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GENDER ISSUES in PSYCHOTHERAPY

As in all areas of healthcare, gender is an important variable in the treatment of a variety of psychiatric symptoms and disorders. Gender is mediated by psychosocial factors and the physiological and metabolic differences between men and women. Gender as a concept encompasses "culturally-determined cognitions, attitudes, and belief systems about females and males; [it] varies across cultures, changes through historical time, and differs in terms of who makes the observations and judgments" (Worell & Remer, 1992, p.9). Therefore, gender can influence the patient's choice of caregiver, the 'fit' between caregiver and patient and the sequence and content of the clinical material presented. It may also affect the diagnosis, treatment selection, length of treatment, and even the outcome of treatment.

Gender Identity and Gender Role

The concepts of gender identity and gender role have become important in treatment (Person & Ovesey, 1983; Stoller, 1976). Gender identity is the internalized sense of maleness or femaleness, and the knowledge of one's biological sex, including the associated psychological attributes. It derives from many influences, including identifications with parents and their attitudes, expectations, and behaviors, as well as biological and cultural factors (Hines & Green, 1991; Kleeman, 1976; Money & Ehrhardt, 1972).

Gender role is a cultural construct referring to the expectations, attitudes, and behaviors that are considered to be appropriate for each gender in that particular culture. There are enormous differences in the roles and expectations of men and women in different societies. During early development, in all cultures, the mother remains the primary caregiver of young children. Thus, the earliest bond is more likely to be made with her. She becomes the primary identification figure in early childhood, for both boys and girls. Thus, for girls, the first identification is with the parent of the same sex. For boys, the first identification is with the parent of the opposite sex.

As girls grow up, this same-sex identification does not have to change in order for a feminine gender identity to consolidate. That is, girls learn a maternal identification. In order for a boy to consolidate his masculine identity, however, he must shift his primary identification away from his mother and develop identification with a male figure. In this process he moves away from his early attachment. The complex process of establishing a male identity, and the separation from early attachments that seems necessary to the process of the development of a masculine identity, may be factors accounting for the higher incidence of gender identity disorders in males (American Psychiatric Association, 1987).

Gilligan found that there are gender differences in self-concept and identity in adolescence. Males generally define themselves in terms of individual achievement and work and females more often in relational terms (Gilligan, 1987). Also during adolescence, conflicts around self-image and body image become more prominent and can be expressed differently for boys and girls.

Gilligan found that in mid-adolescence girls experience a crisis in their relationships with conflicts between selfish solutions or solutions that are selfless and involve some self-sacrifice. This period is also one in which girls become more vulnerable to depression than do boys: by age 15, females are about twice as likely as males to have an episode of depression. It is a time when they begin to assume adult feminine identities and roles.

Values and Treatment

Personal and societal values affect standards of normality and influence the perception, diagnosis, and treatment of mental disorders and emotional problems (Nadelson & Notman, 1977, 1982b; Person, 1983a). Labeling a behavior as deviant or psychopathological reflects a judgment about normality and affects the way a symptom is understood, as well as whether and how it is treated.

Although concepts and standards of what is considered "normal" masculine and feminine behavior have shifted somewhat, these changes in expressed values and attitudes are not necessarily integrated into a cohesive view of normality for either men or women. Even if treatment professionals consciously adopt gender-neutral attitudes, their unconscious views about what is 'normal' may remain unchanged. Those behaviors and attitudes of the patient that are significantly different from the therapist's may be judged as pathological, which can affect treatment (Nadelson & Notman, 1977).

In psychotherapy, therapists communicate values by their selection of material to question or to comment on, by the timing of their interpretations, and by their affective reaction to the content of what is said by the patient. Male and female therapists can view a patient's life experiences differently, particularly if these experiences are gender specific (Shapiro, 1993).

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Gender and Choice of Therapist

Patients give many reasons for their choice of therapist. These reasons are often based on stereotyped views such as that men tend to perpetuate patriarchal values, or that women provide more nurture. It is also true that some patients have no particular preference regarding the therapist's gender and feel that they could work equally well with either gender in therapy.

Identification with a therapist is also important. Although the reasons for the choice may be based on stereotypes, without regard for the characteristics of the specific therapist, the patient's feeling of greater comfort or empathy can facilitate the initial development of a positive therapeutic alliance.

Sexual orientation has also become a consideration. Many gay individuals request treatment from gays, who they feel will not only better understand and empathize with them, but be less likely to judge their sexual choice as pathological (Krajeski, 1984). Although there has been controversy about the appropriateness of this disclosure, some therapists have indicated that disclosure of their sexual orientation to patients may be beneficial in therapy (Gartrell, 1984; Isay, 1989).

Not only do some patients make gender a priority in choosing a therapist, but some therapists also make gender-based recommendations for clients regarding the choice of a therapist. For example, because some women victims of sexual abuse find it difficult to work with men, some clinicians suggest that women should treat them. Others believe that someone of the same sex should treat adolescents because sexual issues are so pressing, embarrassing, and intrusive at this life stage that gender conflicts can interfere with therapeutic progress. Many support the view that women should be treated by women in order to avoid being misunderstood or treated from a male-oriented perspective. This male perspective may oversimplify the effects of gender and minimize the necessary working through of ambivalence and conflict in the therapeutic relationship.

Stereotypes and expectations about women affect male patients as well. A man may seek treatment from a woman in order to avoid a competitive or an authoritarian relationship with a man, to avoid homosexual feelings, or because he has had poor relationships with women in the past and wants to work these out with a woman. His expectations may be that a woman will provide the cure for his problems with intimacy.

The Therapeutic Process

Understanding the concept of transference can clarify aspects of the therapist-patient relationship that may otherwise be difficult to comprehend. A patient brings attitudes and feelings to the relationship from past experiences with important figures, such as parents, which may be problematic and need to be addressed in therapy. If not recognized as transference, the clinician may see this as a reaction to the therapist him or herself rather than a pattern of response to someone in authority carried over from past relationships.

Therapists often do not attend sufficiently to the transference issues that encourage or inhibit discussion of particular material. This insufficient attention may be based on a number of factors, including gender. It can be seen at any phase in a therapeutic interaction and can occur with any patient or in any treatment modality. Many women feel that it is more difficult for a man to empathize with some issues that are gender specific; this may also be true for women who must empathize with male issues (Horner, 1992).

Changing Therapists

Change or reassignment of a therapist on the basis of gender has been widely discussed and is often recommended. Some have suggested that a change of therapist might mobilize a stalemated situation. Transfers on the basis of the therapist's gender have also been made when there is a therapeutic impasse or failure.

It is rare that gender itself is the significant variable in the majority of cases that are not successful. However, unless there has been a sexual interaction, a transfer based on gender may be a way of avoiding responsibility for failure or dealing with the embarrassment of a negative outcome. Because gender affects trust, and even compliance, in other modes of treatment, as well as in psychotherapy, change in the therapist based on gender might be helpful in some situations.

Gender Choice in Couples and Family Therapy

As with other forms of therapy, gender may be a consideration in the choice of a therapist for couples or families. This issue is frequently dealt with by having couples and family therapy performed by male-female therapist dyads. In general, as with individual therapy, issues related to gender choice should be clarified and addressed. A couple with marital difficulties may request a female therapist because it is the wife who has made the call and it is her preference. On the other hand, the husband may choose a woman or comply with his wife's choice of a female therapist because he is more comfortable and less threatened by women, because he does not take the therapy seriously, or because he has negative feelings about women. The choice of a male therapist for some couples may re-create, in the transference, a paternal or authoritarian relationship or even the fantasy of possible sexual abuse. This can be a special problem if abuse has actually occurred.

During the course of therapy, attention must be paid to bias regardless of whether the therapist is male or female. Transference issues in couples and family therapy are multiple and more complex because there are more people directly involved in the therapy. For example, each partner, and the couple as a unit, will have different transference reactions to the therapist and to each other.

Group Therapy

As with couples and family therapy, there are gender issues in group therapy. When group therapy is sought or recommended, the gender of the group therapist is not frequently considered, although the gender composition of the group often becomes an important factor. Some data suggest that group behavior both between group members and with the leader is affected by gender (Forsyth, et al., 1997; Bass, 1990; Mayes, 1979). McNab (1990) reported that men set themselves apart to a greater extent than women at the start of group therapy and become integrated into the group later.

Women often seek women's groups because in groups of men or even in mixed groups they feel powerless, intimidated, and uncomfortable about speaking up. They may feel supported and less anxious in same-sex groups, although mixed groups may be helpful in confronting problems of professional development. Most often single-sex groups have been used for support and consciousness-raising. Both male and female self-help groups often form around a specific focus (e.g., substance abuse, divorce, family violence) and use problem-solving approaches.

Therapy groups with both male and female leaders permit men and women to deal with transference issues, both as peers and as leaders. It is important, however, that the leaders' relationship with each member, just as with male and female therapists in family therapy, be a facilitating rather than inhibiting factor. Mistrust, competition, and anger that are not addressed in either leader or group members can be unproductive and inhibitory to group process.

Psychotherapy Treatments and Outcome

Data are abundant indicating that women have a greater incidence of some mental disorders and men of others. In terms of treatment, most of the early research on treatment outcome did not consider gender as a salient variable. This is beginning to change, particularly in the biological areas of psychiatry.

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In the psychotherapy literature, while there is increasing emphasis on outcome, gender has not been well studied. Cavenar and Werman (1983) in their early critique of studies of psychotherapy outcome emphasized the importance of specifying the treatment approach. They indicated that the gender of the therapist might be more relevant in modalities such as supportive psychotherapy, in which identification with the therapist and restoration of defenses is more critical.

Mogul (1982) suggested that therapist sex matters least in traditional psychoanalysis. The issue, however, may have more to do with the alliance and the transference than the modality or the diagnosis (Kernberg, 1993; Shapiro, 1993; Gruenthal, 1993). Person (1983a) suggested that gender effects are more subtle in psychoanalysis than in psychotherapy but may be just as pervasive.

The popular belief is that women patients do better in therapy with women therapists because women therapists are more relational, empathic and less likely to disempower women patients. There is empirical evidence on both sides of the efficacy argument for a gender effect in treatment, with most studies concluding that there is none (Zlotnick, et al., 1998; Huppert, et al., 2001).

Kirshner et al. (1978) studied a large number of therapist-patient matches in short-term individual psychotherapy and found that female patients showed greater responsiveness to psychotherapy and that greater patient satisfaction and self-rated improvement occurred with female therapists. More improvement was seen in attitudes toward careers, academic motivation, academic performance, and family relations. At the same time, however, these researchers also reported that the female patients of female therapists were less likely to describe their therapists as competent than were the patients of other gender dyads. When therapist experience and gender were considered, more experienced therapists seemed to have had better therapeutic results and showed fewer gender effects than did less experienced therapists.

There are differences of opinion about the importance of therapist experience, with some studies showing that experience is an important variable and that it interacts with gender. Thus, the gender of a less experienced therapist may have a more negative impact on outcome than the gender of a more experienced therapist. There are data suggesting that less experienced women therapists do better with women than less experienced men therapists. The theoretical orientation of a therapist may also be important. Some studies reveal that both men and women prefer therapists of their own gender (Simons & Helms, 1976).

More current work continues to suggest, however, that males are more likely to be referred to a male therapist and that female therapists get fewer referrals of male patients (Mayer & de Marneffe, 1992). This finding implies that gender stereotypes continue to operate.

Conclusion

It is apparent that gender is an important treatment variable and that attention to gender effects together with better understanding of the complex interaction of gender and other variables will shed light on the therapeutic process and contribute to greater therapeutic effectiveness.▼

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