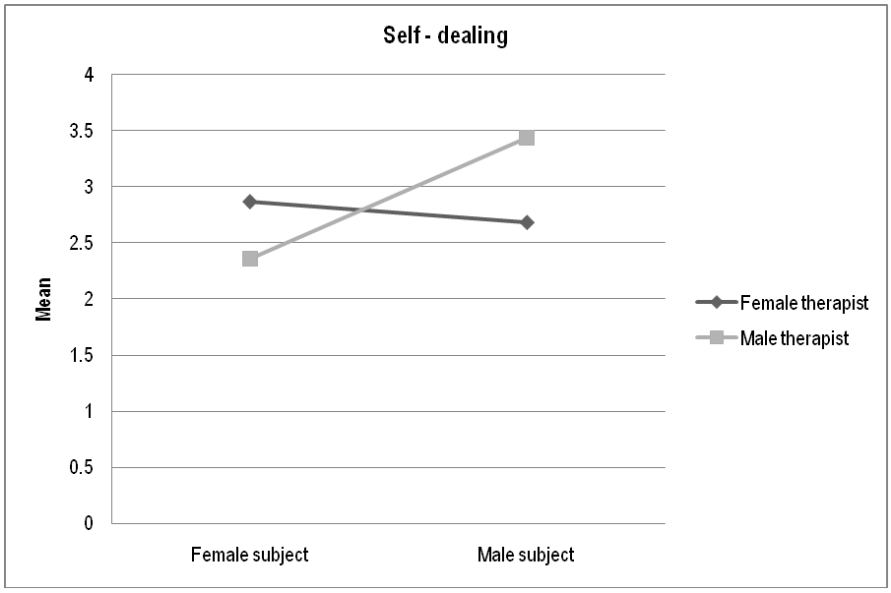


Figure 4. **Resourcefulness — the ability to deal with problems without professional help**

Hypothesis 5: *Moderators — therapists' assumptions about the social order*

After checking the possible moderators of the relationship, it turned out that these differentiation observed among men psychotherapists was not caused either by sexism — (the scale of ambivalent sexism Glick and Fiske, 1996, in the Polish adaptation developed by Janina Pietrzak) [19], or by authoritarianism (the scale of right-wing authoritarianism RWA, Funke, 2005, Polish version: Grzesiak-Feldman, 2012) [20]. This means that these effects are not dependent on beliefs (the level of authoritarianism and sexism was very low in a group of therapists), but most likely stem from perceptions and assessment of the male/female patient through the prism of what is considered to be a manifestation of mental health.

## Discussion of the results

The study showed that, while the female therapists generated essentially the same clinical judgments, regardless of the sex of the patient, male therapists revealed a systematic problem — gender bias. The causes of the female patient's problem in relation to a male patient were attributed by male therapists to internal causes stronger (personality characteristics) than external circumstances. In addition, the probability of self-dealing with the crisis, overcoming emotional problems without professional help, was seen by men-therapists (but not women-therapists) as higher in the case of a male patient. This is despite the fact that professionals of both sexes share the so-called male model of mental health. In the case of a clinical judgment of the female patient, compared to the male patient: (a) clinical signs were seen as more dysfunctional — severity; (b) strategies of direct influence on their environment were suggested to a lesser extend — behavior based on primary control was discouraged. .

A helpful concept to better understand the processes being discussed here of gender bias among therapists is the concept of Carol Dweck [22] saying that people, when assessing other people, use their own

the so-called naive theories of personality. Dweck's theory [22] distinguishes two opposing groups of beliefs. On the one side there are the so-called incremental beliefs, that is the belief that the human personality is plastic and a human being is able to change it through their own efforts. This concept can be described as the causative perception of personality. On the other side there are entity beliefs, where personality is seen as being highly durable, with a non-alterable structure of features [22]. In our study the Dweck's theory is confirmed by attributions which therapists made in two areas of the patient's functioning: determining the causes of the disorder and assessing the resourcefulness of the male/female patient — which means the possibility of self-dealing with emotional difficulties (confirmation of hypotheses: H 3 and H 4).

1. What are the reasons — sources of the male/female patient's problems? To what extend will therapists recognize that the patient's problems are internal, as if in himself/herself — entity beliefs?
2. What is the capacity for self-dealing with problems of a particular male/female patient without using help — for self-guiding — incremental beliefs?

Based on our research we believe that the Polish therapists (regardless of gender) are somewhat followers — often unconscious — of incremental theory of mental health (in the tradition of psychotherapy it is the previously mentioned androcentric model of mental health) [12]. Male patients, but not female patients, as representatives of the social category "men", are stereotypically attributed to a greater extend to the so-called male characteristics and agency, and other features associated with assertiveness, the ability to independently overcome the problems, logic and intentionality. Therefore, people involved in giving professional help may have a tendency to perceive similar emotional disorders as less serious in male patients than female patients and consider them to be more easily overcome by men.

The fact that gender bias detected by us exists only within male therapists, not female therapists, may be due to the fact that male therapists — because they are men themselves — show here a kind of in-group bias, i.e. they accept the idea more easily that men are "mentally stronger" and that "they will get by" which leads to "too liberal" treatment of symptoms and problems in men — it is the so-called diagnostic underestimation [23]. Explanation of differences in gender bias between male therapists and female therapists assumes that — in the case of men — the two forces (sharing the "male" concept of mental health + in-group bias) operate in the same direction so their effects are added together, resulting in gender bias that we observed. However, in the case of women, one of these forces (sharing the "male" concept of mental health) pushes them in the direction of gender bias, while the second force — in-group bias — pushes them in the opposite direction, resulting in the lack of gender bias effect among female therapists.

## Conclusions

The aim of this paper was to revise a mental health model which is used by Polish specialists dealing with helping others. Therapists, before becoming clinicians, are the participants of culture, where they acquire various colloquial ideas about the social world — through their family, immediate environment and

the media, including the belief what is considered to be healthy behavior and what are the appropriate roles assigned to genders. That is why we found the concept of Carol Dweck helpful for better understanding the processes of gender bias among therapists [22] which says that people, when assessing other people, use their own the so-called naive theories of personality. The results of the presented research allow us to formulate the assumption that the thing which is closer to the concept of health among therapists reflects more stereotypically masculine characteristics (agency, assertiveness, clarity of objectives, self-steering), what in the Dweck's concept [22] is closer to the incremental beliefs. This applies to both male and female therapists, but with the difference that only male therapists assess male patients differently than female patients. Clinical judgments are subject to gender bias for male therapists. Perhaps, they are the result of unconscious acceptance of a "growth" theory of mental health, which combined with the phenomenon of unconscious "favoring their own" (representatives of the same sex), leads to the bias in assessments and clinical judgments found in our study.

From our research we draw practical implications that it is worth to take into account issues of gender bias in the training of therapists and clinical specializations.

Our Polish researcher Barbara Józefik [24], being a clinician and psychotherapist at the same time, in her recent book [24] notices that "although medical perspective assumes multifactorial conditions of anorexia and bulimia and their symptoms, its understanding is simplified in comparison to what contemporary sociology of the body and gender studies bring". The author further writes: "… the multiplicity of discourses in which eating disorders are interpreted, their social consequences, causes me to think that it is important to broaden the understanding of knowledge in related as well as distinct fields. I hope that psychotherapists, psychologists, psychiatrists and students of these disciplines will appreciate the cultural threads."

It is noted in the literature that the accuracy and reliability of the findings depend largely on the level of methodological awareness of the diagnostician, as well as members of the community with whom he remains in a professional contact [25]. That is why it is so important to reflect on our own discipline and peculiarities of the diagnosis process [26]. Stemplewska-Żakowicz [25] stresses the importance of cultural competence in a diagnosis and later during giving help. It is a fundamental competence (the other is the ethical consciousness), which is understood as knowledge, skills and attitudes regarding differences in terms of various aspects of identity, and thus gender [25]. It is hard not to recognize this as a key competence, as a professional in his practice always meets a man or a woman. These situations are therefore not exceptions, but the contrary — they happen every time [25].

"Therapists are in danger of taking it for granted that patients can develop positively only within standards and models established by us. However, it often happens that opposing our explanations, guidance and interpretations gives them a chance of development" — Jurg Willi [27].

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