Handbook of Gender and Sexuality in Psychological Assessment brings together two interrelated realms: psychological assessment with gender and sexuality. This handbook aids in expanding the psychological assessors’ knowledge and skill when considering how gender and sexuality shape the client’s and the assessor’s experiences. Handbook of Gender and Sexuality in Psychological Assessment is an informative resource for researchers who want to identify important areas of investigation at the intersection of psychological assessment with gender and sexuality. Throughout the six sections, gender and sexuality are discussed in relation to different psychological methods of assessment; various psychological disorders; special considerations for children, adolescents, and older adults; important training and ethical considerations; as well as several in-depth case discussions.

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“Brabender and Mihura and the esteemed clinician-authors they have assembled have broken crucial new ground in the literature on psychological assessment. This timely volume strikes an optimal blend of scholarly review of research and theory with rich case illustrations to guide assessors in the careful consideration of nuances of gender and sexuality in understanding the people they evaluate. This book epitomizes a model of reflective, empathic, rigorous, ethical, and highly competent assessment for the twenty-first century.”

Anthony D. Bram, PhD, ABAP, Cambridge Health Alliance/Harvard Medical School, Boston Psychoanalytic Society and Institute, author of Psychological Testing That Matters: Creating a Road Map for Effective Treatment

“Despite psychology being an overwhelmingly female profession, the specialty of psychological assessment is dominated by men. Perhaps as a consequence, too little attention has been paid to the role of gender in the assessment process. This volume, edited by two of the leading psychological assessment researchers and teachers in the world, goes a long way toward redressing that balance. They have assembled an impressive group of senior contributors who thoughtfully address such issues as the role of gender in interpreting various instruments, the intersection of gender and psychopathology, and gender and sexuality in the assessor-client relationship. This is a vitally important book.”

Bruce L. Smith, PhD, ABAP, Associate Clinical Professor of Psychology, University of California, Berkeley

“This impressive handbook is an invaluable resource on the often overlooked yet essential aspects of gender and sexuality in psychological assessment. It serves practitioners extremely well with its wealth of case examples, which include many different types of psychopathology from different areas of assessment practice, such as child/adolescent and forensic. Each chapter ends with a set of practical key points and an annotated bibliography. On a firm empirical grounding, this handbook also makes an outstanding scholarly contribution, by providing comprehensive reviews of the current literature and directions for future research endeavors.”

Corine de Ruiter, PhD, Professor of Forensic Psychology, Maastricht University, The Netherlands
HANDBOOK OF GENDER AND SEXUALITY IN PSYCHOLOGICAL ASSESSMENT

Edited by
Virginia M. Brabender and Joni L. Mihura
To Francine Deutsch, my honest and true friend of forty years.
    — Virginia M. Brabender

To my clients, for trusting me with your emerging selves.
    — Joni L. Mihura
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In his 2015 State of the Union address, President Obama used a word that made headline news: transgender. This event captured the attention of the press because never before had a president in a spotlight moment recognized gender identity as worthy of respectful attention. History will show whether this moment was a watershed for the full integration into society of individuals with gender-variant identities, who are able to enjoy the rights and privileges of the cisgendered population—that is, those whose gender identity matches the identity assigned to them at birth. Given society’s reluctance to embrace individuals on the full spectrum of gender identities and sexual orientations, it is not surprising that the field of psychological assessment has paid such little attention to sexual and gender identity statuses that depart from what is seen as normative. More perplexing, perhaps, is that gender has not received the thorough exploration that might benefit psychological assessors. Through the chapters in this handbook, we will see that various issues concerning gender and psychological assessment are far from resolved, issues such as the desirability of gender-based norms or mixed norms. In the past 10–15 years, individual facets of identity such as gender identity and sexual orientation have been explored in the psychological literature. Yet, the intersection of these identities with each other, and with other important identity facets such as race, ethnicity, religion, and spirituality, has received far less attention. This handbook aims (a) to spark the assessment community’s interest in the topic of gender, sex, and psychological assessment; (b) to identify central issues in need of theoretical and empirical attention; and (c) to identify what, in the views of experts in the different areas of this text, constitutes competent, respectful practice in assessing individuals across different gender and sexual identities. However, we recognize that this handbook is only the beginning of the discussion.

This handbook is divided into six sections. Section I provides the framework for ensuing chapters. Chapter 1 defines basic terminology related to gender
Preface

and sexuality identities and discusses how these identities are pertinent to every stage of a psychological assessment. The importance of the assessor’s taking into account potential stigma in relation to gender and sexual minorities is also discussed. In Chapter 2, we underscore the point that the identities related to gender and sexuality must be examined in the context of all of the other identities that define a person. The chapter introduces the useful concept of *intersectionality*, which leads the assessor to consider multiple identities in terms of their combined effects on client experiences, perspectives, behaviors, and symptoms.

Section II focuses on the major assessment tools used by assessment psychologists. Consistent with the multi-method approach, we have invited contributions on a range of methods and instruments. Our contributors discuss the research on how gender and sexuality variables influence clients’ performance on various psychological tests and methods and the practical implications of research findings. In Chapter 3, Whitehead uses a psychoanalytic, intersubjective framework to illumine the interpersonal dynamics of the assessment situation related to gender and sex. He considers how an interviewer might broach topics of gender and sexuality in a way that will instigate a thoroughgoing and respectful exploration of these areas. Whitehead provides case material illustrating some of the obstacles that arise in interviews when assessor and client begin to plumb gender and sexual identities, and strategies the assessor can use for the removal of these obstacles. In Chapter 4, Rourke and Bartolini look closely at cognitive assessment and identify some of the major methodological problems in using extant research to understand sex and gender differences as they relate to cognitive ability. They also consider major types of theories that have been used to explain differences among gender/sex subpopulations and draw out the practical implications of their findings for conducting cognitive assessment. In Chapter 5, Krishnamurthy talks about some of the major self-report personality tools, especially the MMPI-2, MCMI-III, and PAI. Krishnamurthy explores the gender differences obtained on particular self-report scales and their significance for evaluating clients’ self-report data. Chapter 6, by Tuber, Boesch, Gagnon, and Harrison, focuses on the Rorschach Inkblot Method, a performance-based instrument, and the implications of the fairly consistent pattern across research studies of minimal gender differences on Rorschach variables. In Chapter 7, through a series of case illustrations, Silverstein shines a light on narrative techniques and drawings and the new understandings that emerge when they are examined through the lens of gender and sexuality. We believe that, in total, these chapters demonstrate the importance of using the multi-method approach to capture the uniqueness of individuals of all identity statuses, irrespective of gender, sexual orientation, or gender identity.

Section III addresses personality and psychopathology through the filter of gender and sexual identity. In most psychological assessments, the assessor is asked to arrive at a diagnostic formulation. With respect to certain diagnostic conditions, are there demographic differences based on gender, gender identity, and sexuality orientation? How does the assessor factor in epidemiological
findings on various disorders and the meanings of those findings? The chapters in this section explore these issues.

In Chapter 8, Shorey considers how attachment styles may vary as a function of culture and gender. He makes the interesting point that those attachment styles that develop early in life as a consequence of interaction with caregivers may differ from attachment styles that develop subsequently through intensive interactions with peers. He develops the implications of this point for how the assessor investigates attachment style. In Chapter 9, Bornstein and McLeod take up the important topic of personality and personality disorders in the context of sex and gender, and discuss the utility of a multi-method approach in order to get at the underlying dynamics that establish personality style. They also consider how various personality disorders may manifest differently in men and women. In Chapter 10, Kleiger describes epidemiological differences in various types of psychosis (e.g., schizophrenia, bipolar psychosis, schizoaffective disorder) for individuals varying in gender, gender identity, and sexual orientation. He cultivates our appreciation of the fact that “the interface between psychotic and gender-related phenomena is complex, easily leading to erroneous assumptions and misdiagnosis,” and he describes how a combination of narrowband and broadband assessment tools can aid us in avoiding these negative outcomes. One problem he explores in some depth is the interpretation of psychological data pointing to psychoticism in some transgender individuals and the importance of viewing the evidence through the lens of multiple hypotheses. In Chapter 11, Blagov and Goodman describe how variation in gender, gender identity, and sexual orientation is associated with differential base rates of depression and bipolar disorder. They talk about a range of psychological instruments that can be helpful in diagnosing depression and bipolar disorder and the special considerations (such as issues of bias) for using these instruments with individuals of variant gender and sexual identities. In Chapter 12, Hodgson, Preiser, and Cassano look at different anxiety disorders and how anxiety is influenced by trauma, a topic of relevance to gender and sexual minorities. They also review instruments that assess anxiety and discuss their suitability with different populations. Eating disorders and body image are areas where gender and sexual orientation are particularly important; in Chapter 13, Fallon and Lannon discuss empirical findings related to eating disorders and gender and sexuality. They examine many of the major narrowband instruments for eating disorders and consider their use with people of diverse gender identities and sexual orientations. In the last chapter of this section, Chapter 14, Burks and Cramer consider suicidality, sexual orientation, and stigma. They discuss the research showing that the suicide rate is elevated for gender and sexual minorities and consider the various reasons for this pattern. They describe a variety of suicide assessment measures that may be helpful to psychological assessors, but they also underscore the limitations of those instruments in work with individuals with variant sexual and gender identities.
In section IV, our contributors provide clinical illustrations of various types of problems that engage the identity areas of gender and sex in all of their complexity. Through an in-depth clinical example, Yalof’s Chapter 15 explores the dance between assessor and client that unfolds as the assessment progresses, and how the identities of each stimulate transference (client reactions) and counter-transference (assessor reactions) that crucially shape the assessment process. In Chapter 16, Boyer, Schwartz, and York acknowledge that in most clinical assessments, gender and sexuality issues are not part of the referral question. Nonetheless, through these clinical illustrations they demonstrate that the assessor’s sensitivity to both the client’s experiences and his or her own evolving reactions to the client will allow gender and sexuality information to surface. They show how such information can be inestimably important in providing a fuller picture of the client’s struggles. In Chapter 17, Callow helps us to recognize that gender bias can operate in different directions by presenting the forensic case of a male client who was subject to gender bias. Chapter 18 provides an example of the concept of intersectionality, introduced in Chapter 2, as Haas discusses a case of gender and immigration. She talks about the complex identity forged by immigrant women who face various types of stigma and oppression in their host society, considerations for conducting a culturally sensitive psychological assessment, and the special considerations when the assessment work has a forensic aspect. Chapter 19 by Kaser-Boyd continues the discussion of gender and sexuality by illuminating through forensic case illustrations the phenomenon of sexual harassment of both men and women and discussing how assessment psychologists can be helpful in identifying the effects of such harassment. In Chapter 20, gender identity takes center stage as Bullock and Wood provide case analyses of psychological assessments with trans persons. They investigate the complex issues that arise in the interpretation of psychological test data, interpretation—they argue—that requires the assessor to take into account the lived experience of persons with variant gender identities. Finally, in Chapter 21, Finn talks about the usefulness of Therapeutic Assessment in the context of sex reassignment surgery. After providing a brief introduction to Therapeutic Assessment, he talks about the role of the assessor and professional standards in conducting this work. He presents a case that demonstrates how the assessment work provides a vehicle for learning not only about the client but also about the assessor.

Achieving a clear sense of personality identity is, as Erik Erikson taught us, a developmental undertaking, and the chapters in Section V explore the developmental aspects of gender and sexual identities. In Chapter 22, Russ and Zyga examine the relevance of play to gender and sexuality in childhood. In Chapter 23, Wright and Nickleberry extend the developmental trajectory into adolescence, during which time intensive gender-related developmental work occurs vis-à-vis identity. Languirand, in Chapter 24, takes us to the last stages of adult development and the important sex and gender identity work that occurs within that period, particularly in the context of the increasing need to cope
with loss, change, and death. She provides guidelines for conducting psychological assessments with this population.

Section VI features chapters designed to help the reader to take a broad view of the themes introduced throughout the book. Repeatedly, our authors call for the importance of greater graduate-level training in the areas of diversity explored in this text as it is applied to psychological assessment. Chapter 25 by Ortigo and Weiss develops the concept of psychological assessor as ally or advocate. They describe what formative training—didactic, experiential, and field placement—is needed for psychologists to be an effective ally and a competent provider of assessment services to the diversity of clients who need such services. Chapter 26 by Alvelo, Maguire, and Knauss shows how a principle-based ethical framework can be integrated with a feminist perspective to recognize the multiple ethical dimensions of clinical decision making when assessing individuals of varied gender identities, sexual orientations, and gender expressions. They present a series of three vignettes that illustrate the varied problems and ethical conundrums that gender and sexual diversity raise. Finally, in Chapter 27, we look into the future and critically appraise what the prior chapters have taught us about what research and practice initiatives will best serve our varied clients’ needs.
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PART I

Introductory Chapters
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THE CONSTRUCTION OF GENDER AND SEX, AND THEIR IMPLICATIONS FOR PSYCHOLOGICAL ASSESSMENT

Virginia M. Brabender and Joni L. Mihura

A female client calls a male psychological assessor to make an appointment for an assessment. From the first moment of hearing the client’s voice on the phone, the assessor registers one critical piece of information about the client—his or her gender. The assessor gauges from the caller’s tonal quality that he was speaking to a woman. The client probably already knows the assessor’s gender before making the call. Gender-related information possessed by client and assessor is likely to shape the assessment in many ways. From the client’s standpoint, it may affect his or her attitude in coming to the assessment. If, for that client, masculinity is associated with authority, then an assessor’s maleness could provide a measure of comfort and encourage the client’s willingness to appear for a first meeting. It may even affect the client’s willingness to follow through with the assessment. Another client may associate that assessor’s maleness with dominance and find the prospect of meeting with the assessor more intimidating than if he were to be assessed by a woman.

The assessor is also likely to think about the client in gender-based terms throughout the stages of the assessment. Based on his or her own fund of assessment experiences, knowledge of base rates, or other reading of the literature, the assessor might understand the client and interact with the client based upon the assessor’s assumptions about men and women and how they differ. This phenomenon is gender bias (Crosby & Sprock, 2004; Koenig & Eagly, 2014; Sprock, Crosby, & Nielsen, 2001). For example, Samuel and Wieder (2009) found that when practicing clinicians rated a male or female version of a case vignette using the Diagnostic and Statistical Manual of Mental Disorders...
In using the term *gender*, we are differentiating it from sex. Note that the assessor identified the individual as a woman based upon her voice quality. In other words, he associates femaleness with particular vocal characteristics that are different from those connected to maleness. This assignment is part of gender. It differs from *sex* in that a person's sex is the label the person is given at birth and is based strictly on physical characteristics (World Health Organization [WHO], 2014). These sex characteristics usually lead to a classification of male versus female, but they are by no means the only possibilities. Individuals may manifest the physical characteristics of both males and females in varying ways, a status labeled *intersex*. *Gender* is a broader notion that includes all of those characteristics and roles, interests and sensibilities that members of a given society ascribe to a particular gender (McCreary & Chrisler, 2010). For example, the psychologist, reflecting the views of society, might have certain assumptions about his female client, such as possessing certain interests or personality characteristics.

Over the history of psychological assessment, considerable focus has been placed on gender. Yet, to know about the client's gender is not to know enough. That client who called the assessor for an appointment may be called Jane and may have the primary and secondary sex characteristics of a woman. Perhaps the entire world sees Jane as a woman. But this designation may feel wrong to Jane. Even though Jane has never communicated this idea to another person, she senses herself at her core to be male. Her reason for pursuing a psychological assessment is the constant malaise she feels, her lack of interest in her everyday activities. If the assessor gathers evidence from a variety of psychological tools and methods showing that Jane does have a considerable fund of emotional misery but never explores its potential link to her hidden identity, never sees her gender dissonance, then the assessment may not only fail to fulfill its potential to increase Jane’s self-understanding but also may foster a sense of alienation.

What is being described in Jane’s case is the identity variable of *gender identity*, which concerns how a person experiences his or her own identity. Gender identity tends to be particularly inconspicuous because in the vast majority of the individuals in the population, the *cisgender* population, a match exists between an individual’s apparent gender, typically based on primary and secondary sexual characteristics, and his or her felt gender. Yet, by no means do cisgendered individuals encompass the entire population. A group of individuals referred to by the terms *transgender* and *gender nonconforming* lie outside of the cisgender population. According to the American Psychological Association (APA, 2011,
transgender is an umbrella term for “persons whose gender identity, gender expression, or behavior does not conform to that typically associated with the sex to which they were assigned at birth.” Among the subpopulations within this group are transsexuals, whose primary and secondary characteristics are incongruous with their gender identities. Cross-dressers are individuals who dress in a manner that differs from that customarily associated with the sex they were assigned at birth and might identify as transgender. Also present within this population are individuals who have a more flexible gender identity, either identifying with each gender simultaneously or who experience their gender identity in different ways at different times. A still separate group is constituted of those individuals who do not see themselves as relating to the male-female distinction. Individuals who do not ascribe to the gender binary are sometimes referred to as gender-queer. These individuals teach us the valuable lesson that the gender binary is more of a convenience than an accurate representation of the range of ways in which individuals identify themselves with respect to gender. They also help us to see that the gender identities of male and female are not polar in the sense that one necessarily precludes the other.

Individuals who are not among the cisgendered members of society have equal entitlement to competent psychological assessment as those who are. Such competence requires the assessor’s fine-tuned grasp of the psychological issues these subpopulations face. The broad terms of transgender and gender nonconforming can obscure the fact that each group has very specific stressors and challenges. Moreover, although all of these groups are vulnerable to discrimination based on their departure from gender norms, the degree of negative bias from group to group can vary greatly (APA, 2011; Serano, 2007). It is imperative that the psychological assessor recognizes the particular character of each group’s burdens.

**Gender Expression and Related Concepts**

The client’s gender identity does not tell us how that identity will be expressed. For example, a client may have a very strong sense of himself as being a male. At the same time, the client may express his maleness in ways that others regard as not highly masculine. This point speaks to the separateness of a client’s gender identity from gender expression or how the person manifests his or her gender identity. Two clients may each have a strong female identity but manifest that identity in completely different ways. Gender expression may or may not conform to gender stereotypes (APA, 2014), and this aspect distinguishes it from masculinity-femininity, a term that has had a very long history. In their empirical work on this concept using data on the Masculine-Feminine scale of the MMPI-2, Martin and Finn (2010) found that this personality characteristic is not redundant with other characteristics that can be identified through this introspective technique. Moreover, it appears to be composed of three subfactors: (1) an endorsement of stereotypically feminine interests, (2) a disavowal of stereotypically masculine interests, and (3) gender identity. The construct
gender conformity relates to the extent to which an individual embraces a gender stereotypic role. Gender conformity can produce gender role conflict in which an individual's ascription to gender roles has negative consequences for that individual or those around him or her (O’Neil, 1990).

**Sexual Orientation**

Gender identity and gender expression, however, do not complete the story. Understanding gender also involves an appreciation of the client's sexual orientation and how it interacts with other gender characteristics to influence a person's fund of experiences and behaviors, including those emerging within the assessment situation. Sexual orientation is determined by the gender of the other person that elicits sexual attraction and intense positive feelings from a person. Vrangalova and Williams (2012) describe it as the “sexual attraction, identity, arousals, fantasies, and behaviors individuals have for one sex, the other sex, or both sexes” (p. 5). They note that whereas researchers often place individuals into discrete categories of heterosexual, gay, or bisexual, the data suggest more of a fluid-continuum model of attraction to one or both sexes. For example, some individuals are mostly heterosexual (or mostly gay/lesbian), whereas others are wholly heterosexual (or wholly gay/lesbian) (van Lankveld, 2014), a notion that has been supported by multiple studies (e.g., Diamond, 2007; Epstein, McKinney, Fox, & Garcia, 2012). Still others may be variable in their sexuality and abstain from placing themselves on a continuum of sexual preference. Another group of individuals are distinguished by lacking sexual attraction to either men or women (Foster & Scherrer, 2014), which is termed asexuality. According to Bogaert (2015), an individual with an asexual designation might nonetheless have sexual feelings (simply not sexual attraction) or romantic inclinations. He further points out that of all of the sexual orientations, this identity status is the least studied.

An early contribution to the literature on psychological assessment and sexual orientation was a chapter in which Pope (1992) presented a series of cases of individuals whose sexual orientations had implications for their experience of their psychological assessment. One of his clients was seeking to gain entrée into a specialized program within mental health. Admittance required a psychological assessment. The candidate was gay and apprehensive about a possible heterosexist bias on the part of the faculty. He believed that the (original) Minnesota Multiphasic Personality Inventory ([MMPI] Hathaway & McKinley, 1943), which was a component of the evaluation, provided information that could reveal his sexual orientation. The student carefully responded in a way that he believed would steer the committee away from recognizing his sexual orientation. In the process, he produced an elevation on scale 9 (Hypomania) that was absent on a subsequent occasion when he took the MMPI after being accepted into the program. As we will explore, the client's sexual orientation potentially figures into the assessment in many ways. As this example illustrates, it can affect test-taking set in high-stakes testing when, in the eyes of the client,
the outcome could be affected by sexual orientation. In assessments that are not perceived by the client as high stakes, the sexual orientation of a gay, lesbian, or bisexual client could still influence the assessment if the individual wondered how the assessor might regard him or her were the sexual orientation to be disclosed. This uncertainty could add a level of stress to the assessment that might be absent for individuals who are not members of sexual minorities.

The Person of the Assessor

The assessor’s gender and sexual identities are also material to the assessment. Consider a lesbian psychologist who provides psychological services in a rural community with conservative values. This psychologist might harbor a worry that the client’s awareness of her lesbianism might lead that client to be more resistive than he otherwise might. Might not the assessment psychologist’s wariness affect other behaviors, such as showing warmth and other means of building rapport with the client? Likewise, an assessor’s gender role conformity may exert its influence if the demands of the assessment were experienced as at odds with the assessor’s allegiance to a gender stereotype. For example, in the clinical interview, the female assessor might refrain from asking important questions in relation to sexuality because it violated the assessor’s own sense of delicacy connected to her feminine ideal. Conversely, the assessor might be spurred by the impulse to reject a feminine stereotype and broach sexual material in an aggressively probing way.

Also pertinent to the contribution of the assessor is that assessor’s tolerance for exploring identity facets related to gender identity and sexual orientation. The assessor’s identities that are similar to or different from the client are brought to the fore for the assessor to behold. Some identities may be the source of discomfort. The assessor who has never thought deeply about his or her own gender and sexuality may fear the final destination of such explorations. In fact, for some, it may be a cause of the confusion that arises in relation to many facets of identity—the way, for example, that gender expression is confused with sexual orientation. This defensive posture is of course not unique to assessors: We may find it in any professional providing services to a diverse group of clients. However, for assessors, this self-protective reaction limits their capacities to garner and work productively with identity information about the client. Ultimately, it prevents the assessor from accomplishing the central task of the assessment—understanding the client.

In his or her quest to understand a person fully, the psychological assessor has the challenge of grasping all that makes up the individual’s identity and recognizing the presence of different identity elements in the assessment. It entails knowing how the client regards him or herself in terms of gender, gender identity, masculinity and femininity, and sexual orientation. It encompasses recognition of these characteristics as others, including the assessor, perceive them. However, the assessor, too, must have a cognizance of how his or her own gender characteristics
in interaction with those of the client create a dynamic field that can both affect the quality of the assessment and be a rich terrain for harvesting insights about the client. The assessor must engage in the potentially difficult process of identifying gender and sexual biases that he or she might bring to the assessment situation, biases yielding subtle cues to which the client may respond. This task is integrally related to the topic of stigma. Even the most compassionate, broad-minded assessor may be at risk for bringing stigma into the assessment situation.

**Stigma as an Element Within the Client’s Life and the Psychological Assessment Process**

This volume shines a light on aspects of identity that tend to figure prominently in an individual’s view of self. The last section defined these aspects—sex, gender, gender identity, gender expression, and sexual orientation. Over the history of personality assessment, the identities of gender identity, gender expression, and sexual orientation have been addressed minimally. When they were considered, it was generally to ill effect. For example, psychological assessment was used to determine a client’s sexual orientation, sometimes using most famously the MMPI Masculinity-Femininity (Mf) Scale (Hathaway, 1956/1980). However, this attempt confused sexual orientation with gender expression. Psychological assessors would also use assessment findings as a basis of recommending the denial of a client’s request for gender affirmation surgery. When clients gave evidence of experiencing distress, this finding was seen as an indicator of the individual’s unsuitability for surgery. Too often, the possibility that the incongruence between the person’s physical characteristics and gender identity gave rise to emotional symptoms was ignored, as was the role of stigma in generating psychological problems (Serano, 2007; Solomon, 2012).

These misuses of psychological assessment were not problems of assessors alone but part of a broader societal context (Pope, 1992). As Pamela Hays (2005) points out, attached to any domain of identity is variation (e.g., differences in race, sexual orientation, religion) that gives rise to subpopulations (e.g., African American, Asian American, EuroAmerican). Some groups within a particular domain of identity will, for a variety of reasons, achieve dominance over others who constitute the minority. For members of the majority, the privileges they possess are so natural that they are easily unseen. However, the lack of privilege tends to be deeply felt.

Minority status carries with it the potential for stigma, which literally means a mark and is commonly associated with disgrace. The stigmatized person is seen as morally objectionable and in need of banishment, punishment, treatment, or some combination of these. To stigmatize is to give that person a mark, or to call attention to an aspect that will lower the stigmatized person’s worth in the eyes of society (Goffman, 1963). As Herek (2009) elaborated, “stigma constitutes shared knowledge about which attributes and categories are valued by society, which ones are denigrated, and how these valuations vary across
Gender and Cognitive Assessment

situations” (p. 66). He points out that structural stigma entails ensconcing this shared knowledge within major societal institutions such as medicine, law, government, religion, and so on. Gender and sexual variant groups that represent subgroups of gender and sexual orientation are structurally stigmatized groups. That is, the stigmatizing of these minorities is embedded within society’s most important and influential systems. Up until 1973, the ApA viewed nonheterosexuality as a mental disorder. Until recently, some states within the United States viewed same-sex marriage as illegal. However, in June 2015, the Supreme Court ruled that states must recognize same-sex marriages. Still, many of the major religions see same-sex sexuality activity as a sin.

Structural stigma, Herek (2009) notes, creates the context for three other types of stigma to occur, all of which are important for the psychological assessor to recognize: enacted stigma, felt stigma, and internalized stigma. Table 1.1

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<th>Type</th>
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| Enacted   | The enactment of stigma; the manifestation of discriminatory ideas and beliefs | • Assessors must be scrupulous in identifying their own discriminatory views and recognizing when they affect behavior toward a client.  
• Assessors must be open to the possibility that they harbor biases against marginalized groups of which they are unaware.  
• Assessors should recognize the range of enacted stigma that may have contributed to the client’s stress. |
| Felt      | The client’s beliefs about when, where, and how stigmas are enacted and how enactments can be avoided | • The assessor should develop skill in asking clients about their stigma perspective.  
• The assessor should ascertain how a client’s stigma perspective affects his or her willingness to be open in the assessment.  
• The assessor should analyze how the client’s stigma perspective helps, hinders, or fails to affect his or her functioning. |
| Internalized | The individual’s conscious or unconscious acceptance of a societal point of view as part of his or her own perspective | The assessor should recognize the client’s level of internalized stigma, its conscious or unconscious presence, and its influence on the client’s self-esteem, and interpersonal behaviors. |
describes the three forms of stigma and their implications for psychological assessment. 

*Enacted stigma* is behavior directed at minority group members and their allies. For example, failing to consider job applicants because of their race, sexual orientation, or religion would be enacted stigma. To understand enacted stigma in a way that is most likely to be helpful in psychological assessment, it is useful to link it with Sue’s concept of microaggressions because it broadens the behaviors that might be considered to be enacted stigma.

**Microaggressions** are “everyday verbal, nonverbal, and environmental slights, snubs, or insults whether intentional or unintentional, that communicate hostile, derogatory or negative messages to target persons based solely upon their marginalized group membership” (Sue, 2010, p. 3). Sue’s concept underscores that people are often unaware of stigmatizing others. To preserve their self-regard, they will not permit themselves to think that they could harbor prejudicial thoughts and feelings. Of course, not all people always have compunctions about expressing discriminatory views. A conscious direct expression of a prejudicial thought or feeling is termed, by Sue, a *microassault*, and pejorative name-calling would be an example. For example, to say someone throws “like a girl” is a microassault in that it directly conveys that girls are inept in particular areas. Far subtler are *microinsults*, which are unconscious negative communications or actions based on the target’s group membership. For example, a physician who shows a pattern of keeping individuals from a lower socioeconomic status waiting for their appointments much longer than people from a higher status might be engaging in a microinsult. *Microinvalidations* entail denying the reality of the experiences of a stigmatized group. For example, conveying to a client that one’s privileged membership status (e.g., high socioeconomic level) must have shielded him or her from racism, heterosexism, or some other type of discrimination is an example of a microinvalidation.

Like all members of society, psychological assessors have biases of which they are unaware, which can give rise to the various forms of microaggressions. What benefits the client is the assessor’s awareness that he or she has the capacity to commit a microagression. This awareness leads to a watchful stance toward his or her own behavior, with particular attentiveness to behaviors that appear to have affected the client adversely, for example, behaviors that may have induced withdrawal or disengagement from the assessment. Upon recognizing a microaggression, the assessor can modify his or her behavior and work to identify the bias that gave rise to it. Sometimes clients themselves point out microaggressions. The assessor who knows that he or she is not immune to such behavior is better able to be open to the client’s communication, responding with neither rigid defensiveness nor paralyzing self-recrimination.

*Felt stigma* is the recognition of discrimination based on membership in a particular group (e.g., gender or sexual minorities) and conceptualization of the contextual factors that will control the enactment of stigma (Herek, 2009). For groups in which membership is not entirely visible, any member of society is a potential member of that group and thereby vulnerable to
discrimination. Consequently, members of the stigmatized minority or the generally nonstigmatized majority may invest effort in discerning how to avoid discrimination. For members of the nonstigmatized majority, the way of escaping being stigmatized may be to make a show of stigmatizing others, that is, to enact stigma. In minority group members, the avoidance of enacted stigma can take the form of passing—attempting to appear as a member of the majority—but can also involve limiting one’s relationships, venues, interests, and so on to escape adverse experiences. The challenge for the psychological assessor is to ascertain to what extent such efforts are adaptive and to what extent they interfere with having a happy, productive life. The assessor must also discern how felt stigma might motivate a client to alter his or her presentation within the assessment.

*Internalized stigma* is taking into the self society’s negative view of a given group and making it one’s own view (Herek, 2009). The act of internalization need not be conscious, and frequently it is not. It springs from the natural propensity human beings have to identify with one another (Racker, 1968). In fact, many of the more subtle forms of microaggression emanate from internalized views operating outside of awareness. What is crucial for clinicians to recognize is that members of a stigmatized group are also vulnerable to internalizing the stigma attached to that group. Herek (2009) refers to this phenomenon as *self-stigma* in that the condemnatory attitudes of society are now directed at the self. Once again, this internalized stigma may be conscious, unconscious, or have some elements of both. Furthermore, as we will discuss later in this chapter, this stigma may be connected to the psychological problems a client presents (Meyer, 2003). For the present, it is worthwhile to note that psychological assessments, relying as they do on the multi-method approach, offer assessors tools for the detection of internalized stigma that may not be evident through mono-methods such as interviewing.

For individuals who are the victims of stigma due to their group membership or perceived group membership, the consequences extend far beyond the unpleasantness in the moment. Meyer (2003) has proposed the Minority Stress Model to capture the effects of experiences with marginalization. Although Meyer’s primary focus is sexual orientation, the Minority Stress Model has been applied to other marginalized groups (e.g., Wei, Ku, Russell, Mallinckrodt, & Liao [2008] applied the model to Asian international students and Orozco & Lopez [2015] used it in explaining the schooling experiences of Mexican American high school students). Meyer defined minority stress as “the excess stress to which individuals from stigmatized social categories are exposed, often as a result of their . . . minority position” (p. 675). Like others (e.g., Allport, 1954; Goffman, 1963) before him, Meyer points out that members of stigmatized groups carry a burden beyond that of members of dominant groups—a burden that erodes quality of life. His research and that of others points to a relationship between stigma-based stress and a variety of psychological problems. For example, Wong, Weiss, Ayala, and Kipke (2010) demonstrated a relationship
between harassment and illicit drug use over a three-month period in an eth-
nically diverse group of young men who reported having sex with other men.

The Minority Stress Model also posits that the relationship between stress
and distress is moderated by the ways in which an individual copes with stigma
and the degree of social support that person receives. Of significance to the
psychological assessor is Meyer’s point that personality factors play an important
role in how an individual copes with stress. For example, he mentions that the
stigmatized person’s willingness to access external supports is important to that
person’s ability to manage the stress. In this handbook, as we look at various
psychological problems associated with minority stress, we will also be ques-
tioning how minority stress can be buffered through the client’s acquisition of
effective coping strategies, access to social resources, and awareness of person-
ality strengths.

Although Meyer developed his notions on stigma to capture phenomena in
relation to individuals with variant sexual orientations, his ideas are relevant to
the identity domains addressed in this text. In all sectors of societies, discrimi-
nation occurs based on gender. As a report of the APA (2007) notes, although
society has moved toward greater equality for women and girls, significant
oppression, inequality, and discrimination remain. The term sexism generally
refers to male domination over women and reflects a broader societal andro-
centric orientation, wherein males are views as the exemplars of human beings.
Our use of the term will be consistent with this practice. Still, gender bias can
occur in either direction. Wherever gender role expectations exist, one gender
or the other can occupy a privileged or marginalized status. Heterosexism is the
posture that sees heterosexuality as the most normal and natural way for human
beings to relate romantically or sexually. The corollary to this belief is that other
forms of affectional and sexual relating are abnormal, unnatural, exceedingly
rare in occurrence, and even against the will of God. Biphobia is a fear of and
bias against bisexual individuals. Transphobia is a response toward transgender
people that encompasses one or more of the following: fear, loathing, repulsion,
avoidance, and discrimination. These types of stigma need not occur in isolation.
For example, a client may be transgender, female, and lesbian, and each of these
identities can be a source of minority stress. As we will see in Chapter 2, other
identities, such as those related to race, ethnicity, and religion, can add to the
stress burden even further.

The concepts presented in this section, such as types of stigma, provide ter-
minology for describing, and a framework for understanding, material that is
presented subsequently in this chapter and in the other chapters of this text.
This material is relevant to psychological assessors in at least three ways. First,
it provides insight into the early history of psychological assessment in relation
to marginalized groups and invites a conversation among psychological asses-
sors about the possible manifestations of stigma in our current assessment and
research practices. Second, it reveals the importance of psychological assessors
engaging in their own practices of self-examination, as well as exploration in
supervision and therapy, to identify and address any internalized stigma and corresponding enactments that may affect their work with marginalized groups. Third, the framework provides a lens through which to appreciate our clients’ lived experiences more fully and to empathically convey our appreciation. For example, being sensitive to the presence of internalized stigma enables assessors to understand a client’s low self-esteem in the midst of his or her professed pride in membership in a stigmatized group.

**Status of Assessment and Diagnostic Literature**

We now have some tools to examine some of the research efforts that have occurred in the last 50 years or so to explore the identity areas that are the focus of this text: gender, gender identity, and sexual orientation. Changes in how society regards majority and marginalized subgroups in each area of identity are paralleled by changing research questions, and in some cases, differences in how results are interpreted. What is offered in this section is a thumbnail sketch of each area. However, ensuing chapters elaborate on many of the areas upon which we touch.

**Identity Domain: Gender**

Of all identity areas considered in this text, that which has spawned the greatest amount of research over the decades is gender (to get a sense of the extensiveness of this research, see the two-volume handbook on gender research edited by Chrisler & McCrea, 2010). Until very recently, the lack of awareness of the distinction between gender and gender identity led to an emphasis on the former. If, in a research study, a client were asked to identify as male or female, that participant could respond based on gender or gender identity. For most of the population, the cisgendered subpopulation, they are the same. However, for individuals in the trans population, a difference can exist between the two concepts. Whether particular gender study findings from a primarily cisgender population apply to a transgender population can only be determined by future research.

**Searching for Differences**

One question concerning gender has elicited more attention than any other: Are boys and girls, men and women, different from one another on a host of psychological test variables—cognitive, emotional, personality, and variables reflecting psychological symptoms? This question has been primarily posed in a quantitative way: Does the test performance of one gender exceed that of another? Psychological assessors have a particular interest in those studies that have focused on psychological test variables. The outcomes of these studies can affect public policy decisions, attitudes toward men and women,
and self-perceptions. Consequently, how findings of significant differences are treated when they are obtained is very important.

As Baker and Mason (2010) point out, at least three different strategies exist for treating differences between men and women, or boys and girls, on psychological test variables. A first strategy is to provide gender-based norms. For example, in the development of MMPI, Hathaway and McKinley’s (1943) discovery of differences between the raw scores of men and women in the normative sample induced them to create gender-based norms, a practice that has continued with the MMPI-2. However, Ben-Porath (2012) points out that whether such differences should lead to separate norms depends upon whether the differences are attributable to style or substance. If, for example, women were more open to acknowledging particular personality features, then having gender-specific norms could lessen this response style difference. If, however, a particular personality feature were more characteristic of women than men, then gender-specific norms would hide this feature. To allow for the possibility of differences in substance, not simply response style, Ben-Porath argues for non-gendered norms, a strategy that Baker and Mason identify as Gender-Irrelevant.

Ben-Porath’s (2012) distinction between style and substance is a worthwhile one. Of course, style and substance can operate together in the creation of gender differences for any given test scale. Furthermore, even if gender differences are due to substance more than style, the psychological assessor may find gender-based norms might be useful in particular instances. For example, a client who is being assessed for her undue aggressive style at work may yield a score on an aggression scale that is well within the nongendered population norm. Yet, she may be deviant when her performance is compared to a normative group of women. This disparity between her status vis-à-vis gendered and nongendered norms may reveal that her co-workers are viewing her behavior through gender-based lenses (i.e., she is responding aggressively in contrast with other women). Any discussion of gender—be it of a group or an individual—must reference the environment because social environments see individual behaviors through the lens of gender.

The third strategy in the treatment of gender is to construct the scales so that no differences between girls and boys or men and women emerge (Baker & Mason, 2010), as is done in the construction of many cognitive tests. As Baker and Mason note, this approach eliminates gender bias but does not preclude the possibility that individuals of one gender or the other may be disadvantaged at the extremes of the continuum. For example, if girls or boys more commonly engage in an activity that is highly similar to the task used to measure a given cognitive process, that subgroup may be advantaged at the high end of the continuum of performance.

Different test constructors have made different decisions about what normative material is available for a given instrument. It would seem helpful and healthy for a broader discussion to take place among psychological test constructors and psychological assessors about how gender differences are handled. Such
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A conversation should center upon how gender bias can be eliminated, or at least minimized, while recognizing that in particular circumstances, gender-specific information might be useful.

**Explaining Differences**

Apart from how gender differences are used, ignored, or eliminated, psychological assessment research can make a contribution to how gender differences can be understood. Costa, Terracciano, and McCrae (2001), who examined data from the Revised Neo-Personality Inventory (Costa & McCrae, 2008) of individuals from 26 cultures (over 23,000 participants), provide an example of such a study and highlight the complexity of interpreting gender differences. Across cultures, the investigators found consistent differences in the personality traits endorsed by males and females. Men scored higher on Assertiveness, Excitement Seeking, and Openness to Ideas. Women tended to score higher on measures of Neuroticism, Agreeableness, Warmth, and Openness to Feelings. One important aspect of their findings was that although these differences between men and women were consistent, the male and female score distributions were highly overlapping.

The investigators interpret their findings in the context of two sets of theories that have been advanced to account for gender differences. According to evolutionary theory (Buss, 1995), such differences are rooted in the different adaptive challenges faced by men and women. Women, facing the tasks of childbearing and breastfeeding, develop the personality characteristics suited to nurturing children. Personality traits such as Openness to Feelings enable optimal responsiveness to children’s emotional needs. With women focused internally, men must fulfill the responsibilities of protecting the family from threats in the external environment and bringing resources to the family, and personality traits such as Assertiveness support these roles. Costa et al. (2001) point out that if these role-based differences are engrained, species-level phenomena, then a high level of consistency should be observed from culture to culture. Yet, although the pattern was universal from country to country (consistent with evolutionary theory), the extent of the gender differences varied greatly (at odds with evolutionary theory). For example, in Zimbabwe the difference was slight and in Belgium and Croatia, it was relatively large.

From the perspective of a contrasting set of theories, social role theory (Eagly, Wood, & Diekman, 2000), men and women acquire different personality features based upon social conditioning or what tendencies are reinforced for each gender. One would expect, then, that in those countries in which behaviors corresponding to gender stereotypes are highly valued, gender differences would be great. This finding was not obtained: In countries such as the United States, which is known for prizing individualism, gender differences were relatively greater than in many of the countries with more collectivist cultures. One possibility, as Costa et al. (2001) point out, is that in rating traits, responders
may have different frames of references. For example, in collectivist countries, particular behaviors may simply be seen as conformity to cultural expectations, whereas in cultures emphasizing individuality, the same behavior may be perceived as reflective of the responder’s own unique personality. The point they raise about frame of reference is one that has broader relevance beyond explaining ethnic differences or similarities. In any self-report method, the respondent assumes a particular frame of reference in crafting his or her response and, at times, different subgroups of the population may adopt different frames. Research demonstrating gender differences based on introspective data can be most clearly interpretable if the possibility of differences in frame of reference are either ruled out or recognized as having an effect in a particular direction and of a particular magnitude.

Identity Domain: Gender Identity

Until very recently, gender identity, as distinct from gender, was not acknowledged as a basic domain of identity. Pathology was ascribed to any departure from a cisgendered status and societal gender norms (Borden, 2015). Research was done with individuals who were seeking one or more medical interventions in order to bring their sexual characteristics in greater alignment with their gender identity. However, these individuals were often placed in a position of having to prove to the medical practitioner their gender identities—a test-taking set not conducive to the clear and direct manifestation of participants’ psychological situation (Lev, 2005).

As the recognition emerged of the distinctiveness of gender identity as one of the core identity facets and a natural type of diversity among people (Borden, 2015; World Professional Association for Transgender Health, 2010), investigators have undertaken research that holds great promise in aiding the psychological assessor in his or her work. A first line of investigation (Institute of Medicine [IOM], 2011) entails the inclusion of gender identity in some of the large-scale national studies, an effort that will enable the construction of a much more detailed picture of the transgender population. This work holds the promise of helping assessors to understand some of the physical and psychological risks that accompany this status and its barriers to obtaining care. A limitation of most existing studies is that they fail to distinguish among subgroups of transgender individuals, such as individuals identifying as male-to-female versus female-to-male, or generalize from one subgroup to the other (Namaste, 2000). Assessors must be aware that extant research is fairly broad brush, but they should nonetheless be sensitive to how subgroup differences may make a difference in a client’s difficulties, coping possibilities, and so on.

The second line is the study of the development of a sense of gender identity and the factors influencing the coming-out process (e.g., Moller, Schreier, Li, & Romer, 2009). This information assists the assessor in situating his or her child or adolescent client within his or her reference group. For example, Moller et
al’s finding that today’s generation of children typically come out in childhood or preadolescence may be useful for the assessor working with parents who assume that their eight-year-old child’s declared gender identity could not possibly be trustworthy.

A third line of investigation is the study, through both quantitative and qualitative methodologies, of the various factors that are associated with good adjustment in a transgender and gender nonconforming population. For example, Singh and McKleroy (2011) conducted a phenomenological and feminist investigation of 11 transgender people of color—individuals coping with at least double minority statuses—who had experienced traumatic life events in relation to stigma. They found that among the factors that fostered their resilience were pride in one’s gender identity and racial identity, involving themselves with activist groups of transgender individuals of color, and immersion in spirituality. Connected to this line of research are those studies that demonstrate the effects of healthcare (e.g., sexual reassignment surgery or cross-sex hormones) that assists with the transition process (e.g., Johansson, Sundbom, Hojerback, & Bodlund, 2009; Meier, 2013). For example, Meier found that female-to-male transexuals experienced a decrease in gender dysphoria over their initial year of taking testosterone.

These lines of research will be useful to the psychological assessor who encounters gender-variant clients who have as great a range of concerns and presenting issues as any other group. Assessors are sometimes asked to evaluate the client’s readiness for gender transition treatment, particularly surgery (Coolhart, Provancher, Hager, & Wang, 2008). Providing guidance for this type of assessment is beyond the scope of this text. However, the reader can obtain an introduction to it through Stephen Finn’s Chapter 21 in this volume.

Identity Domain: Sexual Orientation

On December 15, 1973, the ApA declassified homosexuality as a form of mental disorder, and in 1975, the APA followed suit (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). Prior to those reversals, mental health disciplines regarded departures from heterosexuality as forms of psychopathology. The very early roots of the categorization of homosexuality as a non-normal condition were those religions that saw it as a form of immorality, and the behaviors associated with it were broadly termed sodomy (Jordan, 1998). However, in the 1800s, some scientists such as Ulrichs pursued the study of male inverts, males who had the qualities of men and women but who were attracted to women (IOM, 2011). The German psychologist Benkert supplanted invert with homosexual (Pickett, 2011), a term adopted by Freud, who had a major role in understanding this area of identity. Freud was ambivalent about the status of homosexuality. On the one hand, in his Three Essays on the Theory of Sexuality, Freud saw homosexuality as a part of all human development and wrote that all human beings are capable of a homosexual object choice, and have made such choices unconsciously (Freud, 1905). On the other hand, Freud saw a heterosexual object choice as the apex
of human development (Robinson, 2001). Despite this position, he did not see homosexuality as psychopathology, and in fact, saw the repression of homosexual urges as one forerunner of neurosis.

Later psychoanalysts such as Rado (1969) advanced the notion of homosexuality qua abnormality saying that homosexuality was the result of disturbances in children’s relationships with their parents. Studies showing manifestations of symptoms in a homosexual sample, difficulties in their upbringing, or both were seen as evidence of this point. For example, Bieber (1962) developed a 27-item questionnaire that tapped aspects of the participants’ childhoods. The questionnaire was completed by clients’ analysts, who reported more disturbances in the childhoods of their homosexual versus heterosexual analysands. Bieber concluded that homosexuality emerged as a compensatory adaptation for difficulties experienced in the child’s relationships with parents, siblings, and same-sex peers. Studies such as those conducted by Bieber and others were criticized for tapping into primarily clinical populations or settings where we might expect an overrepresentation of individuals with psychological difficulties (Gonsiorek, 1991; Hancock & Greenspan, 2010). This critique, the increased awareness that psychological problems exhibited by homosexual individuals are likely due to prejudice, and the burgeoning realization that the prevalence of psychological problems in a group does not mean that the group itself is pathological (no more than it is pathological to be male or female, black or white, rich or poor) led to a shift toward seeing sexual orientation as a normal variation in human relationships. Notably, contributing to this emerging awareness were the Rorschach findings of Hooker (1958), who demonstrated that homosexual males were as well-adjusted as heterosexual males.

As gay/lesbian/bisexuality came to be regarded within the mental health professions as a type of identity rather than a disease category, the research effort on lesbian, gay men, and bisexual individual (LGB) populations flagged. Multiple factors may be responsible for this neglect, among which are three. First, this avoidance may have been due to the association of research on the possible mental health issues of this population with the pathologizing of diverse sexual orientations (Meyer, 2003). Second, this near neglect may be due, as Stephen Morin noted in his 1977 American Psychologist article, to a heterosexist bias within psychology that is derivative of a broader societal bias. In 1991, Herek, Kimmel, Amaro, and Melton wrote an article summarizing the work of the APA Task Force on Non-Heterosexist Research. Like Morin, they noted that the gay, lesbian, and bisexual individuals continued to be ignored in the research literature, and what existed reflected the broader heterosexist orientation of society. Third, the paucity of research may be due to internalized stigma of heterosexual researchers, who are apprehensive about their own sexual orientations being challenged.

Just as in all other areas associated with mental health, the research on psychological assessment and sexual orientation has been quite minimal. Two types of exploration would be particularly helpful to the advancement of assessors’
ability to provide psychological assessments that do justice to the multiple identities of the client. The first is to learn to what extent the gender/sex identity facets of the client relate to the client’s performance across the methods of the multi-method approach, both in isolation and in interaction. That these identity aspects may influence a client’s performance is suggested by findings in other areas of research that demonstrate interactions between different gender and sexual characteristics. For example, Steffens, Landmann, and Mecklenbräuker (2013) examined the interactive effects of gender with sexual orientation on facial recognition, an important everyday activity. Past research has found that women show more accurate facial recognition of female faces over male faces, whereas for men, no conclusive trend has been detected. However, sexual orientation was shown by these investigators to be a moderating variable, which clarified trends. Whereas heterosexual women, heterosexual men, and lesbians showed more accurate facial recognition of female faces, gay men showed more accurate recognition of male faces. These patterns suggest that different gender variables interact on those psychological tests that engage such processes as perceptual recognition.

Also missing from the literature are strong qualitative investigations looking at how the assessor’s and client’s sexual orientations influence their experience of one another and of the assessment process: For both gender and sexual minorities, we need to know how the assessment is experienced. What aspects promote openness? What activities evoke stereotype threat—the anxiety that the assessment is requiring performance in an area in which the client is expected to be weak or strong? How do the assessor’s characteristics (e.g., whether he or she appears to the client to be heterosexual, gay, lesbian, or bisexual) influence the client? What assessor behaviors enable the client to feel that his or her strengths are recognized? Are certain types of feedback more helpful than others? In conducting such research, the investigator does well to appreciate the tremendous heterogeneity among sexual minorities (Herek et al., 1991). Furthermore, as we discuss in Chapter 2, factors such as race, ethnicity, and socioeconomic status are likely to interact with sexual orientation in shaping a person’s experience within the psychological assessment.

Even though the research on psychological assessment and sexual orientation is quite limited, still, research initiatives are well underway in areas concerning sexual orientation that are relevant to psychological assessment. First, a considerable accrual of findings has occurred in the last decade on prevalence rates of various symptom patterns in individuals of different sexual orientations. This research is summarized in a subsequent subsection of this section. Second, we know some of the factors influencing the emergence of certain symptom patterns, such as the presence of particular types of stigma. Third, protective factors such as spiritual and religious coping (e.g., Mizock & Mueser, 2014) have been identified. Fourth, the developmental stages of sexual orientation awareness, how these stages map onto broader developmental trajectories such as that described by Erikson (1968), and the vicissitudes of well-being in those who are
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nonheterosexual versus heterosexual have been outlined. For example, Becker, Cortina, Tsi, and Eccles (2014) conducted a longitudinal study of individuals who were followed from ages 12 to 18 via five waves of data collection. They found, for example, that depressive symptoms and social alienation declined from ages 16 to 28, and suicidal ideation declined from ages 20 to 28. However, alcohol consumption increased with age. Although nonheterosexual individuals experienced greater depression and suicidal symptoms in adolescence than did heterosexual individuals, the scores converged in early adulthood. Interestingly, self-esteem for the two groups did not differ, although women overall exhibited lower self-esteem than men.

Future research on sexual orientation and psychological assessment is useful only to the extent that adequate methodological rigor characterizes the studies on its status as a moderating or mediating variable. The little past research that has been conducted has been characterized by a set of methodological problems. First, a major problem is the difficulty conducting research with probability samples wherein the sample obtained is representative of the population at large. For example, in a probability sample for a study on depression, members of the gay community would be sampled in correspondence to their proportion in the population, and a cross-section of gay individuals would be assessed for depression. This approach contrasts with a nonprobability sample in which, for example, individuals who frequent gay bars are interviewed. These individuals may or may not represent a cross-section of the gay population. Fortunately, recently, national surveys are soliciting some information in relation to sexual attraction or behavior (IOM, 2011), and secondary analyses can be performed on this data (e.g., see Cochran, Sullivan, & Mays, 2003). However, information on a variety of topics, including that related to sexual and gender identity statuses, is generally unrequested (Mayer et al., 2008). One recent encouraging finding is that when sexual orientation information is requested, respondents are increasingly providing it (Jans et al., 2015).

Second, a problem identified by Cochran (2001) is the use of sexual behaviors as a proxy for sexual orientation. For example, a teen who experiments with sexual relations with other male and female adolescents might be inappropriately characterized as bisexual when, ultimately, a designation of homosexual was more appropriate.

Third, research is biased in the direction of looking at the ends of the continuum of sexual orientation (i.e., wholly heterosexual or homosexual) while missing the many other points in between (Van Lankveld, 2014). Fourth, an unusually large, well-designed group of studies go unpublished. Bartos, Berger, and Hegarty (2014) examined a pool of published and unpublished papers on the topic of sexual prejudice. They found in their corpus of studies an unusually large number of unpublished papers. The unpublished papers were largely dissertations of high quality. The investigators looked at a number of hypotheses to explain this phenomenon, but the one that seemed to fit the data best was the operation of courtesy stigma (Goffman, 1963), the notion that researchers by
association with their topics would be subjected to stigma. Courtesy stigma has been observed in a sample of front-line service providers whose work with gender and sexual minorities led them to be accorded reduced resources to perform their jobs (Phillips, Benoit, Hallgrimsdottir, & Vallance, 2012). The extent to which courtesy stigma limits the flow of research merits further study through a method that would directly tap researchers’ expectations about the social response to their work and their decision-making attached to these expectations (e.g., to submit or withhold a manuscript).

Psychopathology and Diagnostic Issues

In the last 15 years, the attention to LGB status and the diagnosis of mental health conditions has increased greatly, while research on the prevalence of psychological problems in transgender individuals is far more limited (IOM, 2011). Recall that Meyer’s (2003) Minority Stress Model holds that gender and sexual minority groups would show greater psychological difficulties than the broader population, a prediction that has generally been confirmed. Overall, research on LGB individuals has suggested that sexual orientation minority status can be a risk factor for some psychological difficulties such as depression (e.g., Fergusson, Horwood, Ridder, & Beautrais, 2005; Meyer, 2013). According to Meyer’s (2003) meta-analysis, LGB persons are three times as likely as heterosexual persons to warrant a current mood disorder diagnosis. Cochran (2001) reports that LGB individuals have poorer health outcomes than do heterosexual individuals, and Blosnich et al. (2014) found that all sexual minority groups were more likely than their heterosexual counterparts to be smokers. They are also one and a half times as likely to suffer from an anxiety or substance-related disorder (Cochran, Sullivan, & Mays, 2003). Population surveys in the United States and the United Kingdom indicate that they are more likely to be diagnosed with a psychotic disorder than is the heterosexual population (Bolton & Sareen, 2011; Chakraborty, McManus, Brugha, Bebbington, & King, 2011). Although the risk of some types of psychopathology is greater in a population with diverse sexual orientations, research has also found that the majority of individuals with diverse sexual orientations do not meet the criteria for a mental disorder (Cochran, 2001). It would behoove the psychological assessor, who is typically asked to provide a diagnostic formulation, to be aware of the research that has accrued in this area. Recognizing, for example, that sexual and gender minorities are afflicted with particular types of stigma enables the assessor to explore whether stigma is one root of the distress of which the psychological assessment provides evidence.

Studies that have found a greater risk for psychological problems in sexual minority groups bear replication given the rapidity of changes in societal attitudes toward these groups. Certainly, society’s increased acceptance of these forms of diversity has some potential for ameliorating the negative effects of prejudice. Still, societal support for changes in social policy often precedes
change at an individual level. As Herek (2009) explains, members of the public may support particular changes in order to embrace the notion of themselves as tolerant, enlightened, and progressive. However, on an individual level, when faced with personal decision-making, less tolerant attitudes are often in evidence and continue to produce the ill effects of stigmatization.

**Bias in Assessing and Diagnosing**

Clients are always regarded through some perspective. A perspective may be created by (a) the capabilities of an instrument to reveal particular phenomena and not others, (b) the theoretical orientation of the assessor/diagnostician, or even (c) the purpose for which an assessment is done. When a lens employed in an assessment results in privileging one group or another or when it leads to a more accurate view of one group over another with respect to the problem at hand, then the phenomenon is correctly deemed as bias. Bias is a negative phenomenon in its own right, but it can lead to other negative consequences: incorrect case conceptualizations, misdiagnoses, and misguided recommendations. When the manifestation of bias is evident to clients, it lessens the regard they have for the value of psychological assessment.

The types of bias that can enter into a diagnosis and psychological assessment are various. In an important article on this topic, Hartung and Widiger (1998) point out that whereas gender differences occur in most psychiatric diagnoses, differential prevalence rates could be ascribable—at least in part—to various sources of error. They point out two sources of error in particular: biased sampling and biases in the construction of the diagnostic categories. Biased sampling occurs when individuals are disproportionately sampled, a phenomenon that can readily occur in clinical settings wherein different subgroups have different levels of willingness to seek treatment, divulge difficulties, or both. Hartung and Widiger give the example that men are far more likely than women to present for treatment for gambling problems. In contrast, epidemiological findings from community samples report no difference between men and women. One factor may be the possibly greater stigma attached to gambling for women than for men. For other disorders, sampling bias may take the form of women being overrepresented. For example, women may tolerate the acknowledgment of depression more than men, a difference that may contribute to the greater number of depressed women in clinical settings than depressed men. This self-presentation interpretation is consistent with a body of developmental research showing consistent differences in the parenting and education of boys versus girls, wherein boys are discouraged from manifesting reactions that are at odds with the presentation of self-sufficiency (Clearfield & Nelson, 2006; Dukmak, 2010; Martin, 1998).

The second type of gender bias concerns the diagnostic criteria themselves (Hartung & Widiger, 1998). Greater access to one gender may lead to the establishment of diagnostic criteria based upon how that gender manifests a form of
Gender and Cognitive Assessment

disturbance. If women, for example, are studied disproportionately to men, then
diagnostic criteria may be established based upon how women behave, think,
and feel when depressed. If diagnostic criteria are keyed to how women expe-
rience depression, then they may be insensitive to men’s depression, resulting in
men being underdiagnosed for this condition.

These same factors can operate in the assessment process as well. Instruments
can be based disproportionately on male and female samples. For example,
Baker and Mason (2010) point out that the Psychopathy Checklist—Revised
(PCL-R; Hare, 2003) was originally developed through testing male prisoners
who were judged to be psychopathic. Subsequent work has been needed to
establish its diagnostic accuracy with women. Such research, particularly on dif-
ferent age groups such as adolescents (e.g., Kosson et al.’s study on the adolescent
version, 2013), is ongoing.

The types of biases thus far described are those that concern the diagnos-
tic systems and assessment tools themselves. However, other forms of bias can
emerge within a client’s assessment process. For example, a particular client may
fail to express his or her capabilities because of the influence of a social stereo-
type on how that client perceives a given task. One of the authors introduced
the Arithmetic subtest to an adolescent girl. In contrast to her rather neutral
reaction to the other tasks, she immediately exclaimed, “I can’t do this kind of
thing!” Indeed, she went on to perform relatively poorly on this subtest. One
factor that may have influenced her performance was stereotype threat—a sense
that this kind of activity is not one in which members of her gender typically
excel (APA, 2007). Such a contributor could be identified through the assessor’s
sensitivity to its possible presence and discussion with the clients of its possible
effects. Other test data might also provide corroboration for its presence. Other
biases may come from the assessor him and herself, and these will be described
in the subsequent section.

Sexual orientation and gender identity are areas of the self not immune to
the kinds of biases previously outlined in relation to gender. Are these individ-
uals included in adequate numbers in standardization samples? Stigma factors
may lead to their underrepresentation in large-scale data collection projects
and in particular clinical settings. Although we know about comparative inci-
dence of various types of disorders based on gender (even if the interpretation is
ambiguous), this information is far less available for sexual orientation and gen-
der. Psychological instruments, too, have been standardized primarily on heter-
osexual and cisgendered populations. Future research that provides evidence of
whether sexual and gender minorities perform differently than cisgendered and
heterosexual individuals would be extremely useful.

An example of the type of study that is needed is Birnholz and Young’s
(2012) investigation of the Center for Epidemiological Studies Depression Scale
(CES-D; Radloff, 1977), a 20-item self-report instrument with robust psycho-
mometric properties. The instrument was administered online to 273 women—
45% heterosexual, 29% bisexual, and 25% lesbian. The investigators were able to
demonstrate minimal bias in the instrument, with the exception of a single item, “Feeling that others dislike you.” This item figured in the severity of depression more heavily for bisexual than for lesbian women. The authors saw their results as supporting the usefulness of this instrument for women who are sexual minorities, but they cautioned that researchers and clinicians should remain alert to subtle differences in the importance of particular items for assessing severity of depression.

Stages of the Psychological Assessment

Research on the nexus of gender and sexual identity and psychological assessment is still limited. Despite the absence of a robust research base in this area, assessors are called upon to render helpful services to clients regardless of their identity status in these core areas. In this section, we examine the stages of a psychological assessment and consider how issues of gender and sex—both as presented and experienced by the assessor and the client—may shape the process. We consider nine stages: meeting the client, conducting the interview, framing the problem, choosing the test instruments, administering the tasks, coding, interpretation and integration, developing recommendations, and feedback (see Table 1.2).

Meeting the Client

Whether the first contact between the assessor and client is on the telephone or in person, that assessor conveys information to the client that will give the client some basis of determining what level of trust should be placed in the assessor. To the extent that the assessor evinces respectfulness of the client’s person, the client will feel able to be open with the assessor and thereby provide the assessor with the information he or she needs to understand the client. One way in which the assessor demonstrates respectfulness is refraining from making assumptions about the client’s status on any identity variable until the client has shared that information with the assessor. The assessor should embrace and convey an agnostic attitude, even if third parties have shared with the assessor defining information about the client.

For example, suppose the client’s therapist has told the assessor that the client is having marital conflict with her husband. Although this communication may lead the assessor to believe that the client is heterosexual, such an inference may prove to be wrong. The client may be homosexual, bisexual, primarily heterosexual, or asexual. If the assessor communicates a classification to the client without the latter having an opportunity to categorize herself, that assessor may foreclose on the opportunity to learn something important about the client. The assessor may also damage the rapport to an extent that makes the assessment a mere exercise. Once that client does self-identify, it is crucial that the assessor use the appropriate pronoun to refer to that person. For example, even
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<td>Meeting the client</td>
<td>• Manifesting excessive anxiety in meeting the client because of an unfamiliarity with the client’s identity status.</td>
<td>• Providing an atmosphere in which the client is able to identify him or herself on important identity dimensions.</td>
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<td>• Making cisgendered or heterosexist assumptions about the client’s status on an identity dimension.</td>
<td>• Relating to the client in a relaxed but respectful manner.</td>
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<td>• Addressing the person in accordance with his or her gender identity.</td>
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<td>• Assuming that when the client says he/she lacks sexual attraction to anyone, that the client simply has not figured out what his or her sexual orientation is.</td>
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<td>• Providing an atmosphere in which the client is able to identify him or herself on important identity dimensions.</td>
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<td>• Relating to the client in a relaxed but respectful manner.</td>
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<tr>
<td>Conducting the interview</td>
<td>• Giving evidence of misunderstanding of the client’s lifestyle.</td>
<td>• Recognizing gaps in knowledge and attempting to rectify them.</td>
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<td>• Failing to ask critical questions out of lack of knowledge about an area of diversity.</td>
<td>• Being sufficiently informed about different areas of diversity to appreciate what core areas must be covered.</td>
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<td>• Unknowingly committing microaggressions such as conveying judgment about the client’s lifestyle.</td>
<td>• Recognizing that no relationship is immune to microaggressions, engage in self-monitoring and client observation to detect them, and acknowledging them when they occur.</td>
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<td>• Claiming to be an expert about the client’s identity status.</td>
<td>• Obtaining consultation and supervision for parts of a case that may be unfamiliar to the assessor.</td>
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<td>• Upon discovering elements in the case (including those related to gender and sexuality) that are beyond the assessor’s knowledge or skill set, failing to remedy this problem.</td>
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<td>• Knowing that all parties (including third parties) can allow bias to color observations.</td>
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<td>• Using a multi-method approach.</td>
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<td>• Selecting instruments with little or no bias.</td>
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<td>• Including instruments that have gender or heterosexist bias.</td>
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<td>• Failing to use narrowband instruments that would enable the assessor to obtain highly specific information pertaining to gender and sexual identity issues.</td>
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<tr>
<td>Administering the tasks</td>
<td>• Exhibiting behavior characterized by aloofness and lack of warmth.</td>
<td>• Throughout administering the tasks, conveying warmth and relatedness.</td>
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<td>• Administering items with wording that is cisgendered and heterosexist.</td>
<td>• Acknowledging when the wording of particular items for instruments used may make inappropriate assumptions about gender or sex.</td>
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<td>• Refusing to attend to subtleties in the client’s reactions as tasks are being administered or to explore their significance.</td>
<td>• Keying into the client’s reactions to the various stimuli of the tasks.</td>
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<tr>
<td>Coding</td>
<td>• Failing to recognize how one’s presuppositions may influence the nuances of coding.</td>
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<td>• Failing to understand the identity subculture’s idioms and thereby making scoring mistakes.</td>
<td>• Striving to learn about the client’s culture, including the idioms that may be part of the test material.</td>
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<tr>
<td>Interpretation and integration of data</td>
<td>• Negotiating to consider how the client’s test-taking set based upon experiences with stigma shaped the kinds of responses the client produced.</td>
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<td>• Contextualizing the test data in terms of the client’s test-taking set.</td>
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<td>• Being aware of assessor biases when examining the test data.</td>
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<td>• Failing to give adequate acknowledgment to the real stressors in the client’s life and placing excessive weight upon the client’s defensiveness.</td>
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<td>• Giving adequate weight to the contribution of stigma in understanding the client’s difficulties.</td>
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<td>• Allowing the client’s diversity status to overshadow the data.</td>
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<tr>
<td>Developing recommendations</td>
<td>• Failing to collaborate with the client in identifying coping strategies for responding to enacted stigma specific to the client’s identity.</td>
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<td>• Educating him or herself on the kinds of coping strategies that have been found to be effective with specific types of stigma when working with marginalized groups.</td>
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<td>• Ignoring the support structures in the client’s communities.</td>
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<td>• Learning about the client’s community and what resources are available to him or her.</td>
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<td>• Failing to provide recommendations that take into account the realities of the client’s situation.</td>
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<td>• Developing a realistic rather than idealistic set of recommendations.</td>
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<tr>
<td>Providing feedback</td>
<td>• Reactivating power differentials that the client experiences outside of the assessment inside by taking an authoritative role in the feedback session.</td>
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<td>• Creating a feedback session that is wholly collaborative, continually tapping the client’s expertise about him or herself, including the client’s identity status.</td>
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though the client may appear to the assessor to be female, if that client identifies as male, masculine pronouns are appropriate (APA, 2002).

Conducting the Interview

The interview is important in that through the assessor’s communication of interest in and empathy for the client during the interview, the assessor forges a therapeutic alliance with the client that bolsters the client’s motivation to participate collaboratively and openly. The interview is important, too, for the opportunity it provides the assessor to obtain essential information about the client, including information related to the client’s identity in the domains of gender and sexuality. In order for the potential of the interview to be realized and the assessment as a whole to be successfully launched, the assessor must exhibit an affirmative stance toward all aspects of the client’s identity, including sexual orientation and gender identity (Bieschke, Perez, & DeBord, 2007; Chazin & Klugman, 2014). Such affirmation is conveyed by an unconditionally accepting attitude and a sense of ease and confidence in engaging in the interview and in pursuing all steps of the assessment process.

Particularly with gender and sexual minority clients, the assessor may encounter obstacles to realizing the potential of the interview. The forms the client completes may convey bias (Hwang & Danoff-Burg, 2010) or the assessor may make heterosexist assumptions. A second obstacle is the conveyance of major misunderstandings about the lifestyle of the gender- or sexual-variant client. For example, the assessor might assume that because the lesbian client is not married, she is not in a relationship with a degree of commitment commensurate with a marital bond. In the face of such errors, the client understandably wonders how the assessor could achieve an accurate picture of his or her life given that the assessor is unknowing about fundamental aspects of her core identities.

A third obstacle is conveyed by the following example:

Martin came to an assessment to gain insight into his constant sense of malaise. The student assessor, Ralph, found that he had an introjective depression characterized by constant self-fault-finding. Martin had mentioned that he was gay during the clinical interview. Although the assessor briefly asked about his family’s reactions to Martin’s coming-out process, the assessor did not inquire how Martin felt about coming out. The assessor also failed to open a line of inquiry that might have revealed internalized homophobia on Martin’s part. When Ralph’s supervisor asked Ralph about this gap, he revealed his own discomfort about pursuing this discussion and pointed out that nothing in his doctoral training had prepared him to have it.

The truth is unfortunate: Although the majority of clinical and counseling programs today provide students with training on LGB issues (Sherry,
Whilde, & Patton, 2005), many midcareer and senior assessors who are in practice today have received little by way of supervision or graduate training that has assisted them in providing effective assessment services to individuals who represent diversities of various sorts, including gender and sexual diversity. In fact, Ralph was fortunate in having a supervisor who had an attunement to Ralph’s discomfort so that it could be explored and, hopefully, not be an obstacle in subsequent assessments.

Some assessors may respond in a very different way from Ralph. An assessor might express disproportionate interest in any facet that establishes the client as a minority because it is intriguing or entertaining to the assessor. A variation on this problem is when the assessor assumes that whatever difficulty the client has must in some way be connected to his or her sexual orientation or gender identity (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991).

Still another obstacle is the conveyance of judgment about the client’s lifestyle:

During the clinical interview, an assessor asked about aspects of the client’s social life. She established that the client, a gay man, was unhappy that his intimate relationships lacked longevity. In summarizing the client’s longings, the assessor implied that what the client wanted was a monogamous long-term relationship. In fact, the client never talked about a wish for monogamy. The therapist’s addition of this element communicated to the client that, in her view, an expectation of monogamy was normal and that he was wrong to want something else.

Within assessment, the power differential between assessor and client typically makes it extremely difficult for the latter to acknowledge a microaggression. However, what the client can do, consciously or unconsciously, is adopt a stance of self-protectiveness that makes accomplishing whatever goals have been established for the assessment well nigh impossible. Even the best-intended assessor may not avoid the commitment of microaggressions. For many clients, the effects lie not in the commission as much as the handling of the breach. Assessors who recognize the limits of their awareness of others and their own capacities to make mistakes are on the lookout for changes in the client’s behavior that may bespeak of an assessor microaggression.

In the interview, the assessor may learn of certain aspects of the client’s identities that were not evident in the initial contact. These aspects may be ones with which the assessor has little familiarity. For example, the assessor may learn that the client is a trans person, although this fact was not shared at the time of the initial telephone conversation. At this juncture, the assessor is confronted with the ethical quandary of whether to proceed with the case. Assessors have an ethical obligation to recognize the bounds of their competence (APA, 2002). One important step would be securing a consultation from another psychological
assessor who has the knowledge base to guide the assessor through the new territory. If the assessor ascertains that he or she is not equipped to move forward with the case, then an obligation remains to assist the client in obtaining effective services. On the other hand, if the assessor upon consultation and reflection believes that moving forward is feasible, then obtaining supervision on areas of unfamiliarity will help the assessor to provide the best possible services to the client.

**Framing the Problem**

The pioneers in collaborative and Therapeutic Assessment (Finn, 2007; Fischer, 1994) have helped the assessment community to recognize that although the referral source and the assessor can play important roles in defining the problem, the client—in most contexts—must have a crucial say in identifying those questions that the assessment is designed to answer. Individuals who have experienced stigma or a lack of power in relationships at the outset of the assessment process may be reluctant to enter into an assessment alliance. Internalized stigma (Herek, 2009) may allow the assessor to accept unwittingly the client’s hesitancy to participate actively in framing the purpose of the assessment, a hesitancy that can then pervade the entire assessment process. In fact, many clients begin an assessment with only a vague sense of what the assessment can accomplish. It often requires considerable effort on the part of the assessor to engage the client in a genuine collaboration (Fischer, 1994). That effort can vary based upon the assessor’s unconscious assumptions about societally based power dynamics.

**Static Versus Dynamic Questions**

Regarding the client’s questions as dynamic is helpful. As Fischer notes,

clarification of the referral is not... a once-and-for-all accomplishment. Upon meeting a stranger (the assessor), the client is not yet sure how much and in what ways to share. Moreover, early sharing typically is in the form of what the client knows explicitly. As a relationship develops, the client becomes aware of additional or deeper concerns. (1994, p. 67)

The identity aspects of gender and sex can be ones that the client is willing to broach only after having achieved some familiarity with, and trust in, the assessor. The assessor, then, must have openness to revising his or her understanding of what the client may wish to garner from the assessment:

An assessor encountered a teenage girl who came to the assessment ostensibly to discover why she was feeling anxious. Over the course of the assessment, her trust in the assessor grew such that eventually she could reveal to her that she was a lesbian. However, she revealed
that only her parents and a few other adults knew this fact. It emerged that she was contemplating coming out of the closet to her friends but wondered if she would fall apart if some of her friends responded unfavorably. This worry was connected to the anxiety that originally brought her to the assessment. However, the revelation somewhat refocused the work on helping the client recognize her own resources, the circumstances that might make it difficult to tap into them, and the possible coping strategies she could summon to enable her to gain access to those resources.

**Third-Party Referrals**

Third-party referral sources typically have their own questions that serve as the basis for the referral. The position of the assessor can be a delicate one in how the third-party referral source’s perspective is incorporated into the planning of the assessment. In some cases, the third party may define the question in a way that draws upon stereotypic notions about men and women, sexual orientations, and gender identity:

An employer referred a female employee for a psychological assessment. He indicated that she was a member of a research team and always seemed to strive for control. She interrupted her co-workers when they were speaking and often failed to incorporate their ideas into her thinking. The employer asked whether psychotherapy could help her to enter fully in the give-and-take of work relationships. When the employee was interviewed, she noted that the other researchers were men. She believed that she was given less latitude in her responses and that what would be seen as appropriate from her male colleagues was viewed as undue aggressiveness from her. For her part, she wanted to know how she could be a vital and active member of the team and true to herself, without alienating others.

Were the assessor to embrace the perspective of the assessee or the employer to the exclusion of the other party, the assessment may not fulfill its potential for elucidating a conflictual situation. Assessors should be cognizant of the possibility of bias. However, they should not assume it in the absence of evidence.

**Choosing the Instruments**

The assessor who seeks to be responsive to clients’ multiple identities must pose to her or himself a number of questions when approaching the task of selecting assessment methods. The first question is how the examiner can select instruments in a way that best satisfies the gold standard of psychological assessment, the multi-method approach, in a way that best serves the needs of clients who
are diverse in gender and sexuality. The multi-method approach is the gold standard of psychological assessment because it recognizes that the information culled from any one method is inherently limited (Campbell & Fiske, 1959; Mihura & Graceffo, 2014). Among the tools that assessors use to characterize personality are introspective methods in which the client offers self-descriptive comments as in the clinical interview or endorses descriptive statements as in self-report tests such as the Personality Assessment Inventory (PAI) or Millon Clinical Multiaxial Inventory (MCMI). To the extent that the client has apprehension, self-consciousness, or shame about revealing aspects of gender identity or sexuality, to that same extent the client may invest energy in erecting walls against self-disclosure. Performance tasks such as the Rorschach Inkblot Method (Rorschach, 1921/1942) or narrative methods, both of which contain structural and metaphorical information, are not invulnerable but are less vulnerable to the client’s self-presentational efforts. It is precisely in bringing together the data yielded from these different methods that the power of the multi-method approach is seen for individuals whose gender, gender identity, and sexual orientation issues are part of what is important to address in a psychological assessment. The contrasts among the pictures provided by different measures reveal to the clinician the tensions within a person related to gender and sexuality and the conflicts the person perceives between his or her own inclinations and the dictates of the social world.

The assessor, too, should select instruments that are free of gender or heterosexist bias. Bias may occur in the set of assumptions underlying test construction. For example, is the instrument predicated on the notion that gender-stereotyped attitudes, interests, and behaviors are what constitute mental health? From a philosophy on health and psychopathology emanate more specific decisions about how items are worded, norms developed, and data interpreted.

An assessor who is attuned to gender-related aspects of the client’s identity will be able to employ data emerging from the assessment to recognize what additional instruments might be introduced to complete the picture of the client. Today, a variety of narrowband instruments provide a close look at various aspects of gender and sexuality. In some cases, the assessor may realize at the outset their germaneness to the case, but in many others, the awareness of the need for further exploration may unfold over time (Bram & Peebles, 2014). For example, an assessor may begin to suspect that a given client’s distress is related to the maintenance of a posture of secrecy with family members about his sexual orientation. An instrument such as the Outness Inventory (Mohr & Fassinger, 2000) can be added to the battery to help the assessor conceptualize the client’s status on degree of outness. As will be discussed in Chapter 2, individuals who have two or more minority statuses, one of which may concern sexual orientation or gender identity, are at risk for exceedingly high levels of stress. Instruments such as the recently developed LGBT People of Color Microaggressions Scale (Balsam, Molina, Beadnell, Simoni, & Walters, 2011) provide the assessor
with an appraisal of that stress specifically associated with racial/sexual/gender statuses. Although a plethora of gender-related instruments have been developed, the assessor must be careful: Many instruments have been insufficiently studied, and their psychometric characteristics are largely unknown (Smiler & Epstein, 2010).

**Administering the Tasks**

No matter how prescribed the administration of a psychological test is, it is vulnerable to the attitudes and sets of the test-taker and test-giver. Groth-Marnat (2009) cites studies showing the power of the assessor’s emotional stance: Whereas the assessor’s evident friendliness and warmth can lead to an increase in IQ scores in children, signs of disapproval can lead to lower levels of performance. Individuals who have been subject to minority stress are likely to be highly attuned to the assessor’s attitude toward him or her. The instruments the assessor uses are an extension of the assessor. Individuals with gender-variant identities may or may not be inured to the difficulty posed in everyday life when asked to declare themselves male or female. Yet, when asked to do so within a context of a psychological assessment—a task in which they are assured that the assessor’s aim is to understood who they are—the gender-binary format may be especially unnerving. So, too, might items in which the client is asked about reactions to “the opposite sex” beget perplexity, annoyance, or some other negatively tinged affect.

**Coding**

The assessor’s accurate scoring of a protocol can be affected by the client’s gender and sexual status in a number of ways. Potentially affecting the assessor are his or her own attitudes and beliefs toward the category of which a client is a member and awareness of the experiences of the client based upon knowledge of cultural factors related to the client’s status. An assessor may have particular beliefs, for instance, about the relative strengths of men and women. In scoring a part of a protocol that represents a particular area of strength in a given gender, when the client is of that gender, the assessor may practice leniency, and in the area of assumed weakness, stringency. In this way, the assessor confirms his or her preexisting beliefs to the detriment of the client.

Individuals who are sexual and gender minorities often find protection from the ill effects of social stigma by immersing themselves in communities that share the stigmatized facet of identity. Such communities develop cultures with their own idioms. For example, while taking the Rorschach Inkblot Test, a lesbian identifies a percept as a “Lavender family.” In coding, the assessor fails to realize that this term refers to an LGB concept rather than the actual color of the blot. The examiner codes the response incorrectly based on the lack of knowledge of relevant terms and idioms.
Interpretation and Integration of Data

Always falling on the assessor is the task of integrating the data by discovering common findings across instruments and reconciling apparent inconsistencies and contradictions. Sensitivity to gender and sexual diversity demands that the assessor be thoughtful about how the client’s attitude toward self-revelation based on his or her identity may differentially affect how the client responds to various types of tasks.

A client who is known to the assessor to be a lesbian participates in a psychological assessment to help a therapist establish treatment goals. On the Psychological Assessment Inventory (PAI, Morey, 2003), the client demonstrates a minimum of distress. On the Thematic Apperception Test (TAT, Murray, 1943), the stories the client produces have a consistent negative tone. On the Rorschach, the client produces a large number of Morbid responses, Color-Shading Blends, and Vista responses. In considering the obvious disparity between the MMPI and Rorschach/TAT findings, the assessor recognized that as a more face valid instrument, the client could mount a successful effort to deny difficulties on the MMPI. At the same time, it seemed odd to the assessor that the client would deny difficulties at the time she is seeking the assistance of a therapist.

What might assist this assessor is the realization that an individual’s responses to cumulative stigma (Herek, 2009) can become engrained. This client might have made a very genuine effort to be true to her own self-construal. Yet, a sense of vulnerability based upon past negative experiences may compel her unwittingly to take on a defensive posture so as to prevent enacted stigma on the part of the assessor. If this interpretation were supported by other data, it could be very useful to the therapist who may be struggling with the same issue as the assessor: Why is this individual not sufficiently forthcoming about her difficulties to enable us to establish goals for treatment?

Developing Recommendations

If an assessor has demonstrated acceptance of the client’s identity throughout the assessment, then he or she is favorably positioned to formulate, in collaboration with the client, recommendations that will be helpful. Psychological assessments are often conducted to advise the therapist, determine the potential usefulness of treatment, establish goals for treatment and intervention strategies through which these goals might be pursued, or some combination of these. A helpful consideration with gender and sexual minorities is how the client’s experiences with stigma are likely to influence his or her willingness to enter therapy and establish a therapeutic alliance with the therapist. Certainly, the
client’s capacity to do so with the assessor serves as a trial run for a client not yet in treatment. For example, the client who worried that the assessor was going to judge some aspect of her identity may well have that same apprehension about a new therapist. Still, even when the assessment process has proceeded smoothly, the client may see particular dangers in the therapeutic relationship that are not as salient in the assessment relationship. To the extent that the assessor can help the therapist to form a reasonable anticipation of what might be the challenges in the therapist’s building a relationship of trust and the reasons for these challenges, that assessor will be catalyzing the work between therapist and client.

In some cases, the assessor’s task may be to recognize when systems-level interventions are needed. Consider the following situation:

A gay man, Sam, was referred for testing by his workplace because he had had what appeared to his employer as an atypical number of absences. His employer wondered if some psychological difficulty prevented his uninterrupted presence at work. In the clinical interview, it came to light that this individual had significant childcare responsibilities. Although Sam and his husband alternated time off, the health issues of one child necessitated frequent absences. Sam described that his conversations with female co-workers had led to the conclusion that he was being treated differently. Female employees had taken off as much time as he did without reprisal. The assessor failed to find any issues that illuminated the pattern of absences except that the individual possesses a degree of empathy and responsibility taking that would prevent him from not wanting to fulfill his parental obligations.

In some cases, assessments may expose enacted stigma (Herek, 2009), which constitutes actions that directly or indirectly undermine the well-being of the individual stigmatized for being a minority (in this case, for being a man). Sam was being subjected to workplace mistreatment (Magley, Gallus, & Bunk, 2010) in that his need to fulfill his parental obligations was denied based on identity facets. In this circumstance, rather than a treatment recommendation being in order, what was needed was education of the employer. In doing so, the assessor would be acting in accordance with the principle of justice, embraced by the Ethical Code of the American Psychological Association ([APA], 2010), calling for psychologists’ efforts to ensure that all individuals are treated equally and fairly.

Finally, the recommendations made by the assessor must take into account the realities of the client’s situations. According to a 2011 report of the Institute of Medicine (IOM), LGBT individuals commonly lack health insurance. For example, Ponce, Cochran, Pizer, and Mays (2010) found that “partnered gay men were less than half as likely (42 percent) as married heterosexual men to receive employer-sponsored dependent coverage, and partnered lesbians were 28 percent less likely to receive such coverage than married women” (p. 66). An
assessor making a recommendation for therapy must consider what resources
the client can realistically access (Wagoner, 2014).

Providing Feedback

For individuals who may have repeatedly encountered being placed in a lesser
position vis-à-vis others, the circumstance of traditional assessment is chal-
linging. Within a traditional assessment, the assessor accumulates a great deal
of data, develops a picture of a client, and then presents that feedback in the
context of one or two feedback sessions (Fischer, 1994). In this model, the
assessor holds the power by holding knowledge. The client can easily and rea-
sonably experience this arrangement as a recapitulation of past experiences
of disempowerment. By embracing a collaborative approach to the feedback
process, the assessor stands to avert this possibility and to garner client reac-
tions to emerging hypotheses, reactions that may contribute to the hypotheses’
refinement.

Although a psychological assessment may identify personality features that
predispose an individual to develop symptom patterns, individuals who are sex-
ual minorities also suffer from the ill effects of stigma (Meyer, 2003). Feedback
sessions that address the role of stigma and how the client can fortify him or
herself in coping with it are likely to be more beneficial than those that ignore
its effects. One means by which members of a minority group fortify themselves
is through affiliation with other similarly situated individuals. Sam from our
earlier example may benefit from participation in a parenting group for same-
sex partners, particularly if that group contains individuals who struggle with
balancing home and work responsibilities. The assessor can augment his or her
usefulness by having an awareness of the diverse resources for, and approaches
(e.g., see Pachankis, 2014) to, assisting individuals who have dealt with or are
currently coping with the presence of stigma in their lives.

Practical Points

• The assessor should be attuned to the multifaceted aspects of the client’s
gender and sexual identity and consider how they figure into the client’s
experience of self and other.
• By having an awareness of how gender and sexual biases may enter into
various stages of a psychological assessment, the assessor may identify ways
to mitigate them.
• The assessor should consider the ways in which stigma may influence the
client’s response to the assessment situation.
• In understanding the client, the assessor should look at the interactions
between personality characteristics, intellectual strengths, environmental
stressors (particularly those related to stigma), and environmental supports
to explain psychological difficulties and ways to ameliorate them.
Gender and Cognitive Assessment

Annotated Bibliography


Comment: These guidelines are extremely helpful. They provide a set of useful definitions and also include an extensive list of references.


Comment: These volumes contain not only recent research on gender roles in general but also material relating to psychological assessment specifically. It gives ample attention to the methodological and statistical issues that are present in gender research, and thereby provides useful guidance for new researchers in this area.

Notes

1 This same document acknowledges that not all individuals who vary in the respects described will identify with the term transgender as applied to them. Terminology in this area of identity is in flux, and many views on appropriate terms exist.

2 Cross-dressers were formally labeled transvestites, a term no longer in use due to its connotation of pathology.

3 Whether the Mf scale was originally designed for this purpose is not entirely clear, as Friedman, Lewak, Nichols, and Webb 2001 note. They point out that whereas Dahlstrom, Welsh, and Dahlstrom (1972) saw the scale as designed to “identify the personality features related to the disorder of male sexual inversion” (p. 201), Colligan, Osborne, Swensen, and Offord (1983) saw it as capturing tendencies toward masculinity and femininity.

4 Wong et al. do not describe their sample as “gay” because in their recruitment they asked if clients were gay or bisexual and/or had sex with other men. Consequently, the participants could have been somewhat heterogeneous in terms of sexual orientation.

5 The term homosexuality was used during this time but more recently has fallen into disuse because of the newer connotations attached to it.

References


Gender and Cognitive Assessment


Gender and Cognitive Assessment


Comprehensive psychological assessments conducted competently and sensitively, we argued in the last chapter, must take into account the various facets of gender and sexuality of the client, as well as the assessor. Yet, an individual’s identity consists of far more than gender, sexuality, and all that they encompass. An array of other facets has a significant role in the identity an individual constructs, and these facets must figure into how the assessor understands the client. Facets beyond gender and sexuality are not the primary focus of this book and are explored in greater depth elsewhere (e.g., Smith & Krishnamurthy, in press). Nevertheless, they have particular relevance for the subject matter at hand in that they provide a context for viewing a client’s gender and sexuality. For example, the experience of being a gay man may be very different if that man is living in Uganda versus Connecticut. The opportunities for a trans person to acquire the skills to cope with stigma may vary depending upon whether the individual resides in the upper versus lower socioeconomic strata, in an urban or rural environment. Knowledge about one identity facet in the absence of awareness of others that may have a moderating effect can lead to mischaracterizations of a person. Therefore, in trying to achieve a full grasp of the client’s experiences, the assessor must attend to the ways one identity influences how another identity is expressed—both for him or herself and the client.

Addressing Framework

For every human being, the potential identities are great and can coexist together. No particular system can capture them all because they are simply too numerous, and some identities are idiosyncratic. Still, a small group of identity factors such as race and ethnicity have been shown to figure prominently in the self-perceptions of many people and have proven through research to shape
experiences and behaviors. Pamela Hays has captured these variables in her ADDRESSING framework. ADDRESSING is an acronym with each letter standing for an identity that has been shown to be influential in a person’s construction of self (Hays, 2008). Within this framework, “A” stands for Age and generational influences, “DD” for Developmental or acquired Disabilities, “R” for Religion and spiritual orientation, “E” for Ethnicity, “S” for Socioeconomic status, “S” for Sexual Orientation, “I” for Indigenous heritage, “N” for National origin, and “G” for Gender. We have discussed how the gender and sexual orientation of the assessor and client can affect the assessment in important ways. However, the ways in which gender and sex operate to shape a person’s experience and behavior can be influenced by all of the other identity aspects in the ADDRESSING framework.

At present, we know little about normative difference on psychological test variables that are the result of interactions between gender, sexual orientation, and other major identity facets. One very practical problem in investigating potential differences among subpopulations is obtaining a sufficient number of participants within each combination of variables. Still, psychological tests and other assessment tools have been used to see if particular groups representing the intersection of identity variables possess special vulnerability for psychological problems. These preliminary investigations have generally suggested that psychological issues connected to gender and sexual orientation identities are moderated by other identities, many of which appear in the ADDRESSING framework. In the section that follows, the identity facets in this framework are reviewed. Research is highlighted that shows how a full understanding of the psychological phenomena associated with gender and sexuality requires a consideration of these additional facets. All of the facets are discussed in the following sections, but Sexual Orientation and Gender will not be discussed separately because we addressed those topics in Chapter 1. Rather, they will be explored in relation to the other facets.

We suggest that assessors contemplate each of these identities within the ADDRESSING framework by themselves and then in interaction with one another. Doing so—we believe—will allow new understandings to emerge not only of the client but also of the assessor’s personal and professional selves. Assessors should also realize that no one system of identities is comprehensive. For example, the ADDRESSING framework does not capture whether a person is a civilian or a military personnel, and this factor may be of great importance. Good practice requires sensitivity to any identity facet that may be of significance to the client.

Age and Generational Influences

Age and generational identities are especially important when thinking about gender and sexual orientation because of the sweeping societal changes that have occurred with respect to how both gender and sexual orientation are regarded.
For example, a woman born prior to the Baby Boom saw during her lifetime the increasing empowerment of women in society and the greater reliance on women for income generation for their families. In the last decades of life, these changes can influence in a host of ways the meaning both men and women find in their lives, meaning that could be linked to psychological health or illness. For example, an older woman may regret that she did not have the advantage of greater opportunities to realize her talents. An older man may wish that he were less confined to the role of income provider and more fully able to participate in childcare, as he sees men in later generations doing. Similarly, an elderly gay man who was preceded in death by his partner may rue his now-permanent inability to establish a legal marriage with that partner, something enjoyed by younger gay men. These regrets can interfere with the client’s capacity to see value in his or her life. Despite their power, these unwanted elements may not be ones that clients can readily share with the assessor—indeed, the client may have erected strong defenses against having a full conscious experience of regret and its sources. However, by knowing key events and movements over a person’s lifetime, the assessor may be aware of glimmerings of warded-off experiences. Hays (2008) suggests making a timeline of the crucial sociopolitical events in the individual’s life and the individual’s age and developmental makers, thereby enabling the assessor to see possible contextual influences on the client’s personal history.

**The Role of Gender**

An illustration of the importance of age as an identity facet that moderates gender differences is seen in research on gender and depression. During adulthood, women are diagnosed with depression more frequently than men by a 2:1 ratio. Nolen-Hoeksema (2001) pointed out that this difference begins to manifest itself in adolescence when what is considered acceptable behavior is specified more stringently for girls than for boys. She notes that girls report lower parental expectations and greater parental control over their behaviors than do boys. Aware of this connection between depressive symptoms and parental behavior, the assessor could be sensitive to family conditions that may aggravate a sense of disempowerment on the part of adolescent girls.

At the other end of the age spectrum, interesting gender phenomena also appear. Some evidence suggests that the gap between men and women lessens past the age of 60 (e.g., Barefoot, Mortensen, Helms, Avlund, & Schroll, 2001), but this trend is reported insignificantly (e.g., Sonnenberg, Beekman, Deeg, & van Tilburg, 2000). Beekman, Kriersman, Deeg, and van Tilburg (1995) found that elderly men’s level of depression was affected by physical health, but women’s was not until both groups reached 75 years. Beyond that marker, depression and physical health were associated for both men and women. Related to depression is suicidality, and here, a clear gender gap exists: Men have higher rates of suicide than women, and, in fact, the difference increases with age (McIntosh,
Santos, Hubbard, & Overholser, 1994). Yet, as Gatz and Fiske (2003) point out, whereas elderly men make more direct suicide attempts, elderly women, when depressed, exhibit a tendency to make indirect attempts. For example, they may neglect their medical regimes in serious ways or refuse water or food. Gatz and Fiske cite Osgood, Brant, and Lipman’s (1991) study showing a high level of indirect suicidal behavior in depressed women residing in nursing home settings. The assessor who is aware of the potential for elderly women to engage in indirect suicidal behaviors could broaden his or her interviewing not only of the client but also of informants to garner information relevant to such hidden efforts. These studies provide mere examples of the necessity of the assessor attending to interactions between gender and age as determinants of health and psychological difficulties.

**Sexual and Gender Minorities**

The experiences of individuals with diverse sexual orientations must also be seen through the lens of age and generation. As Parks, Hughes, and Matthews (2004) point out, much of the identity research has been done with older white gay men. Yet, even a superficial historical survey reveals that older, middle-aged, and younger gay and lesbian individuals experienced a very different sociocultural context. For example, in many cases, the earlier lives of elderly gay individuals were characterized by many experiences of discrimination. Internalization of others’ negative stance has led elderly individuals to form a negative evaluation of the self to which is attached shame and guilt (Morrow, 2001). Upon being faced with the prospect of a psychological assessment, the elderly gay client may be beset by dread at the possible surfacing of those feelings.

The elderly gay client may also be affected by the perspective of the mental health community, reflected in the original *Diagnostic and Statistical Manual* ([DSM], American Psychiatric Association, 1952), that homosexuality is a form of psychopathology, requiring treatment (Institute of Medicine [IOM], 2011). Although attitudes toward gay men and lesbians have drastically changed within the healthcare community, the recollection of stigmatizing practices by psychiatrists, psychologists, and others understandably might lead to wariness about engagement with such professionals. An assessor who is unaware of the root of such wariness would be challenged in helping the client to achieve greater trust in him or her and the assessment process.

An assessor’s awareness of how sexual orientation and generation interact to create a unique profile of life challenges enables that assessor both to identify these challenges and contemplate through what means the client can be helped to meet them. Jones (2001) found that elderly members of the LGBT community experience loneliness and isolation due to the ravaging of their social network by the AIDS virus. Kuyper and Fokkema (2010) found that lesbian, gay, and bisexual elders who had a larger LGB network experienced less loneliness. With awareness of this common problem of loneliness, a psychological assessor...
can be sensitive to subtle manifestations of it in the life of the elderly client. In the feedback process, the assessor can underscore the presence of this state and work collaboratively with the client to identify viable means for its alleviation, such as development of strong ties with the LGB community.

No less important, however, is the assessor’s awareness of strengths that a cohort may develop from the challenges it has faced. Morrow (2001) suggests that elderly gay and lesbian persons achieve a “crisis competence” (p. 161) derived from the burden placed upon them to repeatedly cope with discrimination. She notes that this ability places them in good stead in confronting prejudices rooted in ageism. Another strength Morrow identifies is independence. She notes that many gay and lesbian elderly individuals experienced discrimination within their families. In response, this cohort cultivated their own resources and learned to rely upon them. They thereby enter the later years of their lives without a strong expectation that family members would care for their needs. A MetLife survey suggests that, rather than being a recipient of care, members of the LGBT population are more likely than their heterosexual counterparts to serve as caregivers for a family member or adult friend (MetLife Mature Market Institute, 2006). In collaborating with the client to develop a plan to address any identified sources of distress, the psychological assessor can tap the client’s areas of strength to help him or her to move forward.

**Implications for Psychological Assessment**

Experiencing clients through the intersecting lenses of generation, gender, and sexual orientation is an inherently demanding task for the assessor. Almost invariably, it entails moving beyond one’s own very compelling lived experiences to a recognition of how individuals with other identities can be very differently affected by the same historical events as the assessor, or be influenced by a host of events that took place outside of the assessor’s life trajectory. For the heterosexual assessor born in the 1990s, understanding the anguish of the Vietnam vet, also a gay man, who feels twice discarded by society, or the grief of the older lesbian woman who felt unable to have the family for which she yearned, and now questions that decision, is difficult at best. The first critical step is the assessor’s acknowledgment that certain life-shaping experiences of the client’s are not within his or her ken, accepting that some things may never be fully understood, and committing to understanding these intersections of gender, sex, and generation, even if imperfectly.

**Developmental or Acquired Disabilities**

According to a United Nations report, 10% of the world’s population lives with a disability, thereby constituting the world’s largest minority (United Nations, 2014). As such, it is likely that psychological assessors will encounter individuals with various disabilities in their everyday practices. Yet, of all of the diversity
areas assessed or treated by psychologists, this area is that for which psychologists receive the least training in graduate school (Bluestone, Stokes, & Kuba, 1996). Consequently, it is an area in which psychological assessors’ continuing education efforts are well placed.

Over the past several decades, the concept of what constitutes a disability has changed (see Pledger, 2003, for a more complete history). For many years, disabilities were understood within a medical model wherein a defect was seen as resident within the disabled person. More recent perspectives such as the new paradigm of disability see the disability as existing not within the person but in the relationship between the person and environment, a relationship that limits the individual’s actions. The goal of both assessment and treatment is to identify how these limits can be as small as possible by both marshalling the individual’s strengths, supporting restoration of any lost or diminished abilities, and altering the environment to support the individual’s capacities. For the psychological assessor, an advantage of this new paradigm of disability is that it provides a platform for the assessor’s achievement of an empathic grasp of the client’s experience. At some time, all assessors have not been able to navigate in their environments as fully as they would like. By summoning these experiences of limitation and the associated frustration, the assessor can gain a glimmering of what it is like to be in the client’s shoes.¹

The disabilities the assessor will encounter can be either visible (a client who uses a wheelchair) or invisible (a client who has a subtle memory loss from an accident). The visible disability by definition is one that the individual recognizes will be a part, large or small, of how other people see him or her—it is an element of the person’s social self. An invisible disability may require the person’s willingness to disclose the disability, either through self-report or through engagement in a task in which the disability will become evident. Although disabilities can be roughly categorized as visible and invisible, visible disabilities can have invisible components and invisible disabilities can have aspects that are manifest in some way. As an example of the former, although an assessor may be aware that a client has a mobility problem, that assessor may not have easy access to the client’s feelings about the problem or the meaning he or she ascribes to the problem. Likewise, an assessor may recognize that a client is depressed but not be aware that the depression is linked to an invisible disability, cognitive losses following a stroke, which the client could sense far better than others could see.

Implications for Psychological Assessment

The assessor who wants to learn about the client in all of his or her dimensionality will need to gain access to both visible and invisible elements of disability. The client’s willingness to share these less visible elements will be affected by multiple factors. The client’s own attitude toward the disability will influence his or her readiness to reveal it. For example, if the disability is evocative of
shame, the client is likely to shine a light on the disability with difficulty, if at all. Another factor is the client’s expectation of what the assessor’s response to the disability will be. If the client anticipates the assessor’s responding with negative judgment or condescension, then that client may be motivated to conceal the disability. For one client, the view that the assessor will respond to his or her awareness of the disability in some adverse way may be rooted in actual behaviors of the assessment or attitudes exhibited. For another client, this view may be a consequence of past experiences of stigmatization in relation to the disability. For example, the client may have received unsolicited patronizing help in many past situations (Wang, Silverman, Gwinn, & Dovidio, 2014), expect the same from the assessor, and be ambivalent about how to respond to this microaggression. Still another factor affecting the client’s level of openness is his or her understanding of how the information garnered about the disability will be used. Suppose Ms. Dougherty is being evaluated at the request of her employer who has observed memory problems. The employer questions whether the memory problems are due to anxiety or to a primary cognitive impairment, with the latter being a much more significant obstacle to continued employment. Even though the memory issue is acknowledged and hence to some extent visible, Ms. Dougherty may be in possession of less accessible information (e.g., she knows she frequently loses her keys) that would aid the assessor in making this differentiation. However, knowing that the information could lead to an unfavorable determination may lessen her willingness to be forthcoming.

Issues related to gender identity and sexual orientation may interact with the client’s disability status in determining that client’s willingness to share information. Suppose that Ms. Dougherty of our prior example were a male-to-female trans person who has suffered considerable enacted stigma (Herek, 2009) throughout her adult life. In approaching the current assessment situation with respect to disability determination, Ms. Dougherty has a backlog of experiences that would likely lead her to have a more acute anticipation of the adverse effects of others’ gaining access to personal information than another client who had had few experiences of victimization. Some clients may use one identity facet as a shield against another. For example, a client may elaborate greatly on the challenges of having a particular physical disability in order to camouflage uncertainty about sexual orientation. Still other clients may use one identity facet, such as disability status, as a kind of test run to ascertain the safety of exploring more sensitive identity facets. For example, an individual with a mobility disability may have great difficulty in getting to the assessor’s office (Geisinger & Carlson, 1998). Some assessors may recognize this fact and others ignore it. Each behavior provides information to the client. The assessor must also address within him or herself any biases about disabilities that limit the assessor’s effectiveness. For example, an assessor might assume that a disabled person cannot enjoy a full, rich sexual life. Such a prejudice would discourage the assessor from asking the client about his or her sexual functioning.
In the aforementioned examples, the assessor must think about two or more identities in relation to one another. However, unlike these examples, sometimes one identity alters how the client experiences another identity facet. Obesity is a physical problem that has various negative psychological sequelae, both social and emotional. However, the level of severity of at least some of the psychological effects may be moderated by sexual orientation. Research suggests that heterosexual men are less susceptible than gay men to body shame (Martins, Tiggemann, & Kirkbride, 2007). Whether gender is an additional moderating variable was not addressed in Martin et al.’s study, although in general, women show greater vulnerability than men to body shame (Calogero & Thompson, 2010).

Religion and Spiritual Orientation
Religion and spirituality are aspects of the selves that are highly related. Spirituality refers to a belief or set of beliefs in a sacred presence and a set of practices associated with those beliefs (Walsh, 2012). Religion is an individual’s affiliation with a collective that ascribes to a set of beliefs about the divine and possibly codes of behavior, ritual practices, and so on (Zenkert, Brabender, & Slater, 2014). A high percentage of the American population, surveys reveal, sees religion and/or spirituality as major influences in their lives. For example, 70% of Americans in a 2014 Gallup Poll acknowledge that religion is at least moderately, if not very, important to them. Fifty-seven percent see religion as the answer to most of today’s problems (Newport, 2014). An important contrast is that Americans at large value spirituality and religion far more than do mental health professionals (Post & Wade, 2009; Walker, Gorsuch, & Tan, 2004). This disparity is likely to lead mental health professionals to underestimate religion’s importance to clients and neglect exploring these aspects both in assessment and therapy. Another factor that might lead to an avoidance of religion and spirituality by assessors and therapists is the lack of training most mental health professionals receive in this area during their graduate training (e.g., Schulte, Skinner, & Claiborn’s 2002 survey results of counseling programs). Still, the literature on religion and spirituality and mental health is rapidly increasing (Love, Bock, Jannarone, & Richardson, 2005), as is the awareness of the criticalness of mental health professionals receiving training in this area.

Gender and Religion/Spirituality
Generally, the research points to greater involvement in religion by women than men (see Miller and Hoffman’s 1995 review of several decades of studies). Some recent studies show that exceptions to this trend exist. For example, Loewenthal, MacLeod, and Cinnerella (2002) studied four religious groups in the UK and found that men were more religious than women. These investigators emphasize the cultural specificity of gender differences and the importance of
the method of measuring religiosity. Beyond the question of degree of religiosity is the particular ways in which religion affects men and women. Maselko and Kubzansky (2006), using data from the 1998 U.S. General Social Survey, examined whether religious or spiritual participation differentially affected men and women. They found that participation in public religious activity was associated with higher levels of health and well-being, and these effects were greater for men than for women. Whereas men were more strongly affected by public than private religious activity or spirituality, for women, the effects of public religious activity and spiritual experiences were comparable. If these findings are replicated, they beg the question “Why?” the answer to which is important to psychological assessors. For example, the salubrious effects of public involvement in religious activity may be due to its provision of a social network, a resource women may access in other venues.

Sexual and Gender Minorities

For sexual and gender minorities, religion and spirituality are topics that are often fraught with conflict. Indeed, a qualitative and quantitative study by Schuck and Liddle (2001) found that two-thirds of the gay, lesbian, bisexual, and transgender individuals they interviewed described themselves as experiencing a religious conflict. Many of the major mainstream religions such as Catholicism and Orthodox Judaism have taken a stand against same-sex intimacies, declaring them to be sinful, a departure from God’s plan (Tan, 2008). Twenty-nine percent of sexual minorities indicate that they have felt unwelcome in a house of worship (Pew Forum on Religion and Public Life, 2013). LGBT populations may suffer discrimination not only by organized religions but also by others who use religion as a weapon against minority groups. Although for nonminorities, religion and spirituality can serve as a protective factor vis-à-vis psychological problems, for some sexual minorities in some contexts, they have the status of risk factors in that they constitute a source of enacted stigma (Herek, 2009). Despite the discrimination sexual minorities encounter, many LGBT persons see religion or spirituality as playing a substantial role in their lives (Halkitis et al., 2009).

Implications for Psychological Assessment

In some cases, the client’s religion or spirituality is patently connected to the referral question. For example, a client may come to an assessment to gain insights as to why her interfaith marriage is creating such tension for her. Another client may participate in a psychological assessment to be evaluated for suitability for the ministry. In these cases, it is obvious that the assessor must grapple with the client’s religious and spiritual self. However, psychological assessors should always have openness to exploring this identity facet of clients. In fact, some assessment scholars (e.g., Piedmont, 1999, 2004) are positing that
Bringing Multiple Identities Into Focus

a person’s stance toward religion and spirituality is a fundamental dimension of personality that should be assessed in all comprehensive personality assessments. A key question for assessors to explore is how the client’s religiosity or spirituality affects his or her level of adjustment, and the relationship can be complex, as an emerging research base shows (e.g., Dahl & Galliher, 2010). For example, a woman may derive benefits from participation in a particular religion, such as finding meaning in existence, developing a social network, and deriving comfort in relation to sorrows. At the same time, that religion may reinforce gender role stereotypes in a way that limits her ability to find an array of solutions to the complex problems in her life. It may intensify guilt over small infractions and increase her sense of separateness in relation to those not participating in her religion. When clients have an awareness of these diverse effects, it can instigate an active sense of conflict that can be crucially connected to the difficulties that bring the client to the assessment. The psychological assessor, regardless of his or her stance toward religion and spirituality, should not designate these realms as being beyond the scope of the assessment. Rather, that assessor must possess the tools to explore this realm with the client in an even-handed way and to ascertain its connection to the client’s level of adjustment. The assessor must avoid the common tendency among mental health professionals to regard as pathological religious and spiritual beliefs and practices other than their own (Maynard, 2014). With members of gender and sexual minorities, this readiness to explore the role of religion and spirituality in the client’s life in an even-handed, nonjudgmental way is especially crucial.

When an assessor finds, in fact, that religion and spirituality contribute to a client’s psychological burden, then, as part of the recommendations, the assessor might recommend therapeutic work with a mental health professional who has the necessary background to address these issues. With sexual or gender minority clients, the assessor should assist the client in recognizing that the therapist have the wherewithal to assist the client in developing strategies to negotiate the conflict between sexual or gender identity and religious/spiritual orientation (Haldeman, 2004) or between the client’s identities and the heterosexist or cisgendered attitudes of members within a religious community. Such assessors must have a recognition that the client’s solution to religious conflicts must be uniquely his or her own. For example, a gay-affirming assessor must allow that for a particular client, continued affiliation with a conservative religion may be necessary to avert various types of losses, even though that conservative religion does not provide an ideal context for religious practice for many, if not most, LGBT individuals (Haldeman, 2004).

Ethnicity and Race (Culture)

In consonance with the American Psychological Association’s (2003) “Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists,” we use the term culture to encompass the
categories of race and ethnicity. Within this framework, race is the social construction of a group of people based upon a range of physical features and stereotypic notions associated with these features. It is at odds with the notion that a substrate of biological factors differentiates groups of people from one another. Racial identity constitutes a basic aspect of personality, and its construction occurs through a series of stages or statuses that Helms (1990, 1995) and other racial identity theorists have outlined. Ethnicity comprehends the shared customs, language, rituals, and history of a group of people and the sense of affiliation an individual can derive from participation in these cultural experiences. Through this participation, the individual builds a sense of ethnic identity, the strength of which is associated with well-being, particularly in adolescents and young adults (see Smith & Silva’s 2011 meta-analysis of 187 studies). A strong sense of ethnic identity, which can be a protective factor in relation to a host of psychological problems (Umana-Taylor, 2012), is forged through the processes of exploration and resolution of affirmation of one’s ethnic group membership (Phinney, 1989; Umana-Taylor, 2012).

Culture and Gender Roles

Only since the last few decades have gender differences been explored with attention to ways in which race and ethnicity interact with gender. Research that has accrued over recent decades shows that culture plays a critical role in shaping how gender roles are understood and their degree of elasticity. Nielsen (2004) demonstrated this point in a cross-cultural study involving the comparison of gender and scout camps across four countries: Denmark, Portugal, Russia, and Slovakia. The investigator conducted interviews with scout leaders and scouts and observed the community in action. Nielsen found that in all four cases the scout leaders fostered a gender model that had consistency with the ethos of the country. In the Danish and Slovak camps, leaders espoused a gender equality model, and campers’ behavior conformed to it. For example, Danish girls would not countenance the boys having a separate play area and became angry if the latter tried to establish one. In Portugal and Russia, a gender complementarity model prescribing that girls and boys engage in different behavioral repertoires was operative. For example, in both Russia and Portugal, boys were both more expressive of their needs and active in getting them met, whereas girls assumed a more passive, deferential posture. Demographic data comparing cross-cultural differences in the extent to which women hold political power, receive equal compensation for equal work, are the victims of rape and other forms of abuse, and have access to higher education vary greatly from country to country (Seager, 2009), and also demonstrate cultural variation in views of women and men. These differences are certainly important from a social justice perspective. They are also important for the psychological assessor because a dysfunctional behavior that is consonant with a cultural prescription is going to be more difficult to change than one that does not.
Culture also determines what kinds of sexual expression are acceptable and what behaviors will be stigmatized. Cross-cultural differences in the recognition and protection of LGB rights are quite dramatic. Within the United States, the full legal rights of members of the LGB community are being increasingly recognized. In June 2015, the U.S. Supreme Court compelled all states to recognize same-sex marriages. Some European countries such as The Netherlands, Belgium, and Spain have long recognized these rights (CARE2, 2010). Yet, according to a report of the International Lesbian, Gay, Bisexual, Trans, and Intersex Association, 76 countries in the world criminalize same-sex sexual acts, in contrast to 114 that do not (Itaborahy & Zhu, 2013).

Within the United States, cultural identities shape the experience by which a person’s understanding of his or her sexual orientation crystallizes and how it is integrated into the individual’s social experiences. Parks et al.’s research (2004) underscores the role of social-cultural context in sexual identity development. Their study of 448 women who self-identified as lesbian demonstrated that women of color (African American and Latina) wonder about sexual orientation at an earlier age than do White women, but they contemplated this possibility for a longer period than White women did. Upon coming to terms with their sexual orientation, women of color disclosed it to others more quickly than White women did. Although women of color and White women were comparable in level of disclosure to family, White women were more likely to disclose their sexual orientation identity to nonfamily. Aranda et al. (2014) obtained similar findings. A variety of explanations can be proffered for this pattern. As Parks et al. point out, it may be that women of color have accustomed themselves to dealing with minority stress by finding strength within the family. White women grappling with their lesbian identities may not have had to rely upon family support to deal with prior stigmatizing experiences. For the psychological assessor, this explanation would underscore the importance of the assessor’s looking at the cultural support systems in the individual’s life at various stages of the coming-out process, particularly related to the need to acquire skills for coping with stigma.

Implications for Psychological Assessment

When the client’s cultural identity is understood in the context of variables related to gender and sexuality, assessors are better able to appreciate several points. First, regardless of what explanation is supported by further research, Parks and colleagues’ (2004) study and others (e.g., Rosario, Schrimshaw, & Hunter’s 2004 study of lesbian, gay, and bisexual youths) suggest that assessors must be sensitive to the greater reluctance that individuals with racial/ethnic minority identities may have in disclosing a sexual or gender minority status. Parks et al. found that 11% of individuals interviewed, all of whom identified
as having a lesbian sexual orientation, had disclosed their sexual orientations to not a single health provider. Second, in working with LGBT clients of color, assessors must recognize that research literature pertaining to LGBT persons is based primarily on Caucasians and, hence, may lack broad application (Lewis & Marshall, 2012). Third, the LGBT person’s ethnicity and race can pose particular additional challenges to the individual’s maintenance of well-being, but fourth, these cultural elements can also provide certain buffers against minority stress. Identifying both challenges and resources will help in understanding and helping the client most fully.

Over the last two decades, instruments such as the Race-Related Events Scale (Waelde et al., 2010) have been developed to ascertain the extent to which individuals have experienced various kinds of racist events. Similar scales have been developed to measure exposure to sexism (e.g., Schedule of Sexist Events; Klonoff & Landrine, 1995) and heterosexism (e.g., Park’s Heterosexism Scale, 2001; also see, Goodrich, Selig, & Crofts, 2014). Still others reflect the intersection of race and sexual orientation/gender identity (e.g., LGBT People of Color Microaggressions Scale; Balsam, Molina, Beadnell, Simoni, & Walters, 2011). Scales reflecting different types of minority stress could in principle be helpful in providing a picture of the contribution of different sources of stress in a person’s life. However, some caution is needed in using these narrowband instruments. Helms, a leader in the study of racism and ethnoviolence, makes the valuable point that the psychometric properties on which psychological tests rest sometimes prevent assessors from gaining a full picture of the stress experienced by a client in response to racism. Helms, Nicolas, and Green (2012) note that the requirement upon instruments to satisfy reliability criteria through such statistical measures as Cronbach’s alpha (Cronbach, 1951) leads to the elimination of items that might capture certain aspects of an individual’s experience that may be singular—that is, not correlated with other items on the scale. They argue that the elimination of items that have low correlation with other items may reduce the sensitivity of the scale to racial traumatic events. However, if these items are few in number, it is likely to shift the sensitivity of the scale. It might be more useful to create a separate scale that captures these experiences with particular types of traumatic events involving race.

**Socioeconomic Status**

**Background**

Socioeconomic status refers to an individual’s social position in his or her society, a position determined by income level, occupation, and educational level (Yonek & Hasnain-Wynia, 2011). A person’s socioeconomic status affects his or her access to a range of resources—healthcare, educational, childcare, and so on. It also influences how others regard that individual. The higher his or her socioeconomic position, the greater the power and control others accord that
individual. Moreover, as the term suggests, those occupying the higher echelons of wealth and education are in possession of high status—that is, they are seen as having, by virtue of these possessions, worth and prestige. Reciprocally, others frequently deem those in the lower rungs to have lesser societal value. This valuation of personhood based on socioeconomic status is the phenomenon of classism. As Smith and Redington (2010) point out, prejudices in relation to class have a particularly pernicious effect on those against whom they are directed because, in large part, society accepts classism. They point out that expressions such as “low-class” or “class act” are used with impunity. Working-class and poor people, they note, are commonly represented in the popular media as lazy, shiftless, and irresponsible. Even institutions such as labor unions, which have represented the interests of working-class individuals, have come under widespread attack, Smith and Redington observe. Therefore, individuals who occupy the lower echelons are deprived of both resources and societal affirmation.

**Gender and Sexuality**

Gender and sexuality identities are highly relevant to socioeconomic status in that marginalized versus privileged gender and sexual identities tend to occupy the lower versus higher statuses, respectively. The pay gap between men and women has long been recognized and, according to a report of the American Association of University Women (AAUW), exists across almost all occupations (Hill, 2014). The gap is not due, as some have suggested, to women selecting low-paying professions. The AAUW report also notes that the pay gap is greater for women of color and older women. Sexual orientation is also associated with socioeconomic status. Gay men have lower socioeconomic statuses than heterosexual men who are at the same educational level (IOM, 2011). Studies comparing lesbian women with heterosexual women have yielded inconsistent results, for example, Black et al. (2007) showing that lesbian women have higher incomes than heterosexual women and Badgett (2001) showing no difference between the two groups.

Less information is available on both bisexual and transgender individuals. However, some studies suggest that both groups are economically disadvantaged relative to heterosexual, gay, lesbian, and cisgendered individuals (Carpenter, 2005; Conron, Scott, Stowell, & Landers, 2012; Rosser, Oakes, Bockting, & Miner, 2007). Although gender and sexual minorities appear to face economic disadvantages relative to the heterosexual, cisgendered population, the difficulties are actually worse than are suggested by the data on income. Although this circumstance is changing rapidly, as noted by Yonik and Hosnain-Wynia (2011), these individuals by virtue of obstacles to legally recognized marriages are unfavorably positioned in terms of tax liability and insurance procurement, relative to other groups. They also are at risk for job loss. For example, 15% of transgender individuals reported job loss due to their exceptional gender identity (Xavier, Bobbin, Singer, & Budd, 2005), and 62% attested to discrimination
in employment, housing, or healthcare (Clements-Nolle, Marx, & Katz, 2006). Access to services because of limited income is also a major issue (IOM, 2011) for gender and sexual minorities. According to a recent Gallup (Gates, 2014) telephone survey, whereas 13.2% of the non-LGBT population is uninsured, 17.6% of the LGBT population is uninsured. In some cases, the relationship between lack of income and diminished access to services may be indirect. For example, Wagaman (2014) found that some trans-identified individuals in his sample of young adults could not afford to get proper identification upon having transitioned, and hence, could not gain access to services.

**Implications for Psychological Assessment**

How is this information concerning socioeconomic status relevant to psychological assessors? First, it may affect the affordability of a psychological assessment. The economic issues associated with being a sexual or gender minority may make a psychological assessment, particularly in a private practice setting, inaccessible. Psychological assessors may make the mistake of using education or even income as a proxy for socioeconomic status. If the assessor uses a sliding scale, this mistake may lead him or her to set an inappropriately high fee.

Second, the economic issues that gender and sexual minorities face affect their psychological situation. Demonstrating this point were the findings of a study conducted by Gamarel, Reisner, Parsons, and Golub (2012), who looked at a variable similar to socioeconomic status: socioeconomic position (SEP). SEP takes into account not only the individual’s objective resources but also the person’s perceptions of those resources. Hence, two individuals could factually have the same income but regard that income very differently, leading to varying SEPs. Gamarel et al. found that SEP influences the degree of minority stress or discrimination an individual experiences, which in turn influences an individual’s level of anxiety or depression. The perception of oneself as financially disadvantaged—whether wholly factual or not—positions an individual for psychological problems. The assessor’s awareness of this possible connection enables him or her to point to an area of difficulty that lays the foundation for other problems.

**Indigenous Populations**

The World Health Organization (WHO) defines indigenous peoples as “communities that live within or are attached to, geographically distinct traditional habitats or ancestral territories, and who identify themselves as being part of a distinct cultural group, descended from groups present in the area before modern states were created and current borders defined” (WHO, 2014). According to the 2010 U.S. census, 5.2 million individuals (or 1.7% of the population) describe themselves as American Indian or Alaskan Natives, representing a 39% increase since the 2000 census (Norris, Vines, & Hoeffel, 2012). Notably,
2.3 million classify themselves as being American Indian or Alaskan Native along with one or more other races (Norris et al., 2012), and this group is increasing at a more rapid rate than Native Americans who are not bi- or multiracial. Although these groups are among the largest groups of indigenous peoples, there are others such as Native Hawaiians. Within the United States, 511 federally recognized tribes and 200 federally unrecognized tribes exist, giving rise to tremendous variability among the country’s indigenous people in virtually all respects (Mihesuah, 1996).

**Background**

A key issue for indigenous people, commonly described as the *fourth world*, is the imposition of another culture upon their own, thereby endangering the existence of their culture. For example, many indigenous languages, rituals, and customs in the United States have disappeared (Hill, Kim, & Williams, 2010). These losses, in conjunction with the violence that has been perpetrated upon indigenous peoples, have given rise to a collective group experience that has been termed a *soul wound* (Duran, Duran, Yellow Horse Brave Heart, & Yellow Horse-Davis, 1998). Although the cultural invasion of the indigenous peoples of North America dates back to the colonial era, it continues today. For example, the many Native Americans who dwell in urban centers such as New York and Los Angeles have the advantage of few or no elements that support the presence of their natal culture within their lives. Individuals who live within their tribal communities are likely to find the presence of cultural elements easier to maintain but nonetheless encounter incursions to their ways of life by the dominant cultures. For example, to receive goods and services, they are forced to access a commercial system that may operate by different principles than those indigenous to their culture.

Recently, strides have been made in getting a picture of the mental health status of members of indigenous tribes. The American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (Beals et al., 2003) entailed the administration of a diagnostic interview to members of Southwestern plains tribes and Northern tribes, over 3,000 in all, by members of these tribes. They found elevated levels of psychological problems, relative to the population at large. For example, tribal members showed one-half to two-thirds greater risk of a depressive disorder and two to three times greater risk of PTSD. Suicide rates are also considerably elevated relative to nonindigenous American populations (Gone & Trimble, 2012). The risk of alcohol abuse, starting at a very early age, is extremely high (LaDue, 1994). In accounting for the psychological difficulties experienced by indigenous populations, scholars of indigenous life (e.g., Gone, 2011) identify as a major contributor to the mental health disparities between indigenous and nonindigenous groups, colonization, both historically and contemporaneously. The experience of having core aspects of one’s identity assaulted and other aspects imposed upon the self—it
is argued—cannot do otherwise than destroy an individual’s well-being. The challenge for psychological assessors is how to relate to the client in a way that is not felt to be a new colonization, a reopening of the soul wound.

**Indigenous Identity, Gender, and Sexual Identity**

Prior to colonization, many indigenous tribes had a matriarchal structure wherein women had great power and were revered. Spiritual figures such as the Spider Woman of the Hopi bespoke of the respect if not reverence that was accorded to women (Walters & Simoni, 2002). With colonization, Native American men were encouraged to adopt the ways of European men and to establish families with non-Native women. Since that time, indigenous women have experienced discrimination based both on gender and their racial minority status. One extreme manifestation of this discrimination is violence. Across tribal affiliations, Native American women experience two to three times the level of intimate partner violence than other groups of women, including severe physical activity and forced sexual activity (Malcoe, Durane, & Montgomery, 2004). These findings have been extended to Native Americans (including Alaskan Native women) living in urban areas, and have been shown to be associated with depression, dysphoria, HIV-risk-related behaviors, and help-seeking behaviors (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). Hence, although many life predicaments may lead a Native American woman to require the services of an assessor, her need to cope with the psychological aftermath of domestic violence is a particularly common precipitant.

Historically, Native Americans saw sexual and gender variation among human beings as a natural phenomenon. The term *two-spirits*, an old Algonquin word given contemporary meaning, is used to signify the presence of a male and female spirit within one person and the inseparability of those spirits from one’s culture (Wilson, 1996). With colonization, the model of oppositional gender roles in the context of heterosexual relationships supplanted, although never entirely, this more fluid conception of human relating. Upon identifying with this European American conception of gender and sexual functioning, Natives increasingly perceived gender and sexual behavior departing from the heterosexist, cisgendered mainstream as pathological, immoral, or both. One manifestation of this population’s greater identification with the large American population was (and is) the elevated incidence of child abuse with LGBT Native American youths (Balsam, Huang, Fieland, Simoni, & Walters, 2004), just as occurs in society at large (e.g., Corliss, Cochran, & Mays, 2002). Relative to other ethnic/racial minority groups, two-spirit lesbians report a higher incidence of physical and sexual abuse (Morris & Balsam, 2003).

Still, within many Native American communities, the worldview of gender and sexuality continues to have residency. The identity development process that occurs for non-Natives who are also people of color is somewhat different than for Native Americans (Wilson, 1996). In both identity formation processes,
the racial minority status can assist with embracing the status of being a member of a sexual or gender minority. However, for Native Americans, the culture itself can provide affirmation for the status (Wilson, 1996), given that the culture itself sees variation in these domains as natural and desirable.

**Implications for Psychological Assessment**

Psychological assessors working with Native Americans benefit from knowing the unique history of indigenous populations in the United States and having particular sensitivity to the long-standing psychological aftermath of colonization. Assessors should also be aware of the effects of multiple forms of oppression and how they interact—oppression due, for example, to statuses as a Native American, a woman, and a lesbian. Although the historical perspective is crucial, it can become a detriment if it leads the assessor to assume that from the experiences of many indigenous peoples, we can know the experience of one. Diversity among Native Americans is tremendous, with experiences being shaped by membership in a given tribe, geography, socioeconomic status, and many other identity and contextual factors. With the benefit of general historical knowledge, the psychological assessor can interview the Native American client to discover the specific aspects of his or hers.

In conducting the interview, the assessor should strive to accord the client as much autonomy and freedom of expression as possible, knowing that for many, the lack of these elements has been a source of suffering. The assessor should also recognize that the client might use terminology or reference concepts that are unfamiliar to the assessor but are part of that client’s tribal history. The assessor must exercise care not to ascribe pathological significance to what is simply a cultural expression. At the same time, the assessor should not assume all communications that the assessor views as unusual or unfamiliar are due to culture; the task of the assessor is to do the necessary research to make the differentiation. This point also applies to work with clients from other racial/ethnic groups. If the assessor is a non-Native, it is crucial that the assessor enter the relationship with a stance of humility, always recognizing that the client is the expert on his or her own culture (LaDue, 1994). Further, the assessor must understand that certain terminology that has entered mainstream culture to designate indigenous persons is offensive given its association to human rights violations (see Peters & Cavalieri, 2015), and hence, the assessor should refrain from using it.

Psychological assessment is also usefully informed by theoretical models that have been developed to understand both the psychological issues of indigenous peoples and the resources that can be garnered to enhance their well-being. An example is the “Indigenist” stress-coping model (Walters & Simoni, 2002). This model describes the stressors Native Americans tend to encounter, the health (including mental health) outcomes associated with those stressors, and the factors that can buffer the impact of stressors.
They point out that the relationship between stressors for Native Americans and the health outcomes is well-established by a number of empirical investigations. However, the model developers caution that not all Native Americans are adversely affected, especially to extreme extents, by stressors. Among the factors that appear to buffer negative outcomes are the extent to which one identifies with native culture, resisting internalization of negative views of the culture, practicing spirituality, and employing traditional healing practices. For clients who have experienced gender and sexual discrimination, the particular spiritual beliefs of the tribe will be important (e.g., the extent to which the value of women is affirmed). The importance of this model for psychological assessors is, first of all, to help them recognize the severe toll that minority stress takes on indigenous populations. For assessors who are members of racial minority groups, this model serves as an aid in grasping that the client’s minority stress may be different from one’s own. Additionally, though, the awareness of buffer factors enables the assessor to recognize factors in the client’s life that may be health promoting—and therefore, should be retained—or factors that could be nurtured.

Assessors need more than theoretical models and techniques. Nonindigenous assessors have a cultural participation in the role of colonizer. A variety of unwanted feelings and urges can accompany this position, such as a wish to maintain a position of subjugation, a sense of guilt for being a colonizer, or a longing to repair damage done. The absence of awareness of these or other elements may lead them to be enacted within the assessment relationship. Conversely, recognition of these elements may further illumine the client’s reciprocal experiences, thereby deepening the assessor’s empathy and understanding of the client. For clients who represent gender and sexual minorities, the communication of the assessor’s grasp of the client’s lived experience can have especially potent therapeutic impact.

**National Origin**

National origin refers to an individual’s country of birth (heritage country) or that of one’s parents. When the host country differs from the natal country because the individual is an immigrant, a sojourner, or an international student, that individual faces the task of acculturating to the new environment. The difficulty of acculturation can be small, great, and all gradations in between. Ease or difficulty of acculturation is determined by a range of factors, including the physical and psychological similarity of the new environment to the old, the age of the transition, the supports in the new environment, the degree of discrimination encountered, the capacity to find productive involvement in the new environment, linguistic fluency in the new environment, and the individual’s control over the decision to relocate, to name a few (Akhtar, 2011). Capturing the degree of difficulty in adjusting to the new environment is the concept of *acculturative stress* (Williams & Berry, 1991).
Bringing Multiple Identities Into Focus

Acculturative Stress

Acculturative stress is an important factor because it is linked to psychological problems. For example, acculturative stress in immigrant adolescents was associated with withdrawal, somaticization, anxiety, and depression (Sirin, Ryce, Gupta, & Rogers-Sirin, 2013). Acculturative stress in international Chinese/Taiwanese students attending a large Midwestern university in the United States was found to be linked to depression (Wei, Heppner, Mallen, Ku, Liao, & Wu, 2007). The effects of acculturative stress are moderated by a variety of factors that can be explored by the psychological assessor, such as the individual’s coping strategy in relation to perceived discrimination. Asian international students who used a suppressive coping style (denying or ignoring discrimination) were more vulnerable to depression than those who were using alternate styles such as reflecting on an act of perceived discrimination (Wei, Ku, Russell, Mallincrodt, & Kelly, 2008). Self-esteem is also a relevant factor in that high levels appear to serve as a buffer against discrimination (Wei et al., 2008).

National Origin, Gender Roles, and Gender and Sexual Identities

Research looking at gender and national origin in terms of the interrelationships of these identity variables to psychological adjustment has yet to yield a cohesive pattern of findings. Possibly more fruitful than the study of gender is the investigation of variables related to gender, such as gender roles and gender identity. Many cultures develop expectations concerning the tasks that men and women are to perform within society. Immigration to a new country often involves exposure to a new set of expectations. Individuals must make choices about the expectations they will fulfill and those they will violate. When the individual fails to meet cultural demands, that person opens him or herself to sanctions. If the sanctions are applied by the new culture, then the individual renders him or herself open to minority stress. If the individual modifies his or her behavior in consonance with the new culture, then the disapproval of the guardians of the original culture, potentially family and friends who may be geographically remote or proximate, may ensue. Also affecting the individual’s potential stress load is his or her gender role compliance. The individual may also self-administer sanctions, as when the individual conforms to the gender role expectations of his or her new culture but feels guilty for having done so.

Students who come to study from abroad can easily encounter circumstances that evoke gender role dissonance. A young woman in her twenties who presented for a psychological assessment came to the United States to pursue a very demanding program in the healthcare profession. Although her parents applauded this decision, after two years of study, they sent her younger sister, who was struggling to find a career direction, to live with her. The client was expected to help the younger sister launch herself vocationally and socially in
the United States. Within her country of origin, elder sisters often served as surrogate caregivers for younger sisters. This graduate student was caught between the new cultural prescription that she should devote herself completely to her training and a familial, cultural narrative that she should make room in her life for caregiving responsibilities. Whatever domain of her existence she emphasized, family or training, she felt guilt that she was neglecting the other. To assist this client in moving forward in her life, it was necessary to acknowledge that her participation in two differing cultures gave rise to gender role conflict, which in turn created stress, guilt, and worry.

Sexual orientation and gender identity are identities that have been studied minimally in relation to national origin. However, sexuality is a fundamental element of any culture, and from culture to culture, immense variation exists on the meaning of sexual behavior, its purposes, acceptable and unacceptable forms of sexual behavior, and the allowable co-participants in sexual activity. This variation ensures that with an individual’s movement from one culture to another, conflicts will arise. The greater the variation from one culture to another in sexual beliefs, the greater the potential for acculturative stress in this important area. For those immigrating to the United States from more sexually repressive cultures, opportunities to explore issues such as gender identity and sexual orientation may be dramatically greater. Yet, the heritage culture’s continuing influence may give rise to tension that is connected to the problems that the client is seeking to elucidate through the psychological assessment.

**Implications for Psychological Assessment**

In assessing clients who have immigrated, the assessor must understand the potential sources of acculturation stress for that client. These sources may include matters concerning gender role, gender identity, and sexual orientation. By endeavoring to learn about the culture, the assessor can discover what kinds of disconnection the client may have experienced in transitioning to a new culture. Rather than assuming that the client has a high level of self-knowledge concerning these identity areas, the assessor should appraise where the client resides on a developmental trajectory of self-awareness. This type of assessment is especially important for clients who are emigrating from cultures with highly prescribed gender roles and repressive and prescriptive views on sexuality.

Not only does the client’s developmental stage of identity formation bear upon what he or she feels able to share, but also the specific conditions of the assessment situation itself. The assessor is part, often a most salient part, of that situation. The assessor’s perceived age, gender, and comfort level with discussing sexual and gender identity will likely make a difference in the client’s readiness to do so. Another feature of the environment may be the presence of a translator. When the assessor and client do not share the same language, a qualified translator who is not a family figure or friend is an appropriate aid to communication. An advantage of a translator is that this person can often
aid the assessor in learning about the culture. The potential of such learning is augmented if the assessor has a preassessment meeting with the translator (Hays, 2005). However, a translator adds a level of complexity when topics of a highly personal nature are broached. The translator him or herself may be at different points of a comfort continuum, and his or her level of comfort may affect how the comments of each party are relayed. Moreover, the presence of the translator may play a role in reinforcing the ethos of the heritage culture, leading the client to move to a position that may not be typical for him or her. The personal characteristics of the translator are important. For example, a male translator may have an inhibiting effect on a female client’s sharing of details concerning sexuality and physical health (Hays, 2005). Finally, discussing sexual matters with three people in the room may unnerve the client. Sometimes the obstacles can be lessened merely through their acknowledgment. In other cases, changes may need to be made in the environment to create the necessary climate for openness. If neither of these approaches is possible, the assessor must take care to acknowledge what the assessor was unable to learn about the client given the conditions at hand.

**Intersectionality**

For assessors thinking about the interrelationships of different identities, a particularly helpful concept is that of *intersectionality*. In the sections below, we both describe and illustrate this concept.

**Background**

This term, created by the feminist scholar Kimberle Crenshaw (1991), pertains to experiences resulting from the interactions of multiple identities that are either stigmatized or privileged within a society. Crenshaw’s examples frequently concern race and gender. She held that one is unable to understand the experiences of a woman of color by referencing gender or race separately, or even their additive effects. Rather—she held—at the juncture of race and gender is a distinctive set of experiences, the awareness of which is necessary to fully understand an oppressed person. Further, she held that any plan of intervention to be effective must take into account intersectional dynamics. She gives the example of rape counseling programs that allocate money for counselors to accompany victims to court. Writing at that time, she observed that these funds are misappropriated because African American women tend not to pursue the court system and have other more pressing needs in relation to sexual violence. Intersectionality has been of particular interest to contemporary feminist writers, who see the potential for capturing the heterogeneity among women (Cole, 2009; Shields, 2008), and that it encourages research not only on particular categories of well-studied women but on all women (Eagly, Eaton, Rose, Riger, & McHugh, 2012; Eagly & Riger, 2014; Henrich, Heine, & Norenzayan,
in the context of their other identities (e.g., race, sexual orientation). As Crenshaw’s work also suggests, an intersectional focus is useful in identifying the particular challenges that individuals with multiple minority statuses face in accessing services, including psychological services.

Many of the identity domains considered in the ADDRESSING framework have some aspect of stigma associated with them. For example, age and generational identity is associated with stigma when a particular generation or phase of life is devalued relative to others. Old age is stigmatized when the elderly are seen as unable to make a contribution to others. Children are stigmatized when their needs are seen as burdensome. Adolescents are stigmatized when they are assumed to be impulsive and irresponsible because of age alone. Assessors must continually pose to themselves the following questions: How does the fact that my client has membership on \( x \) dimension and \( y \) dimension uniquely shape his or her daily experience and behavior? Does this multiple minority status affect access or responsiveness of psychological treatments? Are particular types of psychological or social problems intensified by the conjunction of these minorities? Does one minority status buffer another in particular ways? What other identities of the client buffer or intensify any effects of minority status?

Particular attention must be given to the ways in which the assessor is the same as and different from the client. If the assessor shares minority status within one identity, that commonality can certainly be the basis for the development of rapport. For example, if the assessor and client are both African American, that status may provide common ground that enhances the assessment relationship. Yet, if the assessor is male and the client is female, or if the assessor is straight and the client is gay, the common ground may hinder sensitivity to important differences. Likewise, when assessor and client possess different minority statuses, both individuals may share the presence of stigma, but differences in the hues and tones of the stigma may give rise to lived experiences that contrast greatly between the two individuals. For example, indigenous people and immigrants have certain experiences in common, such as the sense that their culture of origin is being threatened. However, the indigenous person has the added aspect that the threat is via colonization, something akin to having one’s home burglarized. Although this sense may not be altogether lacking for the immigrant, other experiential elements may be much more conspicuous.

Vignettes

The following two brief vignettes will illumine how thinking about intersectionality may assist the assessor in conducting one or more aspects of the assessment and how assessment findings can shed light upon the client’s multiple identities. In the first case, the assessor’s openness to possible hidden and intersecting identities enabled her to pursue potential meanings of the assessment data.
Perry is a 77-year-old man whose physician had urged him to obtain a psychological assessment when Perry had appeared for a group of appointments, each time seeming more unkempt and listless than the last time. In the initial interview, Perry did attest to, in his words, “malaise,” which he saw as due to various chronic conditions. One of the initial tasks in which Perry participated was the Draw-A-Person. The assessor noted that the figure did not have an identifiable gender. When instructed to draw someone of the other gender, Perry drew a very similar drawing. The assessor commented on this fact, and Perry shrugged and claimed that his drawing skills had always been very limited. On various self-report instruments, the assessor found evidence of depressive symptoms and a marked tendency toward painful rumination. On the Rorschach, Perry produced three Vista responses, suggesting the presence of intense self-dislike. Converging with this hypothesis was a 2–7 codetype and a Low Self-Esteem content score of 80 on the MMPI.

The assessor sensed that as the assessment progressed, her rapport with Perry was growing. For example, in contrast to his initial withdrawn demeanor, he progressively made off-handed self-disclosures while taking the psychological tests and made comments about the personal objects in her office. She decided to conduct another focused interview using the drawings once again as a point of departure. Amidst tears, Perry revealed to her that since his early childhood, as far back as he could remember, he felt like a girl. He had never shared his secret with anyone. Over his adult life, he had heard about individuals who changed their bodily selves to fit who they knew they were, but he believed he could never be that brave. Still, in more recent years, this possibility seemed so much more real. He said he was filled with regret for having wasted his life in the wrong body and regarded himself as a coward.

The issue of intersectionality is extremely important in this case in that Perry’s experiences were the result of the conjunction of his gender identity and his generation. As was discussed in relation to sexual orientation, older individuals with gender-variant identities have generally been denied both social acceptance of their identities over the course of their lives and the psychological benefits of group identification (Settles, 2014). Although their more junior counterparts continue to face stigma, the picture is less grim than it was several decades ago. By recognizing the gender identity and generational interaction, the assessor could help Perry to see that an important therapeutic goal for him would be to grieve the life he was unable to live while removing self-blame for that loss. The assessor could also explore with Perry the possibilities of establishing connections with a growing elderly transgender community. Assessment can create a special environment in which individuals reveal what has not been previously shared, perhaps even over a lifetime. However, it requires the assessor’s sensitivity to and acceptance of all identities constituting the client’s personhood.
A white heterosexual female assessor received a referral for an 18-year-old lesbian African American college student, Donna, who was making the decision of whether to go away to college. Donna was in the fall of her senior year at a very competitive private high school where she performed at a high level, while taking primarily honors courses. This young woman, an only child, recently had revealed her sexual orientation to her parents. Although initially they responded with moral qualms because they saw homosexuality as contrary to their religious beliefs, they quickly transitioned to expressing their acceptance of and love for her. Donna indicated that she had not disclosed her sexual orientation to any of her friends, but she had a strong belief that her closer friends had surmised her lesbian identity. She expected that she would be disclosing her sexual orientation in the near future. Donna told the assessor that she was tormented by the decision of whether or not to go away to school or to live at home and attend a local institution. Donna reasoned that separating from her parents was a very natural step at this time. She also acknowledged that leaving home would enable her to attend a school that was better aligned with her abilities and interests. She claimed that she could not identify specific fears about leaving home, only that the anticipation of it filled her with dread. The assessor asked Donna if she thought her fear had anything to do with her realization of her sexual orientation, and she said she was not sure.

In the interview, Donna described herself as having a rich social life in high school. She had friends of varied races and ethnicities, sexual orientations, and interests. Most were academically accomplished and shared ambitious plans for their futures. She acknowledged some trepidation in regard to the transition to college, noting that it would take more work to find people with whom she could develop close ties. She believed that this greater challenge would exist regardless of where she went. She also noted that her high school had an atmosphere that embraced differences. She wondered if she would find the same in college.

In the psychological assessment, Donna manifested reality-testing within normal limits, a lack of cognitive slippage, and good affect regulation. She exhibited a capacity to forge relationships with others that are constructive and characterized by give-and-take. Her self-esteem seemed stable and positive. No evidence of depression was present, but across multiple measures, performance and self-report, she exhibited a high level of free-floating anxiety. On the TAT, Donna created narratives of caregivers who evinced fragility or were, in some respect, in harm’s way. For example, on Card II, her story concerned the farming woman’s pregnancy and whether the expectant mother would overtax herself in the fields. On a sentence completion form, she completed the fragments “My mother . . .” with “is prone to worry” and “my father . . .” with “has a lot on his plate.” The assessor was impressed with
Donna’s poise and confidence, even when discussing difficult issues. The assessor noted herself that she related to Donna more as a full-fledged adult rather than as an adolescent.

The assessor developed a hypothesis that one source of stress for Donna was her worry about her parents’ well-being. The assessor gently questioned Donna about her perceptions of her parents, asking her how she thought they were coping with her disclosure of her sexual orientation. At this point, Donna became tearful and said she didn’t really know, but she thought it must be harder on them than they let on to her. Donna pointed out that her family was extremely involved in a religion that regarded nonheterosexuality in very negative terms. Much of her parents’ social life revolved around the church. Donna’s outing herself to her friends would lead, she believed, to the discovery of her status by congregants in the church. Donna imagined that her parents would be treated with unwelcome solicitude, only lightly masking negative judgment. Donna was quick to add that this church had been a safe haven for them all—only now did it pose a problem for the family.

From this exchange, questions emerged for the assessor that would shape the rest of the assessment process. Did Donna see herself as abandoning her parents during a critical period? Did she tend to take undue responsibility for her caregivers’ well-being, and if so, did this role affect her overall functioning? Was her concern about them a mask for her worries about her own adjustment in college, especially in light of her recent process of self-discovery? Did Donna feel pulled by each of the two ways in which she had a minority identity? The assessor developed a plan to look at the data further in light of these questions and to also explore them with Donna and, with permission, her parents.

The assessor began to consider how surrounding herself with others who share aspects of her identity would promote Donna’s resilience and engender in her a sense of safety and inclusion, whatever decision she made. In awareness of the finding that LGB students experience greater distress than their heterosexual peers (e.g., Kirsch, Conley, & Riley, 2015), the assessor decided to research what kinds of resources (e.g., affinity groups, services at the college counseling centers) in a college environment facilitate the transition of individuals who are diverse in multiple ways.

The assessment situation posed by Donna requires that the assessor factor in a variety of identity elements in developing her understanding of the client’s challenges and resources: age, race, religion, sexual orientation, and socioeconomic status. Although the negotiation of race and sexual orientation created an adaptive challenge for Donna and her parents, that challenge could only be grasped fully by also taking Donna’s religion into account. The strength of an intersectional approach is that it enables the assessor to see clients such as Donna in their complexity and serves as an antidote to a tendency to stereotype based upon a consideration of a single dimension (Eagly et al., 2012).
Practical Points

Having examined gender and sex as they intersect with other identity domains, we are now in a position to make the following points:

- Assessors benefit their clients by attending to clients’ multiple identities, not simply those that are initially salient or explicitly linked to the referral question.
- Assessors should be aware of their own identities, which include assumptions, biases, and value systems that can limit assessors’ abilities to allow clients’ narratives to unfold fully.
- The assessor should be aware of his or her reactions to each of the client’s identities, including those to sexuality and gender. When the assessor is unaware of reactions, they can pose blocks to competent assessment; when they are recognized, they can be signposts to particular dynamics of the client.
- In attending to each area of identity, the assessor should consider whether the client has majority or minority status on that dimension. Frequently, minority status is associated with risk for discrimination and oppression.
- The assessor should recognize when the client has minority status on multiple identity dimensions and consider how the client’s intersectional identity affects the client’s daily experience, others’ treatment of him or her, and the client’s access to resources, including resources for treatment.
- In recommending intervention strategies, the clinician must take into account the possible convergences between intersectional identities, because effective treatment based on intersectional dynamics may be different from treatment based on each identity considered independently.
- Assessors do well to remember that although minority statuses may be associated with vulnerability to discrimination, they may also carry strengths that can be tapped both during the assessment and in the individual’s life beyond the assessment.

Annotated Bibliography


*Comment:* The motif of this text, the address framework, was used as the organizing principle of this chapter. Hays offers many other insights into multiple identities, most of which have direct implications for the practice of psychological assessment.


*Comment:* This chapter goes into considerable depth in discussing intersectionality and discusses how membership in multiple marginalized groups can create a multiple jeopardy wherein the individual is placed at considerable risk for negative experiences and life difficulties.
Bringing Multiple Identities Into Focus

Notes

1 Stephen Finn (2005), in an article on compassion and firmness, has written eloquently about the criticalness of the assessor’s dipping into our own conflicts and struggles. He writes, “we are challenged repeatedly to find in ourselves a personal version of the conflicts, dynamics, and feelings troubling the people we assess” (p. 30).

2 Miller and Hoffman (1995) account for gender differences by the hypothesis that women are more risk adverse than are men. They point out that when risk preference is taken into account, gender differences lessen greatly.

3 According to the Gallup report, this disparity—seen in both men and women—has lessened under the Affordable Care Act. For example, in the second quarter of 2013, it was 7 points, and in the third quarter of 2014, as noted in the text, it was 4.4 points, a significant decline.

4 The use of a translator involves many complexities beyond what we talk about in this section. The reader is referred to Sandoval and Duran (1998) for further discussion of use of a translator (1998).

References


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PART II

Assessment Tools
Alexandria arrived at our first meeting promptly, having greeted me with a business-like introduction that was polite and managed to convey that she was ready to get to work on the assessment immediately. Surprised at her eagerness, I invited her to sit on the sofa across from my chair, and we began our first conversation. Alexandria, a Caucasian woman in her early forties, had been referred for an assessment to help explain a lack of progress in her psychotherapy. For the first year of her therapy, she had continued to struggle with a paralysis of her work productivity and been forced to take a leave of absence from her job as an administrative assistant, eventually leading to her resignation.

Introductions already made, I shared with her what I had learned already about her from her therapist and discussed a little bit of what our work together might look like. I noticed how attentively and patiently she listened to me as I spoke, and even today I remember the way her eyes revealed the rapid pace at which her mind worked. She was quick, efficient, cool—almost unperturbed by feeling or worry—almost robotic.

As she spoke during the interview, I became distracted. Something about her was nagging at me. Listening a little more distantly, I looked more closely at her. I noted how pristinely dressed she was, how well pressed her pants were—no wrinkles. I noticed they were pleated like a pair of men’s pants. Her shirt, upon second glance, now registered to me as a plain, long-sleeved cotton shirt with a turtleneck. Odd for this heat wave we’re living through, I thought to myself. Catching myself critiquing her fashion, I suddenly became aware of how unnerved I was that there seemed nothing feminine about Alexandria—no makeup, no perfumed scent, no purse, no jewelry. A scientific quality seemed to replace any sign of gracefulness, sensuality, or passion. I had become struck by what seemed to be an androgynous quality about Alexandria and was quickly suspicious that it might relate to her problem.
But immediately, I began to feel uneasy. How do I know these things I’m noticing might have anything to do with her problem? What exactly do my reactions mean, anyway? Am I unduly pathologizing a woman for presenting in this way, simply because she appears at variance with how women usually appear? Being myself a gay, white, cis male and having worked with so many LGBTQ clients, it was unlike me to be so rigidly concerned about a client’s gender presentation, and my concern made me uncomfortable, as though I was rediscovering the remaining vestiges of my own internalized homophobia and gender biases. Yet, there was something about what I was seeing about her that I couldn’t reconcile. Something important was going on here, but how to get to the bottom of it?

Surprisingly, assessment professionals do not agree on the relative value of the clinical interview and of the assessment data garnered from it. Some authors argue that the clinical interview—too subject to examiner bias and too variable in its execution across assessments and assessors—should be given little emphasis or weight in comparison to the quantitatively rich data of assessment measures (Craig, 2009). Others strongly argue that the clinical interview and its data should be given great importance and should comprise the core foundation of any psychological assessment (Groth-Marnat, 2009; Maruish, 2008). Others still point to the difficulty of integrating interview and test data, arguing that both data are derived from clients’ own subjective self-reports and thus vulnerable to distortion or inaccuracy (Machado, Beutler, Harwood, & Pratt, 2011). Despite such disagreements, there is no question that the clinical interview is, and will remain, a critical component of any psychological assessment, and for that matter, any introductory clinical effort with clients (Karg, Wiens, & Blazei, 2013).

However, very little has been written specifically about considerations of gender and sexuality in the assessment interview. This is somewhat ironic. Gender has been termed “omni-relevant” to human interactions, dictating some of our most fundamental understandings of people and our uses of language (Klein, 2011). Of gender, Brown (1990) states, “There are few other variables that are persistently present in the lives of humans and that cross all bounds of race, class, and place” (p. 13). Yet, surprisingly little has been discussed of these issues in the literature. Most writing about clinical interviewing is done for the purpose of training students and new professionals, and thus provides only broad overviews of formats and styles of interviewing, with very little attention paid to sexual orientation and gender. Writings on the pedagogy of clinical interviewing emphasize the teaching of global knowledge, skills, and attitudes, omitting discussion of how to instruct students to address important issues such as gender, race, class, and so on (i.e., Rudolph, 2005). With so little written about such fundamental aspects of clients’ identities, one wonders at how easy it is for important issues of gender and sexuality to hide in plain sight—right in front of us—in our conversations, our interviews, our measures, and in our interpretations, without perhaps ever looking for it, or ever finding it.
The identity variables of gender and sexuality, while interrelated, are often confused and conflated. Erroneously, practitioners may make generalizations or assumptions about one portion of a client’s identity based on the other; for example, assuming that a transgender man primarily experiences sexual attraction to cisgendered women. Such assumptions and confusions are results of cultural imperatives that have long taught us, falsely, that gender is the singular determinant of sexual orientation, that our biological sex determines our sense of gender, and that all of us belong to one of two fixed and uniform genders (see Chapter 1 for a more in-depth discussion of these points). Indeed, today we are in greater recognition that gender and sexuality are separate though related aspects of one’s identity, that they both are complicated and nuanced in innumerable ways and are critical to understanding one’s personality (Goldner, 2003; Harris, 2005; Hays, 2008; Nichols, 2011; Suzuki & Ahluwalia, 2003; Suzuki, Onoue, Fukui, & Ezrapour, 2012).

In this chapter, I pursue several goals. First, I will discuss the importance of the assessor in the clinical interview, detailing how evolutions in thinking about the nature of the assessment process now encourage us to consider how the personalities of assessors, including their own genders and sexualities, are inevitably relevant and influential in how assessment data are formulated and take shape. These newer, intersubjective (Finn, 2007) models of assessment have important implications for the clinical interview, most importantly that assessors must do more than ask questions in order to conduct an effective and responsive clinical interview. Second, I will review writings on gender and sexual orientation as they pertain to the clinical interview, further illustrating the importance of the assessor’s presence and role when with their clients. In reviewing these works, I will show how they similarly demonstrate that the conventional practice of using predetermined lists of questions is insufficient in ensuring that the assessor has given enough attention to issues of gender and sexuality during the interview—that asking questions alone does not ensure that what may be hiding in plain sight will be found. Third, I hope to offer some general recommendations and suggestions of topics and content areas that assessors might address in a clinical interview. I hope these goals benefit from the inclusion of clinical examples throughout the chapter.

**The Interviewer’s Role: More Participant Than Observer**

Assessors are increasingly recognizing the importance and influence the assessor has on clients, their experience of assessment, the interpretation of test data, and even the data gleaned from the assessment. Much of the current recognition can be traced back to important empirical investigations of examiner influence on testing data, where experimental methods demonstrated that assessors’ behaviors and attitudes, as well as clients’ reactions to the testing process, had observable, measured effects on assessment data and the assessment process (Fischer, 1970; Fiske, 1967; Hamilton & Robertson, 1966). While many such investigations were
conducted in an attempt to eliminate or reduce the influence assessors have on the assessment process, others, notably Fischer (1994), relied on these data to bring about a new, collaborative model of assessment that valued the formation of a relationship with clients over psychometric issues. Where before the assessor’s influence was considered removable or reducible, today there is increasing recognition that the assessor’s influence is inevitable; that is, attempts to try to fully eliminate the effect the assessor has on the assessment process are likely unproductive (Finn, 2007). Assessors are better positioned by accepting the inevitability of their influence and by attempting to understand and explore it.

This development in the assessment field parallels evolutions in contemporary psychoanalytic theory and practice, particularly within the writings of the relational psychoanalytic community (Aron, 1991; Harris, 2005; Hoffman, 1983; Mitchell, 1997). Relational psychoanalysts, heavily critiquing the theoretical and technical tenets of classical and American ego psychology theories, argue that technical ideals such as the therapist’s neutrality and objectivity are impossible standards that often alienate clients and elicit the very kinds of client resistances and defensiveness that were traditionally considered pathological. Today, relational psychoanalytic therapists acknowledge the therapist as an inevitable participant in the treatment relationship and whose very person and character has a role in determining the kinds of clinical data observed in the treatment relationship. As such, relational practitioners place high value in countertransference as a route to understanding clinical process and additionally suggest that therapists often become unwitting participants in enactments of clients’ interpersonal dramas in the treatment relationship. As relational therapists eschew objectivity as impossible, they continually question their subjective impressions and thoughts and often reveal them to their clients in the spirit of collaborative understanding.

Finn (2007), borrowing from one component of relational psychoanalytic writing, intersubjectivity theory (Stolorow & Atwood, 1992), recently described the kinds of consequences of adopting similar understandings for the assessment process. He wrote: “Assessors can never escape the influence of their own subjective views on their perceptions of their clients” and “one can never fully know the extent or nature of one’s contribution to an interpersonal context, although one can be open to and curious about such factors” (p. 244). Assessors, according to Finn, are continually bound by their own subjective ways of feeling, experiencing, and interpreting the world around them, and this has inevitable, and often unclear, effects on their work with assessment clients. It is important to add here that assessors’ subjectivity includes her own biases, anxieties, conflicts, and assumptions, and while assessors may possess considerable self-knowledge and insight, there is always the possibility that they come to appreciate something new and important about themselves, their clients, and their assessments, by continuous self-reflection and inquiry.

These changes in the conception of the assessment process challenge long-standing views of assessment as a procedure that is done to a client, as well as assumptions that the person of the assessor is irrelevant or unimportant.
However, even today, such “one person” views can be found endorsed or evident in writings about the assessment process generally and even the clinical interview specifically. This is especially the case in the writings of authors who place diagnosis as the primary goal and purpose of the clinical interview (i.e., Rogers, 2003; Widiger & Samuel, 2009). One illustrative example can be seen in the work of Craig (2005). Of the clinical interview, he writes:

> The conversation is focused on the patient and is often unidirectional. The relationship is primarily professional, and it is intimate only to the extent that personal material is conveyed with the expectation that such material is protected ethically and legally from evidentiary discovery (i.e. confidential).

(italics added, p. 21–22)

Craig’s view of the clinical interview is in stark contrast with collaborative (Fischer, 1994), therapeutic, and intersubjective (Finn, 2007) sensibilities. Craig’s description suggests that the examiner communicates little about herself, her attitudes or biases, or her character during the interview. This is a questionable proposition. As many clinicians have repeatedly noted (Aron, 1991; Hoffman, 1983; Silverstein, 2011a; Singer, 1965), almost every action taken by the assessor reveals something about her, however large or small. The decorations (or lack thereof) of her office reveal her tastes in art, or perhaps the members of her family. The manner in which she speaks and interacts with her client might reveal her mood that day or her level of enthusiasm for meeting with her client. The questions she asks reveals what she finds interesting, important, or worth additional inquiry. The questions she doesn’t ask reveal what is uninteresting, unimportant, or not considered—and so on. I would suggest, in keeping with Finn’s (2007) adoption of intersubjectivity, that the communication between assessor and client during the interview is bidirectional, though the explicit communication may be largely unidirectional. Clients are capable of observing assessors as closely as we are of them; and as we are able to notice their passions, predilections, and prejudices, so too are they of us. Many assessment professionals appear in agreement with this proposition. Lanyon and Goodstein (1997) acknowledge that assessor cues are often present in an interview and can dictate the outcome of the interview. Baker and Mason (2010) have specifically noted how an assessor’s biases are revealed through any variety of means, including nonverbal body language.

Second, and equally important, Craig’s (2005) description of the interview suggests that the intimacy of the interview is moderated by the client’s expectation of confidentiality. Although clients are more likely to disclose intimate details of their lives when they have the expectation of confidentiality, I would suggest that the most important moderator of intimacy during the interview is the extent to which the assessor is comfortable being with the client. Part of what assessors can unwittingly reveal about themselves during an interview includes how comfortable they feel with the client, having either encouraging
or suppressing effects on clients. Bandura, Lipsher, and Miller’s (1960) often-cited study of therapist reactions to clients’ hostility demonstrated that clients reserve important reactions and emotional expressions from therapists who implicitly communicate their discomfort with those same reactions.

These arguments show why thinking that the clinical interview is not intimate or that communication in the interview is unidirectional is problematic: When an assessor conceives of herself as simply an observer, there is little incentive for her to be in constant circumspection of reactions and participation with the client, and thus risks enabling patterns of interaction that actually suppress productive and useful dialog and/or alienate or trouble her client. She may never have reason, for example, to question if she is not asking enough about certain topics because of her own discomfort; or, conversely, question if she is asking too much about other topics because she finds them exciting or alluring. She does not ask if her client’s hesitation to respond is because of something disturbing to the client in their interactions or in the assessor herself—instead, the client’s hesitation registers only as defense, anxiety, or guardedness. Without this ongoing monitoring of self, client, and the interaction between, the interviewer runs the risk of losing so much important data and perhaps damaging the overall assessment. Indeed, some have proposed including such monitoring of self as a criterion for evaluating a student clinician’s ability to conduct an effective clinical interview (Rudolph, 2005).

Recognizing the influence of the assessor during the clinical interview is especially relevant to considerations of gender and sexuality. An assessor’s personal uncertainties, discomforts, generalizations, misconceptions, familiarities, and even expertise—concerning gender and sexuality or otherwise—can emerge in any number of ways during a clinical interview and thus influence the clinical process. Hays (2008) identified a framework useful to clinicians in trying to help them better understand both their clients and themselves. She suggests that clinicians utilize her ADDRESSING framework (see Chapter 2) to conduct a self-assessment that helps identify important aspects of the clinician’s identity, including gender identity and sexual orientation. This critical beginning stage involves asking oneself questions such as “How might my sense of my gender perhaps have left me unaware of how other people experience their own gender?” or “What if my sense of my gender were different? How would I feel about that?” Inquiries such as these create space for therapists and assessors alike to think more deeply about such issues and begin to contemplate how their own complex identities likely emerge and interact with those of their clients.

The importance of attending to the process of the clinical interview is a theme found in the existing assessment literature on gender and sexuality. As I move on to present these works, the theme of a mindful, active assessor who questions his or her personal biases, prejudices, and clinical activities will emerge as a consistent recommendation. The model of passive observer who reads questions from a list is discarded as insufficient; rather, assessors must acknowledge
they are participants in the interview and that the nature of their participation makes quite a difference.

**Gender and the Clinical Interview**

Much of the existing writing concerning gender and psychological assessment involves addressing gender bias. The first (and only) author to explicitly discuss gender with regard to the clinical assessment interview was Brown (1986, 1990). Brown (1986) first wrote about gender and psychological assessment generally, advocating that assessors conduct “gender role analyses” with each of their clients, in an effort to “enlighten the assessing clinician regarding the impact of her or his own biases regarding the meaning of gender-role-related behaviors” and to “aid in separating out gender-role-appropriate behaviors from psychopathology” (p. 244). Much of Brown’s concern regarded the potential for assessors to inappropriately pathologize behavior that contradicted prevailing societal and cultural understandings of gender; for example, she identified the possibility that women who are comfortable with conflict and exercising interpersonal power could be unfairly or inappropriately judged as evidencing “domineering” personalities (Brown, 1986).

She suggested that clinicians conduct a detailed inquiry into how clients developed their sense of gender and gendered behaviors, covering a wide range of topics about the context in which the client developed, including the following: family roles of women and men in the client’s family of origin, class backgrounds and education of parents, class and cultural difference between parents, wantedness of children, including the client, and how gender may have been variable in the wantedness of any given child (Brown, 1986). Part of what Brown hopes to learn in exploring these topics is how the client internalized and added meaning to each of these important contextual and developmental influences, including how the client came to attach meaning to gender. She suggested that assessors should “critically question and examine the meaning of gender roles, both in the culture in general and for a specific client” (p. 248), as a way to prompt assessors to widen their understandings of gender with each client with whom they work and to loosen themselves from their own gender biases.

In a second paper, Brown (1990) specifically addressed gender and the clinical assessment interview, reiterating her concern about the potential for assessors’ disowned biases to operate outside of their conscious awareness, possibly leading them to render unfair or overly pathologizing judgments about interview data. She elaborated her earlier recommendations, depicting the gender-conscious assessor as taking proactive steps to address bias and to conduct more thorough interviews. She suggested a series of “preassessment” steps assessors could take to prepare for their interviews, including familiarizing themselves with scholarship on gender and its relationship to clinical judgments of mental health, becoming knowledgeable about experiences that occur at higher base rates in one gender than another (i.e., domestic violence, sexual assault), and understanding
the impact of those experiences on the entire gender. In addition, she recommended that assessors, before conducting an interview, examine their own conscious and unconscious biases and expectations regarding gender, a process that might even include consultation and supervision from colleagues who are known for or experienced in thinking about gender issues.

During the interview, Brown (1990) advocates for assessors actively inquiring into clients’ meanings of their gender, including the meanings of gender in their families and cultures of origin. She suggests exploring the changes in the meanings of gender to the client over the client’s lifespan and inquiring about the presence of gendered high and low base rate phenomena for the client’s gender. She encourages assessors to attend to the presence and meaning of “gender role compliance or noncompliance” (p. 14) and the rewards and consequences of doing so. By this, she means that assessors should consider and inquire about any behavior or trait their client demonstrates or reports that contradicts the cultural and societal expectations generally held for members of that client’s gender.

But Brown’s (1986, 1990) recommendations go further than simply suggesting topics the assessor should inquire about during the interview. It is not enough for clinicians, in her mind, to rely on a series of questions in order to sufficiently address gender in the interview. She does not construe gender as a fixed element of the client’s biography. Instead, she suggests that assessors need to attend to how gender is part of the process of the interview, such as the client’s response to the assessor’s gender and assessors’ own responses to their clients’ genders. She goes further and suggests that assessors should notice “how issues of perceived attractiveness of one party to the other have an impact on the interchange and the assessor’s opinions of the client” (1990, p. 14). The gender-conscious assessor, she writes, “develops hypotheses about the gendered aspects of the interaction between the client and the assessor” (1990, p. 14). In these additional recommendations, Brown is clearly articulating a model of interviewing that demands assessors to reflect upon how their own gender and behavior has influence on the interview process as it is taking place. Brown’s (1986, 1990) works have had a great deal of influence on the area of gender and assessment, being widely cited and discussed within the works of assessors who have written on the topic (Eriksen & Kress, 2008; Smart, 2010; Suzuki & Ahluwalia, 2003; Suzuki et al., 2012; Worell & Robinson, 2009). The following case example illustrates how Brown’s (1990) recommendations can be utilized not only to more thoroughly address gender in the clinical interview, but also how attending to issues of gender during the interview can lead to important nongendered understandings of the client.

**Gender as an Opening for Other Issues: Ann**

Ann was referred for an assessment as part of an evaluation of her mental health disability claim. Ann, a project manager in a consulting firm, experienced severe
anxiety, sometimes to the point of panic, whenever she was required to conduct conference calls and other forms of public speaking. Her anxiety had steadily increased over her career, having its roots in an episode in college when she became nervous during a class presentation and her professor, a man, had noticed and commented on this to the entire class. Ever since that day, she would go to great lengths to avoid having to speak publicly.

Ann was the only female project manager in her firm. In the interview, she spoke about the pressures of being a mother, a caretaker for her ailing mother, and managing the demands of her job, while working among peers who had few of these responsibilities and appeared competent and confident in their work, including their ability to interact with clients and important colleagues. She described going to great lengths to hide her anxiety and depression from her male colleagues, fearing they would view her as weak or inferior. She would skillfully avoid the most intimidating demands of her job by inventing last-minute emergencies that would allow her to delegate or cancel these responsibilities. The fear of her anxiety problems being discovered by her colleagues was so intense that she had managed her work role in this manner for over 10 years, until lukewarm performance reviews and stress finally led her anxieties to reach unmanageable levels, and she was having panic attacks in her office.

As we talked about her struggles and as I listened to her repeat the theme of how concerned she was about her male colleagues’ judgments of her, I realized that she had been revealing to me, a male, all about these worries. “I wonder what it’s like to tell me about these struggles you’ve been having,” I said.

“What do you mean?” she asked.

“Well, I’m a man, too, so I just found myself wondering if it’s uncomfortable for you and me to be talking about this, given your concerns about your colleagues.”

“Well,” she thought for a minute. “I do feel embarrassed talking about it with you,” she said.

“Yeah, I had wondered if you might,” I said.

“But it’s not because you’re a man,” she corrected me. “I think it’s because you’re younger than me. You’ve got your office, your busy schedule, and you know what you’re doing,” she began to tear up. “I wish I could have felt so comfortable when I was your age. . . . I’ve been a screw-up all my life!” And in that moment, Ann became incredibly emotional. I was surprised, but I also sensed that it was a relief for her to emote as openly as she was. She moved on to discuss a lifelong trend of feeling incompetent and inferior to many people, including other women in the workplace. In fact, one of her direct supervisors was a woman, and Ann felt deeply inferior in comparison to her.

What is important in this example is that Ann’s narrative seemed to hint that she had understood a good many of her struggles to include something about gender. She felt inferior and judged by her male colleagues who, by her estimation, were confident and capable, whereas she, a woman, was afraid of being discovered incompetent due to her anxiety and lack of confidence. And indeed,
I believe that gender held many meanings for her in her struggles. However, when I commented on the gendered aspects of her struggle in relation to her interactions with me, more elaborate understandings emerged. I was able to see more clearly how deeply ashamed and inferior she felt in many areas of her life and across her lifespan. Her correction that it was my age, not my gender, which had her in touch with feelings of embarrassment, revealed that her shame and humiliation about her anxieties and self-doubt had much greater, overarching meanings to her. Here, by addressing gender between us, my inquiry had opened up meanings and understandings that were also nongendered.

Other authors also focus on the potential for gender-based bias in the assessment process. Much of what has been written, however, has focused on the assessment of women. For example, in discussing assessment issues with women clients, Suzuki et al. (2012) note that psychologists are inevitably tied to their own cultural and gendered contexts and warn about the potential for assessors’ biases and stereotypes to influence how they conduct themselves with clients. They recommend the use of several structured interviews to minimize the impact of such bias; however, such interviews are not always available, may conflict with the goals of the assessment, and, as Brown’s (1986, 1990) work suggests, do not address the need for assessors to consider how interactions between client and assessor are informed by and reflect issues of gender identity. Worell and Robinson (2009) similarly urge the importance of clinicians attending to gender bias in assessment with women, arguing that clinicians should take great care in exploring and attending to their own internalized gender biases in an effort to reduce the impact of them on the assessment process overall. Smart (2010) provides a series of useful questions that clinicians can use to identify potential sources of gender and cultural biases.

**Sexual Orientation and the Clinical Interview**

The writings on gender have emphasized the importance of attending both to bias and to the interactions between client and assessor that can reveal or illuminate gender issues in the clinical interview. In contrast, authors addressing sexual orientation in the clinical interview write much more on the importance of acceptance and affirmation of lesbian, gay, bisexual, transgender, or queer clients (American Psychological Association [APA], 2011; Donatone & Rachlin, 2013; Dorland & Fischer, 2001; Heck, Flentje, & Cochran, 2013). Affirmation with LGBTQ clients comprises many components; however, most authors agree that the most central and important attitude of affirmation includes the clinician understanding that same-sex attractions, feelings, and behavior are normal variations of human sexuality (APA, 2011; Heck et al., 2013).

Many LGBTQ clients arrive to the clinical interview sensitive to the presence of homophobic or transphobic attitudes in others (Heck, Flentje, & Cochran, 2013). For example, Dorland and Fischer (2001) conducted a study in which LGBTQ participants were asked to read a vignette of a clinical interview.
Some participants were given a vignette that contained heterosexist language; in other words, the vignette contained language that revealed heterosexist assumptions and attitudes in the clinician, such as using pronouns that presumed the fictitious client’s romantic partner was of the opposite sex. Other participants were given a vignette that removed the heterosexist language. Participants who were given the nonheterosexist vignette expressed that they would have greater comfort working with the clinician described and would feel more comfortable discussing issues pertaining to their sexual orientation. Their results demonstrate the importance of conveying an accepting and affirming attitude with LGBTQ clients and how nonaffirming attitudes are easily revealed and detected.

The values of acceptance and affirmation are not simply important to promoting the comfort of LGBTQ clients, however. In a study of countertransference reactions to a female client discussing her sexual problems with her partner, Gelso, Fassinger, Gomez, and Latts (1995) found that their sample of clinicians did not report greater countertransference reactions to a lesbian client than a heterosexual client. Nonetheless, clinicians endorsing stronger homophobic attitudes displayed greater avoidance behavior in their responses to the lesbian client, such as exhibiting silence, disapproval, ignoring the client’s material, and/or changing topics of discussion. This replicated results found in a similar study by Hayes and Gelso (1993) of clinicians’ reactions to a gay male client. The findings of the studies suggest that while homophobic attitudes of the assessor may not produce greater emotional reactions to the client, they may indeed elicit from assessors a behavioral reaction of avoidance, a set of behaviors that can easily undermine the effectiveness of a clinical interview and jeopardize the alliance with LGBTQ clients.

Thus, Heck, Flentje, and Cochran (2013) describe affirmation as a “necessary component” of work with LGBTQ clients, especially in the clinical interview. In a similar manner as Brown (1986, 1990), they regard self-examination of biases and prejudices within the assessor as a necessary first component to developing LGBTQ-affirming attitudes. They suggest that assessors refrain from making assumptions about a client’s sexual orientation, even if a client describes sexual contact or relationships with members of the opposite gender. Because sexual orientation is an identity variable that can be concealed, it is important to remain curious and open about all clients’ sexual orientation and history of sexual experiences. They also note that LGBTQ clients, who are often concerned about discrimination or encountering homophobic or transphobic bias, may directly ask assessors about their own sexual orientation and/or gender identity. Assessors may or may not feel comfortable responding directly to such questions, but they should strive toward providing a response that is affirming of LGBTQ persons in either case. For example, for the assessor who prefers not to disclose, Heck et al. (2013) suggest responding, “I don’t usually share my sexual orientation with clients, but I do want you to know that I affirm and celebrate all types of diversity, and this includes gay, lesbian, bisexual, transgender, and people with similar identities” (p. 26). Similar to Brown (1986, 1990) and others,
Heck et al. (2013) offer a series of self-examination questions for practitioners to help them evaluate their own internalized biases as well as to identify areas of development for better competence in working with LGBTQ clients. Notice, again, that simply “observing” a client’s sexual orientation is not a sufficient action on the part of the assessor. Asking clients about their sexual orientation as if it were as simple as asking them what they had for lunch fails the expectation of an affirming assessor.

Practitioners and scholars are increasingly studying and writing on the topic of asexuality and asexual-identified individuals (Chasin, 2011; Foster & Scherrer, 2014; MacNeela & Murphy, 2015). Individuals who identify as asexual report having little or no sexual attraction to others. As Chasin (2011) notes, asexual-identified persons may still experience romantic attractions and thus pursue romantic relationships that may or may not include sexual activity. Foster and Scherrer (2014) note that many asexual-identified persons encounter prejudicial attitudes from mental health practitioners who ipso facto consider asexuality evidence of sexual pathology. As a result of these kinds of biases, found in both clinical settings and in society at large, many asexual-identified persons find support and guidance from web-based media incredibly valuable and may shy away from seeking services from medical and mental health professionals (Foster & Scherrer, 2014; MacNeela & Murphy, 2015). Chasin (2011) provides an excellent review of important underlying theoretical issues in the understanding and conceptualization of asexuality as a variation of normative human romantic and sexual experience. For clients who identify as asexual (and clients who may exhibit qualities of asexuality but do not identify as such), clinicians should be cautious in their inquiries to reserve clinical judgment and attend to biases that may be guiding their questions and interests in clients’ experiences. Asexual clients find affirming responses from clinicians as helpful, supportive, and indicative of clinicians’ willingness to take their sexuality seriously (Foster & Scherrer, 2014; MacNeela & Murphy, 2015).

Affirmation is also an important component of work with transgender clients. While transgender persons are often included in considerations of lesbian, gay, and bisexual clients, they are identified differently and therefore sometimes neglected or misunderstood by their inclusion with LGB persons (APA, 2008). Whereas lesbian, gay, and bisexual clients are distinguished by their sexual and romantic attractions, transgender persons are distinguished by their experience of their gender as different from or in conflict with their biological sex (see Chapter 1). Transgender is a broad label that includes persons with a wide variety of gender identifications, including persons who reject identifying their gender with a uniform, binary-based term like man or woman (Donatone & Rachlin, 2013; Heck et al., 2013). Such clients may prefer to be addressed by their name and the use of nongendered pronouns, such as “they” or “zie” (pronounced “z”) instead of he/she (Donatone & Rachlin, 2013). Because transgender clients widely differ in their identifications, it is necessary and important to inquire respectfully about their identities. Donatone and Rachlin suggest
beginning with asking the client to identify a preferred primary gender pronoun, or PGP. Because of the wide variety of gender identifications these clients hold, it is important to consider the administrative paperwork given to clients, particularly forms that include gender-based items.

A unique issue that pertains to clinical interviewing and assessment with transgender persons concerns access to medical interventions to address gender identity (Donatone & Rachlin, 2013). Many medical professionals follow the World Professional Association for Transgendered Health (WPATH) standards of care (Coleman et al., 2012), which detail the need for mental health professionals to provide assessments of transgender persons mental health and related recommendations before clients can receive hormone therapy or surgical interventions to bring their gender identities and physical sex characteristics into agreement. Interviewers conducting an assessment for this purpose should carefully read these guidelines, as a psychological assessment involving a large battery of tests may, in some cases, represent a violation of these standards¹ (Coleman et al., 2012). Furthermore, it is important to understand that transgender clients frequently receive questions from people who hold transphobic attitudes about their genitalia, transition status, and intentions to receive hormone therapy or surgery (Donatone & Rachlin, 2013; Heck et al., 2013). For many transgender people, such questions can convey an invalidating attitude or belief that gender is solely determined by the state or quality of one’s genitalia or secondary sex characteristics. Additionally, not all transgender persons wish to pursue such medical interventions. While it is often important to discuss these matters with transgender clients in order to better understand their subjective experiences, clinicians should be mindful about the purpose of their questions and the biases they may reflect. Again, affirmation is an important attitude to inhabit and express during interviews with these clients (APA, 2008; Dorland & Fischer, 2001; Heck et al., 2013).

**Hidden Questions Within the Client: Paul**

Paul is a 30-year-old black woman. When we spoke on the phone to set up the first appointment, I had guessed that Paul was a woman but did not ask more about this, feeling open to many possibilities and content to learn more about the client during our first interview together. When she arrived, she was dressed in men’s clothing and with a very short, clipped haircut. In the interview, she quickly volunteered that she identified as a lesbian and that she was concerned about her struggles in finding a girlfriend. As our conversation moved through discussing her relationship history, I realized that I had quickly taken her identity as a lesbian as sufficient explanation for going by the name Paul. Once I had noticed this, all kinds of possibilities had occurred to me: Had she been named Paul by her parents? Had she adopted the name as part of her lesbian identity? Did she experience gender dysphoria, or, in other words, did she not feel comfortable with her sex?
With this brainstorm of activity, I asked Paul about her name and if it had been her birth name or a nickname of it. Born Tanya, she stopped using her birth name in college when she discovered that she was a lesbian. “I hate that name, please don’t ever call me by that name,” she said.

In an effort to both convey my respect for her request as well as my curiosity about this preference, I said, “No problem. Of course, I will not address you in that way. At the same time, I am struck at what you said about hating your birth name. Could you tell me more about that?”

At first she seemed not able to describe anything more than just distaste for the name. When she offered little more than that, I asked about her choice of the name Paul, what she liked about it, and wondered if there was anything meaningful about her choosing a name typically given to men.

This opened up a wide and rich area of discussion between us. I learned that Paul had always preferred imagining herself as a man and that she often did not correct people when they occasionally misidentified her as a man. “I don’t really do labels,” she said, “but I’ve been curious about transgender people lately and have been wondering about that.” She explained that she didn’t think she was transgender because she couldn’t imagine taking hormones or having surgery, even though she often bound her breasts and enjoyed girlfriends who complimented her on her masculinity. It became evident that an important part for Paul’s growth involved exploring questions about her gender identity and the meanings she attached to gender in her life overall. As we moved on in talking about this during the interview, we discovered that she hated the name Tanya because it had been a reminder not only of her femininity and painful memories associated with not being “feminine enough” during her childhood, but also other important traumas from this period of her life.

I think several elements were key in making our interaction successful. First, I think my comfort and familiarity with gender-variant behavior and qualities in people allowed me to be more aware of my reactions and thoughts to Paul and to be able to use them to identify areas we had not yet discussed enough in the interview. In fact, we might never have ended up discussing these matters, as I could have easily moved on to my next series of standard questions. Second, I think my expressing my respect for Paul’s choice to refrain from using her birth name was instrumental in conveying respect to Paul and my affirming attitude. Third, I think asking Paul about her feelings about the name Tanya was the most critical juncture of our interaction. The strength of her request to not be called Tanya might have been enough to elicit anxiety in another assessor, who might not have invited Paul to explain more about her dislike of her birth name, and instead avoided further discussion of the topic. After all, there are many other topics to discuss in the interview. However, had I experienced anxiety in that moment, I hope that I might have considered it a signal that there was something important happening in the moment that could be unpacked and examined further. Last, it is important in moments like these to be aware of
Gender and Sexuality in the Interview

Paul’s case is also useful in demonstrating the complex relationship between gender identity and sexual orientation. While Paul is a woman who identifies as a lesbian and experiences sexual attraction to other women, she is also questioning her gender identity. It is possible that clients like Paul might eventually identify as transgender and may or may not pursue medical interventions. Those who do pursue medical interventions may consider or experience their sexual orientation differently as a result.

Without fail, gender and sexuality overlap and interact, often in complicated and nuanced ways that require careful consideration and thought. One incredibly unique and current contribution to the examination of issues of gender and sexuality in the clinical interview is Silverstein’s (2011b) edited volume, *The Initial Interview: A Gay Man Seeks Treatment*. This is a creative and conceptually rich work that begins with Silverstein, a gay man, presenting the transcript of an initial interview he had with another gay man who is seeking psychotherapy. Subsequent chapters of the book, contributed by a variety of authors representing differing theoretical perspectives, offer discussions of issues raised by the interview presented. While I expect that readers would find the entire volume helpful in demonstrating how issues of sexuality and gender quickly emerge in initial conversations with clients, one contribution in particular is most relevant to the topic I consider here.

Nichols (2011), after reading Silverstein’s interview, provides an in-depth consideration of how the initial interview might have proceeded differently if the client had been a heterosexual man or a woman of either lesbian or heterosexual sexual orientation. She also considers how the interview with the gay male client may have proceeded otherwise if she, a lesbian therapist, had been conducting the interview. Drawing on her own clinical experiences and research on gender and sexuality, Nichols imagines her therapist-client dyads and draws attention to the similarities and differences in the interview that she would expect among them. Her comparisons reveal interesting hypotheses that illustrate how identity variables such as gender can make an important difference in what areas are discussed and explored and how closed or open clients might be. For example, Silverstein’s client, a gay male, reveals in the interview that he suspects he may have been sexually abused by his father and that despite his suspicions, he has never before sought treatment. Nichols (2011) believes that if the client had been female, she would have already received or pursued some form of mental health treatment or support and that the interview would not have been the first time the client would be sharing her experience of abuse. Such observations cogently demonstrate that identity variables such as gender identity and sexual orientation necessarily influence clinical process.

Moreover, Nichols’ (2011) chapter further illustrates how the intersection of client and clinician identity variables is also influential in determining how the clinical narrative shapes or unfolds during the interview. For example, she
imagines when being with Silverstein’s client she would behave much more warmly and maternally, offering the client more encouragement and perhaps revealing more about herself than did Silverstein. She suggests that her feminist inclinations would have her address some topics in the interview in much greater detail, such as the client’s suspicion of childhood sexual abuse, as well as paying greater attention to the client’s reports of suicidal ideation. How such conjecture generalizes to other clinician-client dyads is less important than the theme that Nichols’ (2011) illustration illuminates: The clinical interview will look, feel, and proceed differently based on a variety of client and clinician variables that importantly include both gender identity and sexual orientation.

In summary, it is impossible to adequately consider issues of gender and sexuality in the clinical interview solely by relying on a list of predetermined questions or topic areas. The assessor must be much more active and engaged with these issues during the interview. Assessors must consider their own biases and prejudices, examining how these biases have developed or changed over time and how they may consciously or unconsciously influence their own actions during the interview. Assessors must consider what of their own attitudes and values around gender and sexuality are explicitly or implicitly revealed to their clients and how their clients react to these revelations. They must attend to their own experiences of anxiety and discomfort and use these reactions as a compass that might help them realize the importance of opening up areas of discussion that make them anxious, as this process can often lead to important understandings that are otherwise hidden in front of them in the room in which they sit.

The Assessor’s Gender and Sexual Orientation: Matching Assessor and Client Variables

As much of what I have reviewed already has underscored the importance of the assessor’s attitudes, beliefs, and biases being attended to during the clinical interview, one might raise the question of whether a practice of “matching” assessors and clients on these identity variables makes sense, in an effort to minimize opportunities for bias and discrimination and maximize the likelihood of clients feeling comfortable with the assessor. Indeed, some have suggested that matching assessor and client on these variables, particularly gender, might make a discussion of “sensitive” topics easier (McConaughy, 2013), a practice that some data support. For example, Catania et al. (1996) conducted a study examining the effect of interviewer gender on client disclosure of sexual behavior during an interview. The results were mixed. Offering interviewees the ability to choose the gender of their interviewer did produce interview data of better quality; however, the style of questioning interviewers employed also demonstrated an effect. That is, how interviewers phrased questions, in some cases offering multiple-choice questions to interviewees, allowed greater disclosure and more descriptive responses. Catania et al. (1996) interpret their findings to suggest that matching interviewer and respondent gender when interviewing
about sexual topics is an effective practice, but the individual’s interviewing style is also important.

There is no question that clients often have a gender preference, and sometimes a preference of clinician sexual orientation, when seeking out mental health professionals. Assessors should respect such preferences when expressed by clients or when considering accepting a referral for assessment. In addition, when arranging to accept a referral for assessment, assessors might ask clients if they would feel comfortable working with someone of their own gender, and if comfortable, sexual orientation if the client does not mention such a preference. However, the practice of psychological assessment often occurs in situations where clients and assessors have little flexibility in matching client identity variables; for example, many assessments take place in contexts where the conditions of the assessment are arranged and determined by a third party.

Furthermore, I would argue, the practice of assessor-client matching does not alleviate the need of assessors to attend to their own internalized biases and assumptions. Matching can also lead to an ill-conceived assumption that because the assessor and client share identities on these variables that there is less opportunity for difficulty in the dyad. Assessors of all gender identities and sexual orientations have their own unique experiences, feelings, and conflicts around these identities that are not eliminated because of matching. Last, expression of such preferences can sometimes reflect important aspects of clients’ experiences of their own identities, discrimination, biases, or histories that could be worth exploring.

The following case example illustrates how the assessor’s experience of gender and sexual orientation is activated in the clinical interview, with the consequence of negatively impacting the quality of the interview and the assessment results.

**The Client Reads the Assessor: Frank**

I assessed Frank early in my training, having had some experience with assessment, but I was still very much a novice. Frank was a 19-year-old Mexican American man who had been admitted to an inpatient hospital unit. He had, it seemed, been experiencing auditory hallucinations and delusions. He had been homeless right before his admission, and the referring psychiatrist had wondered if Frank might be faking his symptoms to get off the street for the week. I had received the referral for the assessment from my supervisor, who knew a little about Frank and the referral situation, and together we agreed I might administer the Structured Inventory of Reported Symptoms ([SIRS], Rogers, 2010), a structured interview designed to detect feigned symptoms of mental illness. When I went to meet Frank, I brought the SIRS with me.

After quick introductions, we began the SIRS, me in my button-down shirt and tie, him in his hospital-issued attire. “Do you believe tulips have their own
philosophy?” I ask. “Yes,” he replies, and I know his response is scored in the direction of malingering. A dozen or so questions into the test, Frank interrupts and says, “You know what? I’m hearing the voices again right now.”

“Are you?” I ask, interested, and I can tell he is feeling anxious. “Yeah,” he continues, “they’re telling me that you’re wanting to do something sexual to me,” and as he finishes saying this, he giggles.

Immediately, I was embarrassed. I had not, in fact, been feeling attracted to him, nor had I been thinking sexual thoughts about him. I had, however, been anxious he might sense that I was gay. Whether or not he knew for sure in that moment does not matter. What matters is how it felt in the moment: I felt humiliated. I think it was his giggling that reminded me of so many times when I had been teased, harassed, bullied by others who sensed I was gay before I could ever tell them myself. I felt exposed, embarrassed, and shortly afterward, angry. If this client was faking his symptoms, he was now taunting me (never mind that one could argue that the SIRS is a taunting of the client). I describe my reaction now as though it were crystal clear to me at the time; however, the experience of my feelings in that moment was one of being flooded and disoriented. Without hesitating to understand my reactions in the moment, I tried to ignore them, and we were quickly continuing on with the SIRS. Afterward, my supervisor and I scored and interpreted the SIRS and concluded the client had been malingering.

The next day, I reported to the psychiatrist that there was a good chance the client was malingering. The psychiatrist quickly told me that he disagreed with the findings and suggested I think more about the case. He would treat the patient for schizophrenia and put into place appropriate aftercare plans. In looking back, I think the psychiatrist had been correct: The client was not malingering. By ignoring my reaction, not attending to it enough, I foreclosed too much of my mental capacities to be able to clearly see that the patient had been psychotic, that he had, as many psychotic patients do, possessed an uncanny ability to detect my anxiety, and the consequence had been a strong, unformulated series of reactions that clouded my ability to think and relate to the patient. I did not recover from my reaction during the interview, and today, I strongly question how effectively I had administered the rest of the measure after having been so deeply affected and not having taken the time to regain my bearings. This example clearly illustrates that clients can often, with remarkable ability and accuracy, sense and detect important things about their assessors, including their internal affective states, and that clients’ detections of these states shapes and influences the clinical process.

Specific Areas of Inquiry in the Clinical Interview

While it is essential for assessors to consider how gender and sexual orientation emerge within the interview and how they manage the interview, assessors
should also be mindful of important content areas to inquire about that are specific to gender and sexual orientation. The content areas I include here do not represent an exhaustive list of topics or questions assessors might include in their interviews with clients; rather, they are meant to provide assessors with general guidance and direction.

As a preliminary note, it is important first to know a little about your client’s gender identity and sexual orientation before moving into more gender-specific questions or questions related to specific sexual orientations. Assessors can inquire about a client’s gender identity with questions like, “How would you describe your gender?” and “What is your preferred gender pronoun?” (Donatone & Rachlin, 2013). Similarly, assessors can inquire about sexual orientation with questions like, “How would you describe your sexual orientation?” and “Have you ever had questions about your sexual orientation?” Questions like these open these topics and allow for greater exploration. It is important to be attentive to and respectful of the language that clients use when discussing these issues. Sometimes clients, particularly among those with gender-variant identities or minority sexual orientations, may use language that is confusing or obscure, or in some cases, may exhibit only little familiarity with generally accepted terms. For example, a male client might describe himself as a “cross-dresser,” a term that describes behavior but does not clearly articulate anything more meaningful than his interest in wearing women’s clothing. It does not convey, for example, what his felt sense of his gender is or how he generally experiences sexual and romantic attraction to others. In instances like this one, assessors should try to clarify what their clients are intending to express about themselves and, if appropriate, perhaps offer them more descriptive terms they might use.

**Interviewing Men**

When interviewing men, some authors have noted the importance of recognizing the effect of prevailing attitudes and stereotypes of masculinity that may contribute to how they present during the clinical interview (Person, 2006; Shepard & Rabinowitz, 2013). Specifically, Shepard and Rabinowitz (2013) discuss how some men may experience a kind of shame in conjunction with symptoms of mental illness, as they fear that symptoms and a need for help with them are threats to their masculinity and sense of autonomy. Person’s (2006) work offers a clear illustration of how concerns about masculinity can be powerful among men and how they can inform many kinds of anxieties, including concerns about sexual abilities and sexual endowment. These may be important feelings to keep in mind while interacting with male clients, but these feelings may also be useful to discuss in the interview. Questions like, “How do you view your role as a man?” or “What expectations do you have for yourself because you are a man?” may open up important avenues for exploring feelings and experiences related to concerns about masculinity. It is not uncommon for
Several authors have commented on how gender biases may lead assessors to overlook inquiry in certain low base-rate phenomena with men (Brown, 1990; Burlew & Shurts, 2013; Suzuki & Ahluwalia, 2003). For example, although most research indicates that men are at less risk for disorders of body image like anorexia nervosa or bulimia, it is not rare for men to experience concerns about their bodies and body dissatisfaction (Burlew & Shurts, 2013). Brown (1990) noted that biases about men might lead assessors to fail to inquire about experiences of victimization, such as experiences of domestic violence or childhood sexual abuse.

Neukrug, Britton, and Crews (2013) suggested that clinicians be prepared to discuss common health-related concerns with male clients, specifically citing erectile dysfunction, sexually transmitted diseases, prostate conditions, testicular cancer, diabetes, and accidental traumas and injuries as important topics to not overlook.

**Interviewing Women**

Several authors have proposed important areas of inquiry in working with women. For example, Smart (2010) suggests asking clients to describe their experiences of being women. She suggests asking questions like, “What did you learn about being a woman as you grew up?” and “What kind of messages have you received about being a woman?” She also encourages assessors to ask clients how they feel about other women and their sense of how they are similar or different. She underscores the importance of asking women how they feel their gender impacts their relationships, their feelings about their bodies, and if/how they have benefitted or been limited by their gender.

Worell and Robinson (2009) offer a thorough list of topics for assessors’ consideration when working with women. The topics they suggest include (a) experiences of violence, abuse, and trauma; (b) experiences of being a caretaker of children, friends, and/or parents; (c) medical issues specific to women, including breast and ovarian cancers, and the regularity of visits/checkups to gynecologists; and (d) concerns regarding career and employment, including experiences of sexual harassment and discrimination.

Brown’s (1990) suggestion of inquiring about high base-rate experiences is also pertinent here. For example, women are more frequently the target of domestic violence and sexual assault and, as such, assessors should inquire about these experiences. Some symptoms of mental illness, such as self-injurious behaviors, are also higher base-rate behaviors for women and should be explored. Assessors might also inquire about low base-rate behaviors and experiences for women, such as if they have ever committed a violent crime or been physically abusive toward a partner.
Interviewing Gay, Lesbian, Bisexual, and Transgender Clients

For clients who identify as gay, lesbian, bisexual, or transgender, an important series of questions concerns coming out (Donatone & Rachlin, 2013; Heck et al., 2013; McConaughy, 2013). It is important not to presume that a client who identifies as LGBTQ has come out to persons outside of the consulting room. “Are you out?” is an appropriate question that can lead to other important areas for discussion, including when clients first realized their LGBTQ identity, to whom they have come out, and what their experiences of coming out were like. These experiences are often formative for LGBTQ clients and frequently relate to the extent to which they feel comfortable with their LGBTQ identities (Heck et al., 2013). Furthermore, it is important to note that there is wide variation in when LGBTQ individuals begin to identify as such. For example, many women have been known to live and identify as heterosexual before coming out as lesbian later in life (Heck et al., 2013). For all LGBTQ clients, it is important to assess the level of support they receive from friends and family members, both within and outside of the LGBTQ community. For some LGBTQ clients, disclosing these kinds of information can be difficult; in fact, for clients who struggle with especially high levels of internalized shame and/or with histories of harassment and discrimination, assessors may find that these data emerge slowly in the assessment process—in subsequent discussions or in follow-up interviews.

Additionally, it is important to ask LGBTQ clients about experiences of discrimination, harassment, or bullying throughout their lives, as these are frequent and damaging events these clients may have faced (Heck et al., 2013; McConaughy, 2013). The consequences of such experiences are profound and place LGBTQ persons at greater risk for substance abuse, self-harm, and suicide. In addition, while gay men are not more likely than heterosexual men to engage in unprotected sex, they are at greater risk for sexually transmitted infections. Careful and sensitive questioning about these behaviors can lead to important information regarding clients’ self-esteem, shame about sex, and concern for their own physical health (Nichols, 2011). Women, in contrast, are more likely to report minority stress related to family issues (Lewis, Kholodkov, & Derlega, 2012). Suicide and self-injurious behavior is an important area for questioning, especially among clients who have reported experiences of harassment and bullying.

Heck et al. (2013) correctly note that many bisexual persons experience a particular kind of marginalization due to their sexuality, feeling they neither fit in with gay or lesbian nor heterosexual communities; instead, many bisexual persons feel their sexuality is frequently misunderstood by most people. One particular idea that is harmful to bisexual persons is an assumption that their identification as bisexual is a label of convenience, meant to avoid a more shameful and marginalizing identification as gay or lesbian (Heck et al., 2013). To avoid hurtful assumptions or judgment from members of the LGBTQ community,
bisexual persons might selectively disclose their identity and “pass” as heterosexual. This is why it is important for assessors to remain open to the possibility that all of their clients may have experiences and relationships with members of either sex and make no assumptions about clients’ sexual orientations (Heck et al., 2013). Additionally, assessors might ask clients how they feel about their bisexual identity and if they have struggled to feel understood by others.

Donatone and Rachlin (2013) provide an excellent overview of considerations for interviewing transgender clients. As terminology is complicated and nuanced with transgender clients, it is important to inquire about the client’s preferred terms, identifications, preferred name, and pronouns. Exhibiting interest in and curiosity about a transgender person’s history of gender identifications and development can open up a wide range of issues that can be important to better understanding the client. Binding of the breasts is a common practice among transgender men who wish to reduce the appearance of their breasts. For clients who bind, it is important to ask about their binding habits, including if they have had any medical problems associated with the practice (e.g., bouts of dizziness or difficulty breathing from binders that are too tight) (Donatone & Rachlin, 2013).

For transgender clients, gender transition is an important process that involves planning and implementing a lifestyle change from living as a member of one gender to another. Not all transgender clients have interest in or intend to pursue a transition. One way to open the topic for discussion is to ask, “Do you have an interest in transition?” or “Have you undergone a transition?” For clients who indicate a wish to transition, asking if they have a plan for transition can open discussion about a variety of possibilities, including hormone therapy and surgery and legal proceedings to have a new gender recognized (Donatone & Rachlin, 2013).

**Conclusions: Returning to Alexandria**

Considering gender and sexuality in the clinical interview is a complex aim that requires significant attention, thought, and reflection by the assessor. While some practitioners might argue for a well-regulated, structured approach to ensure that all relevant topic areas are inquired and that opportunities for assessor bias and prejudice are limited, I believe the recommendations and ideas described in the literature are in opposition to such practices. Gender and sexuality are complicated aspects of human identity and experience, but they can be easily swept over as though they are simple and uncomplicated facts. It is easy to miss what is “hidden” right in front of us. To avoid ignoring key identity facets of the client, assessors must acknowledge their own participation in the clinical interview, which includes their own anxieties, beliefs, biases, and conflicts about gender and sexuality, as well as race, ethnicity, age, and class. Assessors must consider how their own gender and sexuality influence how the interview takes shape, monitoring how issues of gender and sexuality are discussed in the interview and how it feels to address them explicitly and implicitly. While arriving to an interview with a list of prepared questions or topic areas is useful to ensure that important
issues are not overlooked, this activity alone is not sufficient. Assessors must carefully monitor their own biases as they are discovered or lost in the interview and work toward affirming clients who encounter such biases regularly.

These remarks bring me back to Alexandria. I had realized when interviewing her that I had felt that she seemed to lack anything feminine about her, and that, for whatever reason I could not determine in the moment, her lack of femininity disturbed me. I quickly judged her gender presentation as odd and off-putting. In observing these reactions, I began to question myself, concerned that I was perhaps unfairly holding Alexandria to a standard of gender that was arbitrary.

Unclear on what to do with my reactions, I held them in mind and allowed the interview to unfold. After awhile, we began to talk about dating and relationships. Alexandria explained that she had never been on a date, nor had any interest in dating, and that she found the idea of love and marriage terribly archaic and useless. She explained that she really didn’t experience any interest in sex and was perfectly content living her life as a single woman. I asked her what she thought about her sexual orientation, and she explained that she wasn’t quite sure; she really didn’t find in herself any attractions or fantasies about members of any gender. Slowly, my initial reactions about her seemed to make sense, even though, paradoxically, I was becoming more confused and puzzled about how to understand Alexandria. Our conversation was going well, though, and I sensed we had established a comfortable rapport with one another. Eventually, I asked her, “I guess I find myself wondering a little bit about how you feel about being a woman?”

She shrugged her shoulders simply and said, “I guess it’s okay. I don’t really enjoy girly stuff or anything like that, but I’m happy to be a woman. Just don’t ask me to wear a dress.”

We laughed a little bit together, and while I asked more about her feelings about being a woman, how she felt about other women, and if she ever felt like she stood out from other people, I can’t say that I ever felt that I fully understood what to make of my reactions to Alexandria. Ultimately, the assessment led us to a diagnosis and a description of her personality that helped to explain some of her struggles. But at the end of our work together, despite my efforts, I still feel like there was something very mysterious about Alexandria. And, I am satisfied with that outcome. In the end, assessors, I think, should feel comfortable with some uncertainties, even after we’ve completed a careful and sensitive assessment of our clients.

**Practical Points**

- An effective clinical interview requires assessors to do more than ask questions; in addition, they must consider how their own personal feelings, fears, hopes, biases, and conflicts shape and influence their participation in the interview, and consequently the kinds of data that emerge.
- To effectively consider gender and sexuality in the clinical interview, assessors must strive to be aware of their own biases, stereotypes, discomforts, and prejudices that concern gender and sexual orientation.
Assessors should attend to how their clients presenting concerns involve or relate to issues of gender and sexuality, and how the assessor’s gender and sexual orientation may influence how these matters are discussed in the interview.

Effective assessors consider both high and low base-rate experiences and behaviors among members of different genders and sexual orientations and strive to inquire about both during the interview.

Assessors should strive toward attitudes of affirmation toward members of the LGBTQ community or decline referrals of these clients. When interviewing LGBTQ clients, assessors should convey their affirmative stance explicitly.

Assessors should consider important content areas specific to their client’s gender and sexual orientation and make efforts to ask questions of the client in these areas.

Annotated Bibliography


Comment: Brown’s specific discussion of gender and the clinical interview is a useful and accessible primer in identifying the need for attending to gender issues in the clinical interview. She offers a useful outline to help clinicians consider important aspects of the clinical interview process and how they intersect with gender.


Comment: The discussion of the initial interview with transgender clients provided by Donatone and Rachlin is an incredibly useful guide that will quickly familiarize readers with the unique needs and areas of concern among transgender clients. The authors provide affirmative and supportive questions that are sensitively worded and easily adapted for practice.


Comment: Heck, Flentje, and Cochran provide a very helpful introduction to interviewing LGBT clients and address specific areas of focus or concern for gay men, lesbians, bisexuals, and transgender clients. A continuous emphasis is placed on affirmation, which is helpful in that they convey how to express affirmation and support clients while discussing important concerns relevant to these communities.

Note

1 The WPATH standards of care heavily emphasize an informed consent–based model of access to such medical procedures. The eligibility criteria do not mandate that clients be free of mental illness or psychological distress before referral for medical interventions; as such, some might view the administration of a full battery of psychological measures with transgender clients who present with little or few indications of mental illness a practice at odds with the standards. The standards of care are also available online at http://www.wpath.org.
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References


Gender and Sexuality in the Interview


A FRAMEWORK FOR CONSIDERING GENDER IN THE COGNITIVE ASSESSMENT PROCESS

Mary T. Rourke and Ellen Bartolini

Much attention has been given to the issue of sex or gender differences in intellectual ability. In the past several decades, teams of researchers have published volumes on purported gender differences in overall intellectual ability or differences in specific intellectual domains such as verbal or spatial ability (Lynn & Kanazawa, 2011). Other researchers have presented data denying such differences or minimizing functional significance of the small, though statistically significant, differences found by others (Hyde, 2005; Spelke, 2005). Additionally, researchers have argued, or refuted, that gender differences are a result of greater variability found in male versus female scores on intellectual ability measures (e.g., Feingold, 1994; Spelke, 2005). While there is some consensus in small areas, the discussion of what differences exist in intellect between men and women continues, and is unlikely to be solved definitively in the very near future.

Certainly, gender and related constructs are commonly acknowledged to be critical components of one’s identity, and they are therefore relevant to all aspects of cognitive and personality assessment:

People are both told how to be either male or female and experience themselves through the lens of their gender, informing themselves about how to be female or male humans. . . . [O]ur behaviors toward others and responses that we elicit from them occur in a gendered context and are likely to be both constructed and experienced by us as gendered in some way.

(Brown, 1990, p. 13)

As often visible and ever-present aspects of one’s self, gender and gender identity shape our behaviors and interactions with others, our appraisals of
ourselves and our own behaviors, how others interact with us, and how others appraise the appropriateness or adaptability of our behaviors (Brown, 1990). Perhaps even more than two- or three-point differences on a measure of specific intellectual ability, then, this aspect of gender clearly has the potential to be operative in the cognitive assessment process in both subtle and clear ways. For example, patterns of referral for intellectual assessment—often made when someone in a client’s context notices a concerning area of underperformance—may be made based on gender-informed or biased expectations, and an assessor’s understanding of the referral issue might be similarly affected. The assessment situation is a social interaction, insidiously informed by cultural expectations; it may also shape behavioral and interpersonal patterns that could affect a client’s performance on a measure, the assessor’s scoring or interpretation of results, or how the results of the assessment are presented to the client (Ardila, 2005; Brown, 1990; Hyde, 2005). In addition, an assessor’s and/or a client’s gender-related beliefs may affect how data from an intellectual assessment are used to inform academic/educational or occupational paths.

Despite these issues, and despite references to the cultural and sociological implications of sex differences (or lack thereof) in the existing literature, the literature offers less guidance on how clinicians who perform cognitive assessment might conceptualize gender-related constructs and how they might practically integrate a gender-informed conceptualization into their cognitive assessment practices. Given the centrality of gender in these processes, it is surprising that a careful and explicit consideration of gender remains on the periphery of intellectual assessment (Brown, 1990). This chapter attempts to address this gap. We will briefly review the status of the literature on documented sex and gender differences in cognitive ability, with an eye toward understanding functional implications of what we know to be comparable or noncomparable among people of varying genders. We will then begin the process of developing a framework for understanding how gender might be operative in all aspects of the cognitive assessment process.

For decades, the only research examining male and female gender and gender identity has conceptualized of gender as a simple binary. Only in recent years have researchers begun to approach gender as a concept that is more fluid (e.g., Dragowski, Scharron-del Río, & Sandigorsky, 2011). Though work in this area is increasing, there are still very small numbers of studies of the specific cognitive needs of gender-diverse individuals; indeed, a review of the psychology and education literatures found no empirical work that explored gender fluidity and ways in which nonbinary conceptualizations of gender might relate to cognitive assessment or cognitive performance. Our conceptualization is necessarily limited by the available research, though, where possible, we will draw on the available research and include relevant considerations, as well as our own hypotheses, in this chapter.

For sake of clarity, we offer the following definitions to the terms used in this chapter. We use “biological sex” to refer to maleness or femaleness defined by
Sex Differences

The idea that males and females may show innate differences on tests that measure intelligence dates back to the earliest days of intellectual assessment. In a review of the history of IQ testing, Herrnstein and Murray (1994) suggest that while psychologists have searched for sex differences in measured IQ, early reports indicated no significant differences in global IQ between men and women (Lynn & Kanazawa, 2011). The long history of research has documented small but statistically significant differences in male and female scores on specific, focused measures of cognitive function. In general, females have been documented to score higher on measures of verbal ability and social/interpersonal reasoning, while males have outperformed females on measures of spatial and mathematical ability (Halpern, 2000; Maccoby & Jacklin, 1974; Wilder, 1996).

Recent studies continue to document very small differences between males and females on specific cognitive tasks, and while there is some consistency in the direction of the differences, there are also some differences across studies. For example, in a study of 788 monolingual Spanish-speaking children ages 5 to 16, researchers identified small gender differences in three of the seven neuropsychological domains assessed. Boys outperformed girls in oral language, spatial ability, and visual perception, while girls outperformed boys in tactile perception (Ardila et al., 2011). The authors were careful to note, however, that the differences, while statistically significant, were in only a few of the domains assessed and were likely to be not meaningful clinically, accounting for only 1–3% of the variance in scores and representing only small actual differences.

Similarly, Gur et al. (2012) administered a neurocognitive battery via computer to a very large sample of 8- to 21-year-olds, with a goal of assessing executive function, memory, complex cognition, social cognition, and sensorimotor speed. Overall they found small but significant differences, with girls outperforming boys in attention, word/facial memory, reasoning speed, and all social cognition variables. Boys outperformed girls in spatial processing, sensorimotor speed, and motor speed. The patterns in scores mirror findings among adults, but again the researchers caution that the effect sizes are small (ranging from .10–.33 of a standard deviation; Gur et al., 2012) and may not be functionally meaningful.

The search for global differences in intellectual ability also continues, after a long history of contradictory research. Lynn (1994) proposed a developmental approach to understanding overall differences in global intellectual function, suggesting that developmental differences in the maturation of intelligence led
A Framework for Considering Gender

to age-related differences in IQ. He presented data suggesting that prior to age 16, girls demonstrated a small IQ advantage over boys, likely due to earlier female maturation of cognitive function. After age 16, however, he documented that males develop a small, but growing IQ advantage over females, which stabilizes in early adulthood, leaving a four- to five-point difference between male and female global IQ (Lynn, 1999; Lynn & Kanazawa, 2011).

Although Lynn’s developmental approach raised important questions about the relationship between maturation and intellectual functioning, other researchers have critiqued various aspects of his methodology, noting that his studies may have been influenced by potential sampling biases and the use of inadequate statistical measures. Additional researchers have attempted to address these issues and have found conflicting results. For example, in a study of 7- to 18-year-olds, using Raven’s Progressive Matrices, which have been hailed as a stronger measure of global intelligence than the series of other measures used in Lynn’s studies, no sex differences emerged in either the 7- to 14-year-old age group or the 15- to 18-year-old age group (Savage-McGlynn, 2012), suggesting that Lynn’s developmental hypothesis was not accurate and that there are no significant differences in global aptitude. On the other hand, in an examination of the WAIS-III standardization sample, males outperformed females on global intelligence, as well as on the Information, Arithmetic, and Symbol Search subtests (females outscored males only on Processing Speed; Irwing, 2012). While the age range of the sample did not allow a developmental analysis, it did confirm a small but significant advantage in overall g to adult males, with effect sizes ranging from 0.19–.022.

The difference in overall intelligence between men and women has also been attributed to a wider variability in male intelligence scores, with more males falling at either end of the intelligence score distribution (Feingold, 1994; Lynn & Kanazawa, 2011). While this variability has been in evidence in some studies, neither the study using Raven’s Progressive Matrices (Savage-McGlynn, 2012) nor the study of the WAIS-III sample (Irwing, 2012) offered evidence of different variability in male versus female samples, leaving the idea of differing variability of scores across sex unresolved.

Claims of sex differences in intellectual ability are presumed to be related to innate biological differences (e.g., Spelke, 2005). While there have been genetic explanations for overall intellectual abilities, there has been no solid evidence that sex differences in IQ are substantially linked to genetic causes, outside of sex-linked syndromes that have known cognitive components (Wilder, 1996). Many researchers have suggested that hormones result in differential brain development and could therefore result in different cognitive ability profiles, though the evidence linking hormonal differences to specific patterns of cognitive performance is inconsistent (Halpern, 2000). Increasingly, with the advancement and increasing availability of imaging technologies, researchers have been working to document structural brain differences and to relate these to performance on cognitive measures. Ingalhalikar et al. (2014) documented gender differences
in brain structure, with stronger within-hemisphere connections in males and stronger between-hemisphere connections in females. While they link these differences to the behavioral sex differences observed in other studies, they do not measure behavior/cognitive performance in their study. Using functional magnetic resonance imaging (fMRI), research has linked executive function and memory to differences in brain volume (Gur et al., 2000) and has identified specific brain patterns common to individuals with reading disability (Shaywitz, Lyon, & Shaywitz, 2006). While both executive function difficulties and reading disabilities are often more prevalent in males (American Psychiatric Association, 2013; Hawke et al., 2009), these studies do not specifically explore gender differences in brain function and do not include considerations of gender differences in brain function in normative populations.

One method of linking sex differences in cognitive performance to biology is via cross-cultural research. Sex differences resulting from human biology should be evident in both U.S. and cross-cultural samples. Feingold (1994) reviewed seven samples assessed across six nations between 1980 and 1994, and examined variability of male versus female scores on valid measures of intellectual ability. He found no consistent gender differences in variability of scores across the international samples. In all samples, variability on verbal tasks was comparable between genders, as is the case in most U.S. samples. In some countries (e.g., England, Sweden, Australia, Peru), male variability on math and/or spatial tasks did exceed female variability, but in other countries (e.g., Scotland, Egypt, Taiwan), female variability was greater. Feingold (1994) concluded that while there are occasional differences in variability, the differences are likely not related to biological factors.

In another consideration of the notion that males and females may have unequal cognitive capacities for math and science, Spelke (2005) critiques three claims that are central to the sex differences argument. She presents evidence that challenges the idea that boys are neurologically prepared to attend to objects and mechanical relationships, while girls are prepared to attend to social relationships. Instead, she reviews research indicating that infant boys and girls are similarly equipped to process all kinds of information. Second, she refutes the claim that boys have a genetic advantage that facilitates their processing of complex mathematical reasoning. Spelke (2005) presents research that indicates that while boys and girls may automatically use different strategies for problem solving, by any number of indicators, male and female basic competence and abilities are comparable. Finally, she suggests that differences in the variability of math ability scores that place more males in the higher ends of the distribution are artifacts of the methodology used; she goes on to review research that indicates that at the high school and college levels, males and females learn complex mathematics equally well.

Similarly, in a review of meta-analyses of sex differences, Hyde (2005) found that effect sizes were small in those studies that did find sex differences. Overall, more than three-fourths of the studies in the meta-analyses she reviewed had a
small or close-to-zero effect size; when looking only at cognitive variables, more than 80% of the studies demonstrated a small or close-to-zero effect size. Hyde interprets her findings as evidence for the gender similarities hypothesis, which suggests that the binary genders are more alike than they are different, and that the small differences documented do not translate to functional differences in aptitude.

Each of the aforementioned studies approaches the question of gendered cognitive differences from the framework of biological sex. Very little research to date has explored the relationship between gendered variables, beyond those related to biological sex, and IQ. One such study looked at IQ as it relates to gender nonconformity and sexual orientation (Rahman, Bhanot, Emrith-Small, Ghafoor, & Roberts, 2012). Using the National Adult Reading Test as a proxy for IQ, researchers obtained retrospective reports of childhood gender nonconformity (apparent very early in life and presumed to be more of an innate variable) from samples of gay men and heterosexual men and women. They found no IQ differences based on sexual orientation and found no associations among IQ, childhood gender nonconformity, and sexual orientation. For heterosexual men and women, however, they did find gender nonconformity related to IQ. Heterosexual men who were more feminine (higher gender nonconformity) had higher verbal IQ, while heterosexual women who were more feminine (lower gender nonconformity) had lower verbal IQ. The authors caution that, as in research on sex differences in IQ, the differences in their study were very small. Despite the small differences found by Rahman et al., this study suggests that an important avenue of research (the relationship between cognitive ability and gender identity) is yet to be explored.

What is to be made of the consistently replicated findings that males score (slightly) higher on tests of math and spatial reasoning and females score (slightly) higher on tests of verbal ability and social cognition? Proponents of the gender similarities hypothesis warn that these differences are gender differences, not sex differences, that they represent differences in attitude, not aptitude, and that interpreting them in any other way carries a significant (and dangerous) risk of reifying gender stereotypes (Halpern, 2000; Hyde, 2005; Spelke, 2005).

The belief that males and females may have different levels of innate ability in different areas could be relevant to the assessment process in many ways. Believing that females may “lag behind” males in math, science, or spatial reasoning may reinforce cultural beliefs about women’s ability to succeed in certain science, technology, engineering, and math (STEM) professions (Eccles et al., 1999; Spelke, 2005) and may shape coursework and career trajectories for both genders (Hyde, 2005). Patterns of referral for special education or gifted programming both for boys and girls could differ based on a belief that boys or girls are doing as well as their biology may allow. Females of all ages may feel constrained in demonstrating their cognitive abilities (Hyde, 2005), and these constraints may shape the behaviors that result in a referral for testing or the
behaviors in the test situation itself. Further, the constraints and effects of over-interpreting the functional significance of sex differences affect males as well, who might similarly be constrained to demonstrate, or inhibit, certain cognitive abilities and might also be under- or over-referred for assessment. In short, it is important not to foreclose on an understanding that ascribes male-female differences in cognitive assessment to innate variables: 

[T]he wealth of research on cognition and cognitive development, conducted over 40 years, provides no reason to believe that the gender imbalances on science faculties, or among physics majors, stem from sex differences in intrinsic aptitude....[W]e must look beyond cognitive ability to other aspects of human biology and society for insights into this phenomenon.

(Spelke, 2005, p. 956)

**Sociocultural Explanations of Gender Differences and the Assessment Process**

The evidence for small and possibly inconsequential innate differences between males and females in cognitive ability suggests the importance of exploring sociocultural explanations for the cognitive differences between males and females and in functional outcomes often associated with those areas (e.g., prevalence of women vs. men in STEM professions, gender disparity in SAT Math scores favoring males; Bembenutty, 2008; Perry, 2013; Spelke, 2005). Given that cognitive assessment is often the “gateway” to important educational and occupational decisions and pathways (Ardila, 2005; Bianco et al., 2011; Brown, 1990), it is critical to understand how those sociocultural factors might be evident in various phases of the assessment process. The remainder of the chapter will focus on these issues.

**Gender Issues and Referral for Assessment**

At the core of the discussion of gender differences in cognition are gender role stereotypes, defined as consensual sets of social beliefs about the qualities, abilities, and behaviors that define males or females within a society (Halpern et al., 2011). Gender role stereotypes define what is adaptive in a society for males versus females and set expectations for behaviors by gender. These expectations and definitions often lead people, directly or indirectly, to behave in ways that are consistent with the stereotype that applies to them (Eccles et al., 1999; Halpern et al., 2011). In these ways, gender role stereotypes may simultaneously define gender roles and enforce them (Halpern, 2011).

Ample evidence exists, for example, that teachers hold views that males and females differ in math ability. In an examination of a large, nationally representative database, teachers reliably reported that math was easier for white male
than for white female students (Riegel-Crumb & Humphries, 2012). Similarly, using a large, longitudinal data set of over 20,000 students in the elementary-age range, Robinson-Cimpian and colleagues (2014) found that, among girls and boys with comparable math achievement, teachers rated girls as being less proficient than boys. The study takes the next step of linking teacher beliefs about gender-related differences to actual performance by presenting evidence that underrating girls’ proficiency contributes to increased gender differences in actual math achievement over time.

Parental beliefs about a child’s achievement may also influence a child’s actual achievement. In a longitudinal study of children across a 12-year period, mothers’ beliefs about their children’s math ability predicted children’s beliefs in their own math ability, which in turn predicted the child’s actual math achievement in adolescence (Simpkins et al., 2012).

The links between parent and teacher gender role stereotypes and children’s performance have significant implications for assessment. Most referrals for cognitive assessment in children and adolescents (e.g., for assessment of learning difficulties and for eligibility for enrichment/gifted placement) come through school or parent input. Gender stereotypes could very well influence the decision of who gets referred for assessment. If this were the case, males may be over-referred for gifted assessment or, in vocational arenas, may be overidentified for assessment related to career advancement opportunities, and females more often overlooked. The reverse pattern may be true for referrals related to suspected learning differences or cognitive injury.

There are few empirical studies of assessment referral patterns and their relationship to gender-related variables, though some studies offer suggestions that gender bias may be operative in subtle ways. In one study, elementary school teachers were presented with a description of a Caucasian fourth-grade student with gifted qualities and were asked to decide if the student should be referred for a gifted placement. For half of the teachers, the child was labeled as a male, and for the other half, the child was labeled as a female; all other aspects of the scenario were identical. Teachers were significantly more likely to suggest that the male student (77%) rather than the female student (54%) should be referred for gifted; the difference was statistically significant with a large effect size (Bianco, Harris, Garrison-Wade, & Leech, 2011). Further, when asked to provide qualitative information about how they made their decisions, teachers tended to describe girls in terms of negative qualities (bossiness, arrogance) and concerns over the social consequences of a gifted placement, while these issues were either not mentioned or mentioned as strengths for boys. It is possible that similar processes shape decisions about referral in other situations as well (e.g., for enrichment/advancement opportunities, including promotion to management, acceptance to specialized programs, and even college admission). Additional research into the impact of gender on assessment referral patterns is warranted, as these patterns, though subtle, clearly have the potential to impact children and adults in significant ways.
Gender Issues and Interpretation of Assessment Data

Gender differences may also influence how assessment results are interpreted and used. Data indicating one mechanism of this form of influence involve children and the use of cognitive assessment results to classify children as in need of special education. School-based cognitive assessment is the gold standard for identifying children who qualify for special education services. Gender disparities in special education placement are common, with boys outnumbering girls in many special education categories (e.g., learning disability, intellectual disability) at a rate of 1.5 to 3.5, depending on the category (Coutinho & Oswald, 2005).

In a review of data from 50 states, Coutinho and Oswald (2005) demonstrated that gender disparity rates, which should be stable across states if they reflect innate differences, actually vary significantly by state/region. This difference suggests that factors other than innate gender differences in prevalence of disorders accounted for differential diagnosis. Share and Silva (2003) provide data that suggest one mechanism potentially responsible for such disparities. They demonstrated that when boys have lower mean scores in general on measures of reading achievement (a common finding), using non-gender-segregated norms to define learning disability (commonly defined by either a cutoff on a particular achievement measure or by a particular IQ-achievement score discrepancy) makes it more likely that boys (vs. girls) will appear impaired. When researchers used gendered norms for reading achievement, numbers of boys and girls identified as having a reading disability were comparable, and patterns of functional strengths and weaknesses in reading in the two groups were also comparable (Share & Silva, 2003). By attending to gender differences in the standardization sample, then, and using appropriate norm groups for comparison, assessors can help ensure that they are using data to make appropriate decisions.

Vignette 1 illustrates how gender-related assumptions might influence decisions based on cognitive assessment data.

Vignette 1: Patterns of Gifted Placement in Suburban Middle School

Dr. Smith is a psychologist working in a public middle school in a mid-sized suburban middle-class school district. Four elementary schools feed the district’s one middle school. The sixth-grade math gifted program teacher in the middle school has noticed that there are more boys than girls entering her sixth-grade gifted math classes each year. As gifted placement in the district is based on WISC-IV scores, Dr. Smith asks the psychologists at the elementary schools to review their gifted assessment data for the past three years. The psychologists do so, and they find no differences in the mean FSIQ scores or in the WISC-IV index scores of boys and girls who were entered into the gifted program and no differences in the means of the scores of boys and girls who did not qualify for the gifted program. However, Dr. Smith also notices
that in sixth grade, gifted programming has two tracks: a math program and a language arts program. Children can qualify for one or both tracks and are assigned by their fifth-grade teachers in consultation with the psychologist. When Dr. Smith reviewed the data separately for each track, she noted that disproportionately more boys were assigned to the math track and disproportionately more girls were assigned to the language arts track. However, when she reexamined the WISC-IV scores for the boys and girls assigned to each track, there were still no significant differences between the two tracks. In other words, children in the math and reading tracks had comparable IQ profiles; a subtle gender bias on the part of the teachers assigning children to tracks appears to have affected placement. Based on these findings, the school district psychologists made two changes. First, they focused on developing concrete score-based criteria for the assignment of children to different tracks. Second, they agreed to review the data on placement by gender each year in order to have a process that would allow them to look for trends that might lead to inappropriate disproportionality.

Dr. Smith and the team of psychologists adhered to best practice standards in their use of IQ tests for the gifted assessments, and their review of their data indicated no gender disproportionality in their identification of gifted students. Their review did identify bias later in the process, when gender implicitly affected decisions about what kinds of enrichment programming might best fit each student’s needs. By engaging in this review process, Dr. Smith and her team upheld the ethics code outlined by the American Psychological Association, particularly the principle of Justice, which states that psychologists should “exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence and the limitations of their expertise do not lead to or condone unjust practices.” The vignette is also a good example of the need for occasional inspection of trends in how assessment data are used, even when actual review of data for equity already occurs.

**Gender Issues and Individual Performance During Cognitive Assessment**

Individual beliefs about the relationship between gender and ability also exist and may conform to cultural stereotypes. A group of over 200 British adults were asked to rate their own level of overall intelligence, as well as their intelligence in a series of subdomains, by indicating their ability level on a bell curve. Participants also rated the intelligence of four hypothetical figures: a feminine male and a feminine female, as well as a masculine male and a masculine female. Males rated their mathematical IQ higher than did females, while females rated their social-emotional IQ higher than did males (Szymanowicz & Furnham, 2013). Further, all participants rated hypothetical males to be more intelligent than hypothetical females and rated masculine figures to be more intelligent than feminine figures (Szymanowicz & Furnham, 2012). There is evidence that
beliefs like these about the intersection of gender and cognitive ability significantly relates to achievement. Eccles’ expectancy value model of motivation suggests that an individual’s expectations that she or he will be successful, coupled with beliefs about the value of the task, will predict achievement (Bembenutty, 2008; Eccles et al., 1999; Fredricks & Eccles, 2002; Simpkins et al., 2012). These expectations and values are heavily socialized, according to the model, and result from messages from the world around about what behavior is appropriate. The sociocultural messages become internalized and grow to be part of an individual’s self-concept, directing motivation and academic behavior (Eccles et al., 1999).

By first grade, girls already believe that they are not as good as boys at math, and that they are better at reading than they are at math (Bembenutty, 2008; Eccles et al., 1999). Following groups of children across a 12-year span, Eccles and colleagues (1999) demonstrated that mothers’ beliefs about their children’s abilities in math were related to mothers’ behaviors supporting math achievement, which were in turn related to children’s math behavior (e.g., number of math courses taken, achievement) during adolescence (Simpkins et al., 2012). In high school students, similar evidence suggests that attitudes, and not aptitude, predict achievement (Else-Quest et al., 2013). In a group of 10th-grade students, males and females had similar grades in math and science. Boys, however, reported a stronger sense of math self-concept and a greater expectation of success in math than did girls. If boys and girls, despite relatively even ability, begin believing that they are “better” or “worse” at one subject than another, then their performance on a cognitive test may be colored by this expectation and not by their general levels of aptitude (Else-Quest et al., 2013; Halpern et al., 2011).

While there is little data on how situational cues might support or activate gender-related expectations and affect performance in the assessment situation, studies of stereotype threat illustrate how situational cues may activate gender beliefs about achievement in other situations. Stereotype threat theory predicts that when beliefs about stereotypical behavior in an area deemed important are activated, those beliefs contribute to stereotype-consistent behavior (Franceschini et al., 2014; Halpern et al., 2011; Steele, 1997). There is some mixed evidence that stereotype threat appears across the age span. Kindergarten through second-grade girls demonstrated lower math performance after hearing a story about a stereotypically feminine girl, but not after hearing a story that did not invoke a gender stereotype (Tomasetto, Alparone, & Cadinu, 2011). Further, the effects were most pronounced for girls whose mothers reported higher levels of gender stereotyping regarding math achievement (Tomasetto et al., 2011). Similarly, six-year-old girls exposed to stereotype-consistent information had lower math performance than those exposed to stereotype-inconsistent information (Galdi, Cadinu, & Tomasetto, 2014).

Inducing stereotypes may be accomplished relatively easily. A study using science textbooks showed high school girls and boys a lesson with photos of
either a male or a female scientist. Girls did better on a subsequent test of comprehension if they had seen the picture of a female scientist; boys did better if they had seen a picture of a male scientist (Good, Wooswzicka, & Wingfield, 2010). Work with adults demonstrates similar stereotype threat mechanisms. A study of adult men and women indicated that on tasks that often reflect gender differences (i.e., mental rotation, verbal fluency, perceptual speed), both men and women did better if tested in mixed-sex groups and when gender stereotypes were not activated (Hirnstein, Andrews, & Hausmann, 2014). Among college students, women with more intrinsic and traditional gender stereotypes, but not those without traditional stereotypes, demonstrated lower math self-efficacy and performed worse on a math task after traditional stereotypes were invoked (Franceschini, Galli, Chiesi, & Primi, 2014). Susceptibility to stereotype threat may be highest at the upper end of the ability distribution. Advanced undergraduate women majoring in STEM-related fields performed worse on a calculus task when stereotypes were induced, performed moderately in a condition in which gender performance was said to be equivalent, and did best when there was no mention of stereotype (Steinberg, Okun, & Aiken, 2012).

While there is ample evidence to support the induction of stereotyped beliefs as a contributor to gender differences in cognitive tasks, Ganley and colleagues (2013) warn that stereotype threat is not a full explanation. Specifically, they review research on girls from elementary school through high school and report mixed results, with some studies finding and others not finding results consistent with stereotype threat. In addition, they suggest that the same pattern of conflicting findings may be true across the range of studies of adults.

While stereotype threat may not offer a full explanation for gender differences, it does appear that, at least under some circumstances, activating gender stereotypes affects performance on some tasks. It is easy to see how gender stereotypes might be activated during the cognitive assessment process. The process itself is a social one, governed by social scripts that are internalized both by the client and the assessor (Ardila, 2005; Brown, 1990). An assessor’s expectations, perhaps subtly or implicitly cued by the presentation of the client, could easily activate a script that brings gender expectations into the room. Even verbal or nonverbal patterns of interaction might cue gender-related expectations. Test materials might present images that activate gender stereotypes (images or stories of men or women in traditional tasks). Finally, ways in which assessors offer feedback or encouragement between subtests could reflect and activate gender expectations. While we could find no empirical research that explored this issue, it seems possible based on the stereotype threat research that this process could occur and could affect performance on cognitive measures. Further, illustrated in Vignette 2, stereotypes activated in the assessor, based on perceptions of the client or the client’s behavior, might also affect the client’s performance and/or the assessor’s behavior.
Dr. Lisa Ambler was completing her postdoctoral training in an outpatient facility that provided cognitive assessment to adolescents and adults. She was scheduled to do a full neurocognitive assessment of a young adult woman who had been forced to leave college after two years due to academic failure. In the intake assessment, the client arrived dressed in a typically feminine and almost provocative way and was heavily made up. She made a point of discussing her fashion with the assessor and spoke in a casual tone, cracking her gum and rolling her eyes when asked about her academic history. Dr. Ambler was aware of her own stereotyped impressions of the client, and as the testing ensued, she worked hard to stay aware of how her view of her client might affect the assessment. Later that night, she decided to review her scoring of the IQ test. As she did, she recognized that she had underscored several of the original responses. Overall, the rescoring raised the client’s Full Scale IQ by four points.

The vignette offers an example of how an assessor might be influenced by stereotypes induced by the client. Dr. Ambler typically did not rescore all of her cognitive assessments, but she was feeling unsettled about her impressions of the young woman she assessed, and this prompted her to more carefully scrutinize her work. In her discussion of the role of gender in the assessment process, Brown (1990) notes that an assessor’s responses to gender issues in the assessment interaction can have a “profound impact” (p. 12) on the assessment process. Dr. Ambler’s response to her client is one example of this effect. From a stereotype threat perspective, it is also possible that Dr. Ambler, by her appearance, the ways in which she responded to the client, and the content of what she discussed with her in the interview, in some way activated (or did not activate) gender stereotypes of the client, thereby affecting performance. Dr. Ambler protected herself against this risk by being aware of her own gender biases, being mindful of her responses to the client in the moment, and by reviewing the test data carefully at the conclusion of the testing.

More recent research reminds us that the experience of gender is not always confined to the gender binary and that the gendered lens referred to by Brown (1990) might also include an individual’s more gender-fluid understanding of self (Dragowski, 2014). There is no research to guide our understanding of how gender stereotypes might operate during a cognitive assessment of a gender-fluid individual, though almost certainly ideas and stereotypes about gender would be present and operative in some ways. Title IX laws have been extended to protect gender-diverse students from discrimination in the academic environment (Dragowski, 2014). The National Association of School Psychologists (NASP, 2014) has issued a position statement affirming the development of safe and supportive environments for gender-diverse students. Most work in this area, however, has focused on affirming gender identity and invalidating supposedly
“therapeutic” attempts aimed at enforcing behavior that is consistent with gender stereotypes (NASP, 2014). Toward that end, assessors can focus explicitly on how gender might be operative in the referral of gender-diverse students, and they can carefully explore how gender stereotypes and living as a gender-diverse individual might be affecting patterns of performance. There has been no work identifiable at this time that explores gender diversity and performance on cognitive assessment. As such, this area remains particularly ripe for psychological research.

Practical Points

While the question of the existence of innate sex differences in cognitive performance continues to be a complex one that research will continue to explore, there is ample evidence that the innate differences between males and females that may exist are small and relatively inconsequential to overall aptitude (Hyde, 2005). In short, the literature examining the question of innate gender-based cognitive differences suggests that males and females may be more similar than they are different (Hyde, 2005; Halpern, 2000). It may be more important, then, to understand cognitive differences as a function of sociocultural factors, and, for those professionals who assess cognitive function, to specifically understand how the assessment process may exacerbate or mitigate the relationship between sociocultural messages and cognitive performance.

The information reviewed above suggests that one’s own gender beliefs and those of others, as well as situational cues (which may activate one’s own gender beliefs to influence behavior) could affect the assessment process in multiple ways. Patterns of referral for cognitive assessment, patterns of performance on the assessment measures, and how assessment results are interpreted are all aspects of cognitive assessment that may be affected by gender. Therefore, cognitive assessment must include a careful consideration of gender, from the moment of referral. Some guidelines for how to accomplish this include:

- **Explore and clarify the role of gender in the referral for cognitive assessment and in how the results of the assessment will be used.** As illustrated above, at least with regard to referral of students for cognitive assessment, there is some gender bias in what cognitive performance is expected by gender, which may translate into differential rates of referral and/or different outcomes based on the assessment data (e.g., Bianco et al., 2011; Coutinho & Oswald, 2005). “[There is] a possibility of deliberate or inadvertent bias on the part of educators who may not implement referral and identification policies in the same manner for males and females suspected of a disability” (Coutinho & Oswald, 2005, p. 13).

  Cognitive assessors are trained to carefully craft a referral question; a piece of this work must involve a consideration of how gender-related
factors might have contributed to the need for referral, the patterns of achievement that prompted the referral, and how the client might then use the assessment data (Brown, 1990). Part of this process involves asking questions of referral sources, making oneself knowledgeable about a client's context, and observing the client's reactions. In addition, cognitive assessors must periodically step back from their work and look at overall data on referral patterns, assessment findings, and outcomes of their assessments (Brown, 1990; Coutinho & Oswald, 2005). This may range from reviewing their own scoring of protocols, to consulting with peers, to monitoring how frequent referral sources are using data to guide decisions.

- **Attend to and manage gender-related factors in the assessment interaction.** Cognitive assessment is accomplished via an interpersonal interaction, which is culturally embedded and carries with it all of the cultural rules about gender and performance (Ardila, 2005). In a number of ways, assessors can attend to gender during the assessment process. First, assessors should be aware of their own reactions to gender issues, as these issues can have a substantial influence on the experience, and potentially the performance, of the client (Brown, 1990; Eccles et al., 1999). Reactions to gender-related issues, unless extreme or identified as the focus of the evaluation—unusual in the field of cognitive assessment—tend to be unexamined, perhaps because there is no good framework for how to consider these issues and their effects on cognitive performance (Brown, 1990). Simply being aware of one's reactions and periodically using consultation to understand them is a good first step. Second, assessors can use what we know about engagement and motivation to sidestep the kinds of challenges that gender stereotypes may offer. For example, the achievement literature is clear that when individuals have a belief that they can be successful, see a positive value to the work they are doing, and feel a strong interpersonal connection to a teacher or mentor, they are more likely to show their strongest performance (Bembenutty, 2008; Fredricks & Eccles, 2002; Halpern, 2000). Building this kind of context within the assessment interaction should therefore be an explicit goal of all cognitive assessment. Assessors, from the earliest moments of interaction, can work to build positive rapport and co-create an understanding of the assessment process that aims to maximize client expectations for success/accomplishment and value. Finally, assessors must be aware of patterns of performance in the assessment room that might be related to gender issues. The discerning of patterns requires assessors to become culturally literate on two levels. On a more global level, it is important to understand the sociocultural contexts of the communities in which they are working and the role of gender in those communities. On a more individual level, the assessor must consider, explicitly, the gendered meaning of achievement for the individual
and for the important people in that person’s life who may be using the results of the assessment (Brown, 1990). Being familiar with the academic literature on the relationship between gender and cognitive variables and achievement processes is part of this task.

• **Attend, in concrete ways, to how gender-related patterns might influence data-based decision making that is associated with cognitive assessment.** Cognitive assessment results are often used to make decisions about academic or occupational/vocational placements or trajectories. Attending to gender differences in standardization samples can ensure that you are providing the most accurate look at what an individual’s score tells you about his or her cognitive profile (Share & Silva, 2003). When there are gender differences on a cognitive measure, and gender-specific norms are available, consider how using these might be helpful.

• **Consider your role as a local and global advocate and educator.** On a local level, by giving assessment results to individuals, the people in their lives, educators, medical professionals—or simply by putting results in a report that will be consumed by unknown others in the future—assessors are shaping the ways in which others understand cognitive functioning and potentially any gendered aspects of cognitive performance. Feedback, then, offers an enormous opportunity for assessors to educate a population of people about how gender might affect how we understand someone’s cognitive strengths. While, of course, the first priority of any assessment is to be sure that the referral source (e.g., educators, physicians, clients) understands the cognitive profile and its implications, it is also important to incorporate considerations of how gender might have affected the results or might give meaning to the results. Further, assessors who work within systems can provide inservicing or education individually at multiple points in the assessment process. Over time, by including referral sources in the process of examining trends in referrals or considering gender-related factors, assessors may be able to provide important instruction or leadership in how to mitigate effects of gender bias in referral or interpretation. On a more global level, advocacy for awareness of gender bias and stereotypes, and support for including sociocultural considerations in all assessment, including cognitive assessment, is critical. Advocacy may occur in social or legislative forums, but it should also include advocacy for continued research that includes a focus on gender in cognitive assessment and performance on cognitive measures (Ardila, 2005). By engaging in advocacy work in this area, psychologists are employing best practices by furthering the ethical principles outlined by the APA, particularly in the areas of Justice and Respect for People’s Rights and Dignity (APA, 2002).
Annotated Bibliography


*Comment:* Ardila presents a conceptual framework for understanding how cultural variables can influence neuropsychological assessment. He presents eight different values that underlie testing and can affect the relationship between the examiner and the examinee, which can in turn affect test results. It is a thoughtful consideration of how variables other than those being assessed can affect outcomes.


*Comment:* This article is one of the few that explores gender stereotyping and the accuracy of what adults believe about gender differences. The researchers compare adult ratings of gender differences to published data and show that adults are aware of common gender differences but underestimate their size. The data are discussed in terms of a rich conceptual framework for understanding how these beliefs might affect performance or interpretations of others’ performance.


*Comment:* This is one of the few studies that looks at how gendered behavior might relate to performance on measures of IQ. The authors look at intelligence measures in gay men and heterosexual men and women, and they present data that explore relationships among intelligence, sexual orientation, and gender nonconformity.


*Comment:* This article represents a strongly constructed critical review of a literature that has documented gender differences in math and science. Spelke’s compelling commentary and a review of additional research, taken together, suggest that prior conclusions about these gender differences are not supported by the scientific findings.

References


Mary T. Rourke & Ellen Bartolini


Gender Considerations in Self-Report Personality Assessment Interpretation

Radhika Krishnamurthy

Self-report measures of personality and psychopathology rely on clients’ ability and willingness to describe themselves in a reasonably candid and accurate manner through endorsing items that fit their self-description. These self-descriptions are influenced by individual factors, including people’s degree of self-knowledge and self-reflection or their defensiveness and guardedness. However, they are also filtered through their gender lenses. A troubled female client might more readily recognize and acknowledge feelings of inefficacy and despair than explosive anger. A perturbed male client might admit to restlessness and loss of temper but deny fears and somatic symptoms. Among less symptomatic test items, women may relate more easily to items dealing with being affectionate and avoiding arguments, whereas men may identify more comfortably with items representing excitement-seeking and being independent. These generalized and seemingly stereotypical examples of men’s and women’s descriptions of themselves and their psychological disturbances are congruent with meta-analytic findings indicating that men generally score higher than women on measures of assertiveness, whereas the reverse is found for scales of anxiety, gregariousness, trust, and tender-mindedness (Feingold, 1994). They are also consistent with findings concerning differences in type and frequency of psychiatric diagnoses—mood disorders such as Major Depression, Dysthymic Disorder, and Generalized Anxiety Disorder at twice the rate or higher for women than men, and a higher rate of Antisocial Personality Disorder for men compared to women (e.g., Hartung & Widiger, 1998)—albeit qualified with questions of criterion and clinician bias in diagnostic determinations.

Are gender differences evident in self-report personality test scores and profiles real and meaningful reflections of differences in personality and expressions of psychological disturbances? The answer is not simple or straightforward, as a
host of multifaceted and interacting variables play a role in self-report disclosures. Among the contributing factors are sex-role socialization and gender-related life experiences. For example, there is well-documented evidence that women tend to express more emotional distress than men do (e.g., Cook, 1990) and seek help and utilize mental health services more often than men do (e.g., Kessler, Brown, & Broman, 1981; Russo & Sobel, 1981), although moderated by other demographic, sociocultural, and attitudinal factors. Men’s underutilization of medical, mental health, and substance abuse treatment services relative to women has been documented for men of different ages, nationalities, and ethnic/racial backgrounds (Addis & Mahalik, 2003). Does this mean that women as a whole are more troubled than men? This is certainly plausible if we consider gender-related inequities and the various forms of violence against girls and women seen worldwide, both historically and currently. On the other hand, biologically based tendencies combined with gender-related societal prescriptions incline girls and women toward emotional display and boys and men toward emotional reserve; furthermore, expressions of anger by males and anguish by females are typically viewed as gender-congruent presentations of emotional discomfort.

Gendered experiences shape people’s responses to self-report questionnaires and influence the findings in multiple ways:

(a) Through the frequency of endorsement of specific items on self-report personality measures. For example:

- On the Minnesota Multiphasic Personality Inventory–2nd edition (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), the standardization sample women’s endorsement of items dealing with experiences of lacking self-confidence, embarrassment, having headaches, and getting easily upset exceeded men’s endorsement rate by more than 10% (Butcher et al., 1989).

(b) In scale scores. For example:

- On the Personality Assessment Inventory (PAI; Morey, 1991), the standardization sample men’s T-score mean for the Antisocial Features scale was 53.38 (SD=10.57) compared to 46.91 (SD=8.31) for women, reflecting a difference in scale means exceeding the standard error of measurement for the scale (Morey, 2007).
- On the Millon Clinical Multiaxial Inventory–III (MCMI-III; Millon, Davis, & Millon, 1997), men consistently score higher than women on scale 6A (Antisocial), whereas women score higher than men on scales H (Somatoform Disorder) and CC (Major Depression) (Strack, 2002).

(c) In research-based correlates of scale scores and profile patterns. For example:

- On the Minnesota Multiphasic Personality Inventory–2-Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008/2011), a high score
on the Behavior-Restricting Fears scale is correlated most strongly with nightmares, nervousness, multiple specific fears, and suicidal ideation for women and inversely with competitiveness, achievement needs, and self-reliance for men (Tellegen & Ben-Porath, 2008).

Such gender-related response variations influence the conclusions derived from the personality assessment. Additionally, as discussed later in this chapter, instrument-related factors could produce spurious differences in scores between the sexes and skew profile interpretations. The issues get further complicated when we take into account variations based on gender identity (type, strength, salience), degree of subscribing to traditional gender roles, and different sexual orientations, as well as intersections with ethnicity/minority group membership, socioeconomic status, and religion. This chapter presents various gender-related considerations in interpreting findings from major self-report personality measures, with central focus on the MMPI-2/MMPI-2-RF, PAI, and MCMI-III.

Psychometric Considerations

Self-report personality test results are influenced by factors extending beyond the client’s response style and content of endorsed items. In the process of making sense of gender differences on personality test scores, one needs to be cognizant of several psychometric factors that may affect the results. Prominent among them are issues of gendered versus nongendered norms and potential gender bias in test items and scores.

Gendered and Nongendered Norms

The self-report personality measures developed in the first half of the 20th century provided separate norms for women and men. This approach was based typically on observed differences in the raw scores of men and women in the tests’ standardization samples. Most prominent among them is the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1943), and the second edition (MMPI-2; Butcher et al., 1989) continued this tradition in the restandardization of the inventory. Specifically, raw score distributions for the MMPI-2 were derived separately for the 1,138 men and 1,462 women in the standardization sample, and linear and uniform T score conversions were computed separately by gender. The same approach involving provision of gender-specific (i.e., gendered) norms was taken with the Millon Clinical Multiaxial Inventory from its original version to the third edition (MCMI-III; Millon, Davis, & Millon, 1997). This means that an identical raw score produced a different T score on the MMPI-2 or Base Rate (BR) score on the MCMI-III depending on the sex of the test-taker, because the score is presumed to have a different connotation for men and women (Samuel et al., 2010).
A vivid illustration of this issue, provided by Hsu (2005), relates to the MCMI-III Dysthymia scale, where a raw score of 3 transforms to a BR score of 20 for women but 60 for men—a startling difference of 40 points that would be associated with markedly different implications.

The trend has since reversed in the direction of providing combined-gender (i.e., nongendered) norms for the major self-report inventories. Specifically, this was done for the MMPI-2 by pooling data from the 1,138 men of the MMPI-2 standardization sample and a randomly selected subgroup of 1,138 women from the 1,462 women of the standardization sample (Ben-Porath & Forbey, 2003). For the PAI, a single set of nongendered norms was developed by using a mixed-gender community sample of 1,000 adults (PAI; Morey, 1991). The MCMI-III was updated in 2009 with combined gender norms based on a national sample of 752 psychiatric patients.

The issue of gendered versus nongendered norms is a complex and often confusing one to personality assessment researchers and practitioners alike. The common assumption is that gendered norms protect gender differences, allowing them to be fully evident in scores and profile patterns. However, a more recent viewpoint explains that the implicit assumption in gender-specific norms is that there are few meaningful gender effects in the measured constructs. As discussed by Ben-Porath and Forbey (2003), the assumption underlying MMPI separate-gender norm development seemed to be that differences in the scores of men and women in the MMPI standardization sample were a product of gender differences in response style (i.e., in the differential willingness of men and women to report certain self-characteristics), rather than “true” differences in psychopathology. In actuality, it is difficult to disentangle gender-related level of disclosure from gender-influenced experience of psychological disturbance. Nonetheless, the point is that some gender-related variance is eliminated when gendered norms are applied; for example, when a female client’s anxiety score is compared to the mean anxiety score for women, the gender-related variance related to anxiety reporting is removed so as to get a relatively pure measure of the particular client’s level of anxiety. Overall, gender-specific norms actually serve to reduce gender influence in scores.

The movement toward the development of nongendered norms was spurred largely by new legislative developments in the 1990s in response to employment-related discrimination lawsuits. Although self-report personality tests had been widely used in personnel selection in employment settings, legal challenges led to new provisions in the Civil Rights Act of 1991, involving greater specification of nondiscriminatory hiring practices. Specifically, Section 106 of the Civil Rights Act of 1991, which prohibited the discriminatory use of test scores in employment and promotion decisions, made it unlawful to “use different cutoff scores for, or otherwise alter the results of, employment-related tests on the basis of race, color, religion, sex, or national origin” (U.S. Equal Employment Opportunity Commission, 2014). This was widely construed as an injunction to stop using gendered norms for tests used in personnel screening (Ben-Porath &
Forbey, 2003). In the clinical assessment domain, the use of nongendered norms was supported by some evidence, from MMPI-2 research for example, that they operated in a manner similar to gender-specific norms and could therefore be expected to yield comparable profile interpretations. However, they were also fueled by psychometric arguments such as Morey’s (1991) contention that T scores derived from gendered norms would likely obscure differences between groups on certain diagnostic/psychopathology variables identified in epidemiological studies. Subsequent empirical studies have provided further clarification. In comparing the impact of gendered and nongendered norms of the NEO Personality Inventory–Revised (Costa & McCrae, 1992) on personality disorder scales, Samuels and colleagues (2010) concluded that gendered norms provided no advantage and, instead, introduced a limited amount of systematic variance unrelated to the personality disorder measurement. Overall, they proposed that the absolute level on a personality trait provides for a more valid assessment than the standing in relation to gender peers, while acknowledging the possibility of gender biases embedded within personality disorder criteria.

The use of gendered norms for deriving the scale scores on self-report measures also presents a curious disjunction from the subsequent interpretive process. As noted by Baker and Mason (2010), test manuals generally do not provide gender-specific interpretations of scores; rather, a standard clinical interpretation is usually provided for a given score and deemed applicable to both men and women. This is often the case even in many scholarly texts, and it may be considered another reason for shifting to the use of gender-combined norms. On the other hand, use of a single set of nongendered norms is not fully proven to be the most effective strategy for dealing with gender differences on self-report measures, as there is limited research on it to date. Moreover, there is a dearth of information on whether either type of norms is suitable when assessing individuals whose gender identity conflicts with their assigned gender.

The central issue ultimately is more about how the results are used than about how the test norms are constructed (Baker & Mason, 2010). Future research will hopefully uncover pros, cons, and best applications of gendered and nongendered norms. Until then, the personality assessor will currently use nongendered norms with the MMPI-2-RF, PAI, and MCMI-III, and has the option of using either or both norms with the MMPI-2. In selected scenarios of MMPI-2 assessment, the assessor could choose to plot two profiles, using both sets of norms, to attain a comparative sense of the client’s functioning relative to a standard reference point and to gauge the degree of gender-related response style contribution. This is particularly beneficial when important dispositional decisions rest upon the assessment findings.

**Gender Bias**

The knowledgeable assessor understands that gender differences in personality test scores and descriptions do not necessarily equate with gender or sex bias.
An assessment-based sex bias is implicated when a faulty conclusion, particularly in the direction of overpathologizing for a given sex, is based on the instrument itself (Widiger & Spitzer, 1991). This type of bias can occur at the item level and the score level. An item on a self-report personality and psychopathology measure may be considered sex biased if it contributes to a pathological impression when the item does not represent a dysfunctional characteristic and if it is found to apply to one sex more than the other, that is, leads to a differential sex prevalence of false positives (Lindsay & Widiger, 1995). Similarly, test score bias is indicated when the score has a different relationship to external criteria, and therefore a different inference, for demographic subgroups. From a statistical standpoint, test score bias is determined through examination of correlations between predictor and criterion variables for different subgroups. Test score bias is shown when there is (a) differential validity of test scores (i.e., differences in the magnitude of predictor-criteria associations for the subgroups, known as slope bias) or (b) differential prediction of test scores when they under- or overpredict the criterion performance for a given subgroup (known as intercept bias). At an item level, item bias is best determined through examination of differential item functioning, seen when different subgroups who share a trait characteristic differ in how they respond to a test item relevant to that trait (Urbina, 2014). For contemporary self-report personality measures, methods to prevent or minimize these potential sources of instrument-related bias were implemented during the test development and validation phase. For example, gender bias evaluation during PAI development included use of a bias review panel to identify and remove gender-offensive items, empirical evaluation of item means to examine gender-related disparities, and deletion of items that produced significantly different item-scale correlations across demographic groups (Morey, 1991).

While such efforts minimize the operation of gender bias, subsequent research following the test’s release may reveal some previously undetermined biases. For example, Hynan (2004) asserted that several MCMI-III personality disorder scales produce gender differences in scores that are not compatible with research evidence on base rates. He observed that gender-based raw score to BR score transformation produces unduly higher scores for women compared to men on the Histrionic, Narcissistic, and Compulsive personality disorder scales, thus disadvantaging women, and the reverse is found for the Dependent personality disorder scale. He cautioned against use of the measure in diagnosing personality disorders. Using a sample of outpatient mental health clients, Lindsay, Sankis, and Widiger (2000) demonstrated that several items from MCMI-III and MMPI-2 Narcissistic Personality Disorder scales were potentially gender biased, determined by their positive correlation with socially desirable masculine gender trait indices and lack of association or inverse correlation with indices of global dysfunction. The authors cautioned that such gender bias would be of particular concern if these scales are used to measure treatment outcome because the post-treatment scores would be lowered only if adaptive characteristics, as opposed to pathological narcissism characteristics, were to lessen.
Other studies suggest gender bias occurring during specific assessment applications, as seen in the controversy surrounding the use of the MMPI-2 Fake Bad Scale (FBS, renamed Symptom Validity Scale; Lees-Haley, English, & Glenn, 1991) in personal injury evaluations. Butcher, Gass, Cumella, Kally, and Williams (2008) argued that FBS items contain a potential sex bias due to their substantial overlap with items on MMPI-2 somatic symptom scales of Hypochondriasis, Hysteria, and Health Concerns; because women tend to endorse somatic symptoms more frequently than men, and because a single raw score cutoff is applied for both sexes, women can be misclassified as malingerers more often than men. In fact, Butcher, Arbisi, Atlis, and McNulty (2008) observed that a cutting score of 26 classified almost twice as many women than men among various clinical groups as malingerers, and they advised against the use of the scale especially in assessing women.

Various counterarguments to FBS scale bias allegations have been offered, including the assertion that different cutoffs for women and men have been recommended from the start, and several empirical studies have attested to the overall effectiveness of the scale. Notable among them is Lee, Graham, and Sellbom’s (2012) investigation of potential gender bias associated with the FBS scale. These researchers reported that, although (a) women scored higher than men, (b) there were significant gender-related item endorsement differences for approximately one-third of the items, and (c) there was evidence of intercept bias, they found negligible-to-small differences in classification accuracy using T score cutoffs. Lee and colleagues concluded that there are minimal-to-none meaningful differences in correct classification accuracy for men and women in relation to credible versus noncredible symptom validity test failures. The personality assessor should carefully consider these various points in determining the appropriateness of using this scale in clinical and disability assessments of women.

The MCMI-III has received severe critiques of gender bias in its use in child custody/parenting capacity evaluations, based on findings from several studies. For example, Lampel (1999) identified multiply-elevated MCMI-III profiles for women relative to men in a sample of 100 child custody litigants. She noted that 40% of the mothers obtained Histrionic scale elevations at a prevalence rate that was four times the prevalence for a clinic population, whereas the prevalence for fathers was comparable to that of a male clinic population. McCann, et al. (2001) reported that a majority of women, but few men, in their sample of 259 child custody litigants obtain high BR scores indicative of histrionic and compulsive traits or disorders. Overall, these and other similar studies indicate that female child custody litigants obtain scale score elevations at a higher frequency as well as higher elevations than their male counterparts on several MCMI-III scales. Such evidence suggesting overpathologizing bias for women should create reservations in using the MCMI-III in child custody evaluations. While score adjustments to some scales have been recommended to correct for unjustified gender differences (e.g., McCann et al., 2001), they require further
Gender Considerations in Self-Report substantiation. A moratorium on the use of the MCMI-III in this context may be advisable, especially as it is basically designed and validated for use with clients in clinical settings and not for assessing individuals from the general population.

Empirical Findings

Gender-related differences in self-report personality test scores are reported in a multitude of research articles, usually as secondary to major findings. These findings cut across earlier research using gendered norms and recent articles using nongendered norms. This section presents some representative findings for the MMPI-2/MMPI-2-RF, PAI, and MCMI/MCMI-2/MCMI-III.

**MMPI**

Assessment of gender characteristics has been a part of the MMPI from the original version of the test, which contained a Masculinity-Femininity scale (Mf, Scale 5), to the MMPI-2, in which two separate gender scales—Gender-role Masculine (GM) and Gender-role Feminine (GF)—were introduced. These have generally come to be considered nonclinical scales that assess personality characteristics rather than psychopathology. Although the original intent of Scale 5 was to identify male homosexuals, it was seen to be better suited for examining gender-related interest patterns. However, some empirical correlates are also identified for clients in clinical settings, such as passivity and insecurity for high-scoring male clients and interpersonal aggressiveness and dominance for high-scoring female clients (Greene, 2011). A detailed and nuanced examination of Scale 5 is provided by Martin and Finn (2010), including identification of its multiple meaningful dimensions, intercorrelations with other MMPI-2 scales, and relevance for assessing gender identity. Some MMPI-2 texts (e.g., Friedman, Bolinskey, Levak, & Nichols, 2015) describe Scale 5’s role in moderating the effects of other clinical scales. Other efforts have been directed toward the development of MMPI-2 gender-oriented symptomatic scales such as the Masculine-Feminine Pathology Scale (McGrath, Sapareto, & Pogge, 1998) and identification of clinical symptom correlates of Scale 5 (Ward & Dillon, 1990). The MMPI-2 GM/GF scales were developed as separate measures of masculine and feminine traits in contrast to the bipolar representation of them on Scale 5. However, they are mostly deemed not to be effective measures of sex roles (Graham, 2012). The MMPI-2-RF does not retain the aforementioned gender scales but contains two interest scales—Aesthetic-Literary and Mechanical-Physical—that were derived from Scale 5 and appear to represent gender-stereotypical interest areas. They have received little research attention to date.

In addition to the specific gender-relevant scales discussed above, a substantial research literature has identified gender influences in MMPI-2 score patterns. Schinka, LaLone, and Greene’s (1998) examination of the influence of
demographic characteristics on MMPI-2 scale scores showed that while most of the individual demographic variables contributed little incremental variance in scale scores over that accounted for by psychopathology, gender had a potent influence. Gender effects were prominent for the Fears and Antisocial Practices content scales and the supplementary MacAndrew Alcoholism Scale–Revised, in addition to gender-focused scales 5, GM, and GF. Greene’s (2011) overview indicates consistently higher endorsement of items on Hypochondriasis, Depression, Hysteria, and Psychasthenia scales by women than men in clinical settings, although only by two to three items. Among codetypes, the 2–3/3–2 codetype is found to be substantially more frequent for women than men. Women also produce 1–2/2–1 and 1–3/3–1 codetypes more often than men, whereas men have higher rates of the 6–8/8–6 and 7–8/8–7 codetypes than women.

Several MMPI-2 content and supplementary scales scores are found to be slightly higher for women than men in clinical settings, including Anxiety, Fears, Depression, Health Concerns, Low Self-Esteem, Work Interference, Welsh’s Anxiety, College Maladjustment, Post-Traumatic Stress Disorder–Keane, and Overcontrolled–Hostility. Men are found to score slightly higher than women on Cynicism, Antisocial Practices, Type A, Hostility, and the alcohol/drug problem scales MacAndrew Alcoholism–Revised, Addiction Admission, and Addiction Potential. These trends reflect a pattern of greater subjective distress and negative affect reports by women and behavioral disturbances by men. Greene (2011) noted that the effect sizes of the differences were very small and largely disappeared when raw scores were converted to gender-normed T scores. However, small gender-related differences were also found at the item level on the MMPI-2-RF, with women slightly more likely than men to endorse items on Emotional/Internalizing Dysfunction, Demoralization, Somatic Complaints, Low Positive Emotions, and Dysfunctional Negative Emotions scales, and men more likely than women to endorse items on Behavioral/Externalizing Dysfunction, Cynicism, Antisocial Behavior, Hypomanic Activation, Aggressiveness–revised, and Disconstraint–revised scales. The non-gendered norms of the MMPI-2-RF would likely minimize these differences at the scale score level.

Some interesting MMPI-2 studies have focused on issues of gender-related concerns, sexual orientation, and gender role implications. Miach, Berah, Butcher, and Rouse’s (2000) MMPI-2 study comparing transsexual and gender identity disordered male candidates awaiting sex reassignment surgery demonstrated greater psychopathology in the gendered identity disordered group and, in fact, lack of significant psychopathology in the transsexual group. This study demonstrated the utility of the MMPI-2 in detecting differences in level of maladjustment among various sex reassignment surgery candidates. Griffith, Myers, Cusick, and Tankersley’s (1997) research evaluated differences in MMPI-2 clinical scales scores and profile configurations among self-identified heterosexual and lesbian women with and without histories of childhood sexual abuse.
Their results showed no significant score or profile differences for heterosexual and lesbian women, except for a significantly higher Depression scale score for the heterosexual group, whereas more prominent differences were based on abuse history. Haslam’s (1997) investigation of the MMPI-2 standardization sample men’s Scale 5 score distribution used multiple models to evaluate if male sexual orientation occurs on a continuum or in discrete categories. His findings suggested that male heterosexual and homosexual dispositions assessed with Scale 5 vary along a continuum, although the ultimate sexual orientation may fall into discrete homosexual/heterosexual categories.

Lawson, Brossart, and Shefferman (2010) investigated gender role orientation differences among a sample of men on probation for intimate partner violence (IPV) offenses. They identified four subtypes based on MMPI–2 profile features and found they differed in traditional masculine or feminine gender role orientation. Notably, severity of violence was not associated solely with a traditional masculine orientation; characteristics of insecurity and dependency in a subgroup with traditional feminine gender role orientation appeared to be contributors to IPV, and less traditional gender role appeared to be less associated with IPV. Woo and Oei’s (2006) investigation of MMPI–2 GM/GF scale scores among psychiatric patients revealed that masculine traits denoted by high GM scores were more strongly associated with psychological adjustment, assessed with self-esteem and ego strength measures, than were feminine, androgynous, and undifferentiated traits. The authors commented that the advantages of masculinity in this regard may be explained by the greater value placed by society on masculine attributes such as goal-directedness and self-confidence than on nurturing/expressing feminine attributes.

The five studies discussed above aid in refining our understanding of MMPI–2 assessment of gender role concerns, alert us to the mental health implications of gender role orientation, and enable us to avert simplistic assumptions about sexual orientation.

**MCMI**

Gender differences in scores have been observed across various editions of the MCMI including the MCMI–III, particularly when gendered norms are applied. Many of these findings reflected expected and plausible directions of differences. However, as noted earlier, this measure has been plagued with questions of gender bias in certain evaluation contexts, and questions may also be raised about overall greater pathology identified for women on the MCMI. Among single-gender sampling MCMI–II and MCMI–III studies, some investigations involving all-male or all-female samples have tended to follow stereotypical gender directions, focusing on women with anorexia nervosa or bulimia and male criminal sex offenders. Others have examined male drug abusers, incarcerated female substance abusers, and psychiatric inpatients of both sexes. These studies are not discussed here due to space limitations, as they do not involve
gender comparisons within these groups and are focused more on pathology/offense rather than gender issues, but are mentioned for interested readers who wish to do a database search for them.

A few exemplifying studies comparing male and female MCMI profiles are presented here. Using the original MCMI as a treatment outcome measure in a sample of psychiatric inpatients, Piersma (1986) reported that women obtained significantly higher BR scores than men on the Dependent, Borderline, Somatoform, Psychotic Depression, and Psychotic Delusions scales shortly after hospital admission. They continued to score higher than men on Dependent, Psychotic Depression, and Psychotic Delusions scales at pre-discharge assessment and also on Avoidant and Psychotic Thinking scales. Men scored higher than women only on the Histrionic scale at admission and the Antisocial scale at discharge. Similar MCMI findings were reported by Cantrell and Dana (1987) using an outpatient psychiatric sample. These researchers additionally found a significantly higher number of elevated clinical syndrome scales and personality disorder scales for women than men, causing women to appear more disturbed than men. Sinha and Watson’s (2001) examination of personality disorder prevalence rates among university students showed a gender difference for dependent disorder based on the MCMI-II. Furthermore, the MCMI-II yielded higher rates of antisocial and narcissistic disorders for men and avoidant and histrionic disorders for women relative to two other personality disorder measures used in their study.

Although several adjustments were made in the revision to the MCMI-III to address gender imbalances in scores, the gender-related trend appears largely unchanged, at least with use of the gendered norms. Rossi, van der Ark, and Sloore’s (2007) analysis of the Dutch language version in a combined sample of patients and inmates revealed significantly different mean scale scores by gender for all but four scales. Women obtained significantly higher mean scores than men, with medium effect sizes, on Debasement, Anxiety, Somatoform, Dysthymia, Posttraumatic Stress, Thought Disorder, and Major Depression, and on several additional scales with small effect sizes. Men scored higher than women on Desirability, Histrionic, Narcissistic, Antisocial, Alcohol Dependence, and Drug Dependence scales with small-to-medium effect sizes. The researchers observed that most of these differences were in expected directions, and the same factor structure emerged for men and women. On the other hand, Blood (2008) found that, in a parental capacity evaluation sample, women scored higher than men on multiple pathology-oriented scales, whereas men scored higher than women only on Desirability; this finding suggests an important disparity that may differentially affect overall determinations of maladjustment.

A recent research report by Howes and Krishnamurthy (2014) provided a comparison of MCMI-III, MMPI-2, and MMPI-2-RF scores in a sample of 168 child custody litigants (82 men, 86 women). The researchers found several significant gender differences on the MCMI-III and MMPI-2 and minimal differences on the MMPI-2-RF. On the MCMI-III, women scored significantly
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higher than men on Dependent, Anxiety Disorder, Dysthymic Disorder, Post-traumatic Stress Disorder, and Major Depression scales and on facet scales of Temperamentally Apathetic, Immature Representations, Cognitively Diffident, and Uncertain Self-Image. Men scored significantly higher than women on Antisocial and Drug Dependence scales and on Cognitively Expansive, Acting-Out Mechanism, Temperamentally Hostile, and Eruptive Organization facet scales. The pattern of gender differences was consistent with that reported in the gender literature and hypothesized for this study. However, it is noteworthy that women obtained higher mean BR scores on more MCMI-III scales and facet scales than men, consistent with prior claims that the MCMI may be overpathologizing women. When significant gender differences were found on the MMPI-2, women always had higher scores than men, suggesting that women appear more psychologically disturbed than men on this measure too. Specifically, women scored significantly higher than men on Infrequency, Variable Response Inconsistency, and Masculinity-Femininity basic scales, Repression, Posttraumatic Stress Disorder, and Marital Distress supplementary scales, Bizarre Mentation content scale, Harris-Lingoes subscales of Lassitude-Malaise and Lack of Ego Mastery-Cognitive, and the Familial Alienation content component scale. On the MMPI-2-RF, women obtained significantly higher scores than men on Somatic Complaints and Neurological Complaints scales.

Howes and Krishnamurthy’s investigation showed that, across the three self-report measures, women scored significantly higher on 21 of the 27 scales for which differences emerged. Furthermore, the types of scales for which women scored higher than men represented more severe psychological disturbance. They commented that although the final conclusion rests with the evaluating psychologist as to whether the woman’s “weakness” or the man’s “acting out” is more unfavorable to child custody determinations in a given case, the overall profile patterns appear more detrimental for women than men. Their comparison of the MMPI-2 and MMPI-2-RF suggested that the MMPI-2-RF is more gender fair, whereas the MMPI-2 produces a greater interpretive yield in terms of overall scale score elevations, and these relative advantages have to be weighed against each other in child custody evaluations.

**PAI**

Although there is currently an extensive research literature for the PAI, very few published studies examine gender differences in PAI scores. Most psychometrically oriented PAI studies have tended to use mixed-gender samples in evaluating external correlates of PAI scores (e.g., Slavin-Mulford et al., 2012) or have employed predominantly male (e.g., Ruiz, Cox, Magyar, & Edens, 2014) or female samples (e.g., Stein, Pinsker-Aspen, & Hilsenroth, 2007) and have reported results only for the total samples. A limited number of studies have centered specifically on women (e.g., abuse survivors; Cherepon & Prinzhorn, 1994) or men (e.g., male inmates; Wang et al., 1997), and therefore did not
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involve male-female score comparisons. Overall, gender-comparison studies are relatively limited for the PAI in contrast to the MMPI-2 and MCMI-III.

Among the limited number of psychometric evaluations of PAI scores by gender, findings have shown strong similarities in the underlying structure of score patterns and in test score validity for male and female samples. For example, there is evidence of no significant gender-related differences in PAI score reliability and concurrent validity among low-socioeconomic-status African American and Latino methadone maintenance patients (Alterman et al., 1995). Walters, Diamond, Magaletta, Geyer, and Duncan (2007) provided evidence of a stable and consistent dimensional structure for the PAI Antisocial Behaviors (ANT) scale and its subscales among male and female federal prison inmates. Similarly, Guy, Poythress, Douglas, Skeem, and Edens (2008) demonstrated that ANT scores were similar for men and women and had an invariant dimensional association with the antisocial personality disorder (ASPD) module of the Structured Clinical Interview for DSM-IV across gender, and De Moor, Distel, Trull, and Boomsma (2009) reported Borderline Features (BOR) scale scores to be measurement invariant across sex. In a study using college student samples, Hopwood and Moser (2011) reported that a simplified internalizing/externalizing structure for the PAI, consisting of three scales for each, was invariant across male and female undergraduate students. They noted that such integrative structures for common forms of psychopathology are not expected to differ by sex. This is consistent with a point made previously by Hoelzle and Meyer (2009) that although men and women endorse certain types of self-report test items differently, the structure of self-report measures in terms of correlations between items and scales tend to be similar across genders. These findings for the PAI suggest that when gender differences in scores are found, they reflect true differences in the measured characteristics as opposed to instrument-related artifacts. Further evaluations of this sort on the full range of PAI scales would help solidify this point.

Despite the evidence of structural similarity in PAI scores produced by men and women, some interesting differences in test score implications have emerged. For example, although Guy et al. (2008) found overall hit rates for ASPD classification using ANT scores were comparable across gender, men were more frequently correctly classified by ANT as having ASPD, and women were more frequently correctly classified by the scale as not having ASPD. De Moor et al. (2009) reported that women scored higher than men on three of four factors of the BOR scale—Affective Instability, Identity Problems, and Negative Relationships—across the older and younger age groups they examined. In a study examining relationships between PAI configural profile clusters and factor-analytically based COPE inventory coping style clusters in a community sample, Deisinger, Cassisi, and Whitaker (1996) found gender differences on factors of Social Support and Hedonistic Escapism, with greater likelihood of social support seeking and emotional venting by women and use of alcohol/drugs and humor by men for coping with stress. Such findings provide guidance
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for interpretations derived from the PAI in clinical assessments of male and female clients.

As mentioned earlier, a few gender-specific PAI studies can be identified through a database search. Studies involving male samples have dealt with PAI score patterns among male combat veterans, prison inmates, criminal defendants, sex offenders, batterers, and substance abusers, to mention a few. The strikingly fewer PAI studies focused on female samples have examined findings for incarcerated women, abuse victims, women with posttraumatic stress disorder, egg donors, and gestational carriers. The personality assessor could consult these studies for guidance in assessing clients from these specific groups.

Implications

Research on self-report personality measures such as the MMPI-2/RF, MCMI-III, and PAI identify several noteworthy differences in score patterns of women and men. For the most part, these differences reflect true variance both in type of symptom expression and level of reporting of psychological difficulty. However, the relative contributions of these two factors are difficult to tease apart from each other. Therefore, the assessor would need to carefully contemplate the degree to which test findings reflect the nature and intensity of maladjustment, as well as weigh in the role of gender-related self-expression pattern. Unfortunately, no specific algorithms are available to steer this reflective process. The research literature provides some guidance in terms of illuminating the relative frequency of emotional distress indicators among women and behavioral disturbances among men in clinical settings. Thus, when a man's profile shows high scores on substance abuse indicators, the test interpreter could recognize that this is a fairly common manifestation of psychological difficulty for men but, nonetheless, should be a target for treatment recommendations.

The greater challenge is when score patterns are counter to gender expectancies; for example, when a man's profile shows high levels of somatic complaints in the absence of identified physical health problems or a woman's profile is marked by physical aggression tendencies. In such scenarios, it is important to avoid overestimating the difficulty simply because it is unusual, even while addressing it in the test report descriptions and recommendations. Further complications arise for the limited number of test scales for which gender bias has been reported, indicating the need to exert considerable caution in interpreting the results in order to avoid overpathologizing errors. Overall, the test interpreter has the challenging task and responsibility of arriving at accurate determinations of maladjustment that are influenced but not confounded by gender expectancies.

Special care is warranted in the use of self-report assessments in conducting child custody/parenting plan evaluations in order to avoid gender-related adverse effects. Much of research literature on custody evaluations using various editions of the MCMI (discussed earlier) and MMPI (e.g., Archer, Hagan,
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Mason, Handel, & Archer, 2012) points to differential patterns of scores based on gender. Of particular concern is that women typically score higher than men, which could be erroneously construed as reflecting greater disturbance and could potentially contribute to an unfavorable result for mothers. There is currently little published research on PAI results for men and women in child custody evaluations, an issue that needs attention, as it is increasingly being used in child custody evaluations (e.g., Mullens & Edens, 2008).

The self-report assessment literature is markedly limited in exploring interactions between test scores and variables of sexual orientation and gender identity, and intersections of gender and other demographic variables such as ethnicity and age. Further studies are also needed on how gender-related beliefs, expectancies, and life experiences may influence the assessment process, clients’ test profiles, and assessors’ conclusions. There is practically no information on the impact of assessor gender on client responses, such as on degree of openness or guardedness in self-disclosure, or of gender/cultural background combinations of both assessor and assessee.

With reference to the MMPI-2, but relevant to all self-report personality measures, Friedman et al. (2015) usefully note:

What has not yet been adequately considered in interpreting MMPI-2 patterns are the gender-specific situations that may need to be considered in understanding the clinical significance of an MMPI-2 profile. For example, spousal abuse is disproportionately an occurrence with wives, and the knowledge that a woman is being abused would make the anger reflected in an MMPI-2 pattern more understandable. . . . The clinician must be sensitive to such gender issues to effectively interpret MMPI-2 code patterns. (p. 477)

Accurate interpretation of self-report assessment profiles necessarily involves understanding the results in the multiple contexts of the client’s experience. To illustrate, consider the following two vignettes:

1. A 42-year-old, recently immigrated Asian Indian woman was referred for assessment and treatment of trauma following the sudden death of her husband in a vehicular accident involving a drunk driver. This client had been a homemaker who raised their children while her husband provided the income. The marital relationship was strong, and she was very devoted to her family. The client discussed her loss during the clinical interview but appeared fairly unemotional, contrary to gender-role expectations. Her MMPI-2 profile showed no evidence of emotional distress and no significant guardedness or repression to account for it. Results from a trauma measure were congruent with the MMPI-2 findings. Upon further investigation, two contexts came to light: (a) The client’s stoicism arose from her religious beliefs, being based on the Hindu doctrine that one’s destiny is
determined before one’s birth per the natural laws of causation. Subscribing to this belief system served to protect her from trauma reactions and did not constitute a defensive denial of grief. (b) Following cultural and familial traditions, her brother-in-law took over the role of provider, giving this client and her children a home with the extended family and ensuring her financial and familial support for the remainder of her life. This vignette highlights the intersection of cultural factors and gender-related experiences. It shows how religious convictions can account for a woman’s impassive demeanor in the face of loss, which otherwise appears as a violation of gender-role expectations and/or pathological emotional blunting. It demonstrates the role of cultural/familial traditions in removing any disadvantages associated with a woman’s traditional gender role of wife and mother. Overall, it illustrates the combined effect of these cultural factors in serving as safeguards against acute trauma and maladjustment.

A 28-year-old unmarried man presented with seemingly straightforward complaints of depression, anxiety, and relationship stress. His PAI profile was multiply elevated, conveying high emotional stress and behavioral inhibition. A deeper understanding of his distress came from noting the following: (a) He experienced pressure based on his Middle Eastern heritage and his parents’ traditional expectations that he should be married, employed, and should invite his parents and younger sister to live with him in his home; (b) he had experienced physical abuse by his military father during his childhood and was raped at age 9 by an older boy in the neighborhood; (c) he was currently involved in a polyamorous relationship with a man and a woman who lived with him, ostensibly as roommates; he was unsure if he was homosexual, bisexual, or confused; (d) being obese, he felt no one other than his current partners would enter into a relationship with him. This case example reflects multiple layers of gender-related cultural prescriptions, abuse considerations, sexual orientation confusion, low self-esteem, and intricacies of family and partner relationships that come into play in assessment situations. In this case, cultural/familial prescriptions to be a heterosexual married man and provider for the family of origin, along with the other described experiences, produced considerable anguish for the client and overrode cultural/gender dictates about male emotional expression.

**Practical Points**

- The assessor should be cognizant that gender differences are widespread in self-report personality test profiles. On the MMPI-2, gender effects are seen in greater emotional distress/dysfunction and somatic concerns in women’s profiles and greater substance use and antisocial tendencies in men’s profiles. On the MMPI-2-RF, women seem to express relatively greater somatic and neurological complaints than do men. On the MCMI-III,
typical patterns are in the direction of dependent, histrionic, and depressive features for women and narcissistic and antisocial features for men. On the PAI, women are more likely to report disruptions in affect, identity, and relationships in contrast to antisocial problems among men.

- There is an overall slant toward the pathologizing of women in several of these self-report personality and psychopathology measures, as feminine characteristics are often equated with maladjustment. However, this slant appears reduced when nongendered norms are applied. The assessor must be aware of the impact of such psychometric issues on profile features to avoid making incorrect and skewed interpretations. He or she is also advised of potential gender bias associated with selected test scales. Sensitivity to these matters and mindfulness of one’s own gender stereotypes will facilitate deriving appropriate conclusions from self-report test profiles.

- The findings reviewed in this chapter suggest that homosexual/bisexual orientations and transsexuality are not necessarily associated with greater distress or psychopathology than a heterosexual orientation. Gender dysphoria may hold greater significance for psychopathology assessment, an issue that warrants further attention in clinical assessment practice and research.

- An understanding of clients’ life contexts infuses meaning into test results. The assessor should attend to a host of interacting background factors, including the client’s gender identity, sexual orientation, culture, and socioeconomic status, in interpreting test results, as demonstrated in this chapter’s case examples.

Annotated Bibliography


Comment: This chapter offers an excellent overview of gender implications in personality assessment, addressing issues of test selection, norms, and various sources of bias. Importantly, it discusses contexts and assumptions in assessment and offers useful directions for practice.


Comment: The meta-analytic findings presented in this article include several self-report personality inventories beyond those addressed in the current chapter. It discusses the agentic versus communal divide in men and women’s personality test scores and the constancy in gender differences across ages, generations, educational level, and nationality.

Gender Considerations in Self-Report

Comment: This chapter delves into intersections of sociocultural factors as they impact assessment processes. The authors offer new directions for thinking about gender, race, and ethnicity, illustrated through a case example, and provide a thoughtful set of recommendations.


Comment: For the reader interested in learning more about gender constructs, this chapter discusses gendered personality dimensions and goes into assessment of gender role ideology, attitudes toward transgender individuals, gender identity, and gender-role conflict. Topics of sexism and discriminatory practices are also covered.

References


Gender Considerations in Self-Report


SEX AND GENDER DISTINCTIONS AND THE RORSCHACH INKBLOT METHOD

Conceptual Implications of a Minimum of Difference

Steven Tuber, Kira Boesch, Gregory Gagnon, and Devon Harrison

The field of psychology has produced a substantial literature on the differences between women and men: in mid-2014, a search of PsycINFO for the subject “Human Sex Differences” yields over 90,000 results. For adults, this research has historically relied nearly exclusively on self-report measures, making it prone to the distortions that can arise from either pleasing the examiner and/or displaying an overly simplistic, idealized, or even disparaging (as in cases of malingering) view of the self. The present chapter will address issues of sex and gender through the Rorschach Inkblot Method (RIM; Weiner, 1994), a performance-based technique that largely bypasses these self-report difficulties, but whose nature adds its own complexities to a discussion of differences across the sexes.

Psychology’s broad investment in the differences between the sexes and gender identities appears simply to replicate a primary concern of laypeople, for whom sex and gender serve as efficient criteria for social categorization (see Brabender & Mihura, this volume). Psychological studies have found, for example, that humans are more likely to categorize others on the basis of their biological sex rather than on their race (Stangor et al., 1992), and that newly expecting parents are likely to be asked first about the child’s sex before being asked about either the child’s or the mother’s health (Intons-Peterson & Reddel, 1984). Sex is an essentialized social category (Haslam et al., 2000; Prentice & Miller,
Steven Tuber et al.

2006), on the basis of which people are likely to make assumptions about an individual with little evidence. This tendency carries significant and well-documented implications, including lower pay offered to female workers performing the same duties as their male counterparts (Blau & Kahn, 2007), lower self-ratings of intelligence provided by women than by men (Furnham, 2001), and an implicit bias against female authority shared by people of both sexes (Rudman & Kilianski, 2000).

Personality assessment research, which has historically sought to measure differences between persons as a function of sex, has played a role in maintaining these social phenomena. For nearly half a century, the automaticity of examining personality by sex has been criticized, with an emphasis placed on providing theoretical justification that is often sorely lacking (Cronbach, 1968; Knaak, 2004). Hattie (1979) further notes that many inquiries into what distinguishes the sexes fail to also examine possible similarities. More recently, it has been proposed that the binary division between male and female in the assessment of personality may overlook more meaningful distinguishing properties of sex: That is, sex differences may be best understood as adherence to certain gender-roles or commitment to gender-relevant traits (Bursik, 1998; Prentice & Miller, 2006).

Why Use the RIM to Study Gender?

In their introductory chapter to this volume, Mihura and Brabender note how the emphasis in the assessment literature on self-report measures leaves the client’s responses as highly subjugated to the biases endemic to our culture regarding sex and gender norms. These authors note that performance-based methods like the RIM, although not invulnerable to such cultural biases, nevertheless may provide a useful means for getting at intrapsychic processes that are not as likely to be experienced solely through the prism of cultural norms.

What is the RIM and how is its very nature potentially useful as well as problematic for the study of gender? The RIM, and other performance-based techniques, rests on a foundation that implies a continuum of consciousness. To get beyond the limitations of self-report measures, it seems especially relevant here to broaden our discussion to include the nature of implicit or unconscious processes. A generative paper by Mayman (1967) defined the experience of the RIM as initiating a “reparative” process by which the formlessness of the RIM is replaced by “reminders of the palpably real world” (p. 17). Mayman posited that the nature of the images a person internalizes throughout the lifespan serve as templates for the expectations of future interactions. For the purposes of this chapter, he goes on to note that these earliest images are: “largely tactile and kinesthetic . . . certainly pre-verbal, and in their *enduring form largely unconscious*” (p. 19, italics added).

Mayman’s (1967) paper can rightfully be argued as a cornerstone for the development of measures that utilize the RIM to assess object relations, the
templates we create from interpersonal interactions we experience throughout development. A rich and broad literature has been generated that has demonstrated strong, respectable reliability and validity in the measurement of these largely unconscious internalizations (e.g., Bombel et al., 2009; Graceffo et al., 2014; Stricker & Healey, 1990; Tuber, 1992).

**How Can the Nature of the RIM Be Harnessed to Study Gender?**

If the RIM is rightly viewed as a repository of at least some blend of conscious and unconscious (implicit) ideas and images, then the next question to ask is: Does the unconscious linearly define gender? The answer can be taken from the definition of the unconscious: “the part of mental life that does not ordinarily enter the individual’s awareness yet may influence behavior and perception or be revealed as in slips of the tongue or in dreams” (Merriam-Webster’s online dictionary, n.d.). It is a hallmark of dreams and especially their interpretation (Freud, 1900) that any person in a dream may represent any other, across gender, age, or any other demographic characteristic. Indeed, it is intrinsic to the dream process that specific identities, wishes, and behaviors are markedly fluid, such that unconscious processes have been termed aspects of “primary process” (Freud, 1900), a process whereby the normal rules of space, time, and identity may be discarded or upended to protect the self.

If the unconscious largely consists of consciously unwanted or conflicted thoughts and wishes that must be kept at bay, it follows that while cultural norms may push us to adopt stereotyped gender roles on a conscious level, it is extremely unlikely that unconscious processes could be linked to such fixed conceptions of gender. To take this line of reasoning one step further, if the RIM stimulates at least partly implicit, unconscious associations, it would seem remarkably far-fetched to believe that RIM percepts would also fall neatly into specific categories defined by gender. This notion is further supported by the characteristics of the unconscious system that Freud (1922) specified; impulses “exist side by side without being influenced by one another, and are exempt from mutual contradiction” (p. 285). RIM percepts are also hard pressed to reflect gender differences because gender, as discussed by Brabender and Mihura (this volume), has been increasingly viewed as dimensional and not categorical in nature.

Consistent with contemporary social cognitive research, this perspective on the nature of unconscious processes notes that people quite naturally try to organize and make sense of ambiguous information based on existing cognitive and affective schemas (Tuber & Meehan, 2014). Although conscious deliberation may contribute at a later stage of percept formation, the first (and most influential) steps in processing information occur quite quickly and outside of conscious awareness (Hassin, Uleman, & Bargh, 2005).

It is important to note that as the inherent ambiguity of a stimulus becomes greater (as in the taking of the RIM), the interpretive process becomes more
taxing and reliant on implicit memories and associations as opposed to the
simple retrieval of known information. The use of inherently ambiguous stimuli
prevents the respondent from relying on an easily retrieved, more objectively
derived response. The RIM can be readily understood through the processes
by which the subject produces implicit associations, the content therein, and
the dialectical relationship between process and content. To the extent that this
reliance on idiosyncratic, implicit, and unconscious assumptions defines the
RIM, it makes problematic an attempt to use the RIM to discriminate by gen-
der. Even if gender is considered a categorical variable on a conscious level,
shouldn’t implicit, unconscious associations defy the effects of this categoriza-
tion? Conversely, if conscious experiences of gender are more of a continuous,
dimensional variable, then shouldn’t one’s implicit associations also be placed
on a continuum that equally defies simple categorization? The inability to settle
firmly the question of whether gender is a dimensional or categorical variable,
coupled with the complexity of the associational processes that underlie the
RIM, combine to make the likelihood of empirical findings of gender differ-
ences vis-à-vis the RIM especially problematic.

There is yet another degree of complexity we can add to this dilemma. If we
follow Freud’s (1905) conceptions regarding bisexuality as an innate aspect of
the human experience, with the implication that everyone incorporates aspects
of both sexes, what effect would this have on the unconscious and therefore
on RIM responses? Certainly it provides more support for the idea that on
an unconscious level, human representations cut across both sexual and sexual
orientation boundaries. This, in turn, provides further support for why RIM
studies assessing gender differences rarely find distinctions worth noting.

Are Certain RIM Cards Male or Female?

In contrast to more recent findings, early research using the RIM found evi-
dence of gendered responses. However, these studies prompted participants to
label cards in gendered terms, and thereby, they may not reflect an organic
proclivity to perceive gender in the inkblots. For example, in a 1961 study by
Sappenfield, adults were able to label certain blots as masculine or feminine
when prompted to do so: Although there was no significant difference among
male and female responses, college students rated eight of the 10 blots as gen-
dered when presented with a projection of the standard inkblots and asked
to respond on individual forms with achromatic blots. These distinct patterns
found that Cards III, V, and VII evoked feminine connotations while Cards I, IV,
VI, VIII, and IX were popularly associated with masculinity. Blots II and X
were considered gender ambiguous, as they were equally coded either male or
female. It is essential here to note that seeing specific RIM cards as more likely
male or female can be a function of the perceptual characteristics of the blots
themselves, as opposed to specific gender differences among the persons taking
the task.
At this same time in history, Zax and Benham (1961) investigated this phenomenon among children, asking fifth- and sixth-grade participants to rate cards as either masculine or feminine. They found four cards were rated as either masculine (I and IV by males but not females) or feminine (V and VII by females not males).

Other historical assessors argued that certain cards generated gendered percepts that not only pulled for masculinity or femininity but also for the archetypically masculine and feminine ideas of father and mother. While Cards IV and VII were considered by some to consistently capture paternal and maternal themes, respectively (Bochner and Halpern, 1945), later reviews of the empirical research in this area (Charen, 1957; Laiboe & Guy, 1985) cited poor empirical support for the mother/father card. The critique advanced by Laiboe and Guy (1985) centered on the diversity of hypotheses and methodologies used by the researchers studying the existence of the mother and father cards. This critique also highlighted the extent to which interpretative leaps would be necessary in order to view the study’s results as proof of the existence of a mother and father card. For example, the hypotheses included the suggestion that reactions to Cards IV and VII will be more distinct for adolescents who lack parental figures, as well as the idea that card preference will be influenced by differential attitudes toward the parents (Laiboe & Guy, 1985).

Charen’s (1957) critique raised the question of idiographic versus nomothetic analysis—that is, whether assessment should be conducted under the assumption that “each personality harbors laws peculiar to itself” (Allport, 1947, p. 57), thus requiring the derivation of those laws through careful observation of the idiosyncrasies of an individual person, or whether it is rather necessary, for purposes of prediction and generalization, to derive laws through the application of statistical procedures to large groups of cases. Modern literature on the Rorschach, perhaps more so than any other tool in the assessor’s kit, has been marked by disagreements over which approach to assessment yields more valid and useful results. Is it more profitable to assume that the RIM provides insight into the unique personality structure of an individual, or that it measures the extent to which an individual personality matches—or deviates from—an expected profile?

In the realm of gender research, nomothetic applications of the RIM initially played a prominent role in the assessment of sex-related disorders, when the Rorschach was first thought to pull for themes of male homosexuality. Further early research revealed that both males and females saw male figures on Card III and females on Card VII (Brown, 1971). The literature suggested that responses to these two cards in particular may communicate information about the respondent’s sexuality or attitudes around sex and gender (Ames, 1975). Yet theories vary in their analyses of these communications. Early research believed the presence of bisexuality or two different genders on Card III was an indication of a feminine identification in a biological male (Shafer, 1948, as cited in Ames, 1975). Similarly, gender blurring on this card was once thought
to suggest masculine identification among biological females (Shafer, 1948, as cited in Ames, 1975). Other theorists believed that the description of percepts as males on Card III indicated emotional distress and disturbance in females (Hammer, 1966).

In an attempt to apply empirical rigor to some of these theories, Ames (1975) systematically looked at responses to the RIM as a function of sex and age. Analyzing the RIM records of over 1,000 individuals of both sexes and of all ages, Ames considered the frequencies with which individuals saw men and women on Card III and the other Rorschach cards. The patterns Ames (1975) found challenged extant notions, including the hypothesis that the individual’s response to Card III was an expression of sexual orientation. It is worth noting that Ames’ (1975) nomothetic approach was perhaps the key to this study’s ability to dispel several theoretical misconceptions at once.

Why Are These RIM Studies So Old?

It is essential to note how long ago most of these studies on the RIM and the pull of gender were conducted. It is rare in psychological reports of any kind to so heavily present data that are 50–70 years old. Why do we include such outdated information in this chapter? We argue that it is essential to note these data because they tell us implicitly how naïve, and hence narrow, the field’s thinking had been regarding the complexity of gender. Of course, this thinking was a reflection of a broader social and cultural view of the gender binary. Mihura and Brabender discuss in their introduction to this volume how conceptions regarding gender have historically been blindly placed in a polarized, either-or state: Either you were gay or straight, masculine or feminine, male or female. Categories were discrete, fixed, and permanent; dimensionality or placing any of these polarized variables on a continuum was simply not regularly addressed. Similarly, each of the studies presented above on RIM card differences by gender have at their core this discontinuous depiction of gender. We may argue, then, that the dearth of investigations of gender differences using the RIM in studies of the past 20 years may constitute an implicit recognition that such discontinuous notions of gender have had little place in our field. Our decision to review these historical data is thus an attempt to make this distinction more explicit.

Cultural Shifts in Understandings of Sex and Gender

Brown (1971) was an early pioneer in the consideration of the role of culture in determining gender norms as demonstrated by responses to the RIM. In examining gendered Rorschach responses on Cards III and VII, Brown noted a shift in content from studies conducted from 1956–1959 and those that emerged from 1960–1967. Brown also cited a marked increase in male patients and younger patients (under 40 years old) who see Card III as female or feminine.
In exploring this reversal trend in Rorschach response, scholars pointed to the way this performance-based technique is quite capable of capturing cultural shifts in sex and gender. We argue that this research may indeed be found to be limited further over time, as cultural prohibitions regarding dynamic shifts in gender identity may be increasingly relinquished. There is already some indication of this in the extant literature around other unconscious processes, namely dream content. Differences in manifest dream content that had been established in research dating from prior decades, when studied again in 1998, were shown to no longer remain (Bursik, 1998). Differences in manifest context were observable on the basis of gender role, but gender role did not significantly predict gender. Bursik concluded that gender role may present a more useful dimension than gender for understanding individual differences in dream content.

RIM Studies Questioning Stereotypical Gender Positions

It has been argued that certain RIM patterns may emerge in populations with alternative or less defined gender identifications. For example, in one small study, the Rorschach responses of transsexual men and women tended to capture a heightened emphasis on the concrete features of the actual inkblot, almost prohibiting an abstraction or interpretation and focusing on the physical nature of the card (Mormont, Michel, & Wauthy, 1995). Such response tendencies were thought to parallel the transsexual position, wherein reality and perception stand in conflict: An individual identifies with one sex, despite a contradictory perception of anatomical sex organs. As compared to a heterosexual control group, the transsexual population reported notably fewer Popular responses on the RIM and demonstrated more difficulty with logical thinking in their interpretations. This pattern was indicated by a deficit in form quality or plausibility of response and overall level of realism in Rorschach perception. In this way, the transsexual population studied exhibited a distinctive relationship with reality. It is important to note, however, that in this study the effect of transgender identity status is confounded with the effect of a high-stakes testing situation, since individuals were being assessed for sex reassignment surgery. The results of the study might be explained in part by the stress induced by the test-taking situation itself—an issue to which we will turn shortly.

Another area in which sex-typed responses to the Rorschach have historically been examined is among children who exhibited cross-gender behavior and carried a DSM-III diagnosis of Gender Identity Disorder. Tuber and Coates (1985) looked at the RIMs of 14 boys who expressed much interest in stereotypically feminine pursuits. They found that these “feminine boys” saw human figures significantly more often than was reported in age-relevant normative data in prior studies. Tuber and Coates also found that the boys in their sample produced a similar pattern of responses. While this study did not include a control group, the researchers found that the content of the Rorschach protocols of
these boys included many stereotypical female representations, as well as overall gender confusion in which male and female elements were combined into one response, or the gender of a percept changed, or the subject could not decide the gender of the percept.

In their subsequent investigation of thought organization and ego functioning among such boys, Tuber and Coates (1989) found an increased presence of pathological RIM responses marked by deficits in thought organization and disturbed object representations. Boys who exhibited expressions of their gender that were not congruent with those culturally expected of boys at the time of the study tended to respond to the RIM with malevolent, even violent, object relations and confused boundaries between emotions, perceptions, and abstractions. These poorer quality responses distinguished this group of boys from two other same-aged male clinical samples consisting of a separation anxiety–disordered group and a clinical sample without anxiety (Goddard & Tuber, 1989). These RIM responses helped to highlight the general behavioral disturbance and psychopathology among severe presentations of Gender Identity Disorder, likely influenced by social pressures as much as internal processes.

Zucker et al. (1992) used Tuber and Coates’ (1985, 1989) gendered framework to code the RIM responses in a larger sample with three control groups. Interestingly, Zucker et al. found that 87% of the children in the study offered at least one response that could be reliably scored by independent coders as stereotypically masculine or stereotypically feminine. Based on these scores, the authors found that the gender-referred group (those whose gender expressions were more aligned with the traditional behaviors of those of the opposite sex) gave more cross-sex human responses, in contrast to the psychiatric and non-clinical control samples, which both gave more same-sex responses.

Benziman and Marodes (1997) looked at the RIM protocols of latency-aged boys with a feminine gender identity (as assessed by clinicians familiar with the boys, on the basis of external behavior and knowledge of intrapsychic conflicts) in Jerusalem. Looking specifically at the gender of the human responses, Benziman and Marodes found that while all the children gave more same-sex responses, a greater proportion of the boys in the feminine gender identity group produced cross-sex responses. Furthermore, a majority of boys with feminine gender identity provided a low number of male human responses and a high rate of female human responses. These authors further suggested that the higher response rate of “butterfly” rather than “bat” to Card V, produced by the feminine gender identity sample, is indicative of a feminine representation. These authors conclude that they have identified diagnostic indicators of feminine gender identity in latency-aged boys.

Considered in tandem, and applying present-day nomenclature, each of the studies cited above could be said to have found that boys with feminine gender expressions see more feminine percepts on the Rorschach than do boys with masculine gender expressions. In line with our arguments thus far, the
interpretation of these results would require a consideration of the cultural climate within the 12-year period in the 1980s and 1990s in which all of these studies were conducted. As such, present-day research on gender and the RIM should be more conscientious about current social understanding around the fluidity of gender identity.

The Effect of Administrator Gender

The relationship between gender and the RIM expands beyond sex differences in certain clinical populations; it further includes the effects of test administrator gender on response content and quantity. Early research on examiner gender demonstrated its impact on the total number of responses, suggesting the male examiner and female patient permutation was the most productive or prolific (Greenberg, 1972; Harris & Masling, 1970). In their review of the literature, Milner and Moses (1974) cite test administrator gender as a factor that likely influences sexual content in any given Rorschach response. In their sample of 60 male and female undergraduates, the male subjects, when paired with male administrators, generated significantly more sexually coded responses than any other gender dyad. Male subjects produced significantly fewer sexual responses when paired with an administrator of the opposite sex, while females, who generated fewer overall sexual responses, responded with a similar number of sexual interpretations regardless of the sex of their administrator.

In an effort to understand whether this gender bias was developmentally specific, Tuma and Raw (1975) expanded the subject-experimenter gender research into the realm of childhood and adolescence. A study of over 200 boys and girls, ranging from 4 to 18 years old, revealed that the experimenter’s sex does not make a significant difference on RIM response for male or female youth. Contrary to earlier research, this study found that for both the younger child group and the adolescent group, the impact of examiner sex was minimal. This study did reveal that when compared to their female counterparts, male experimenters have significantly more variability in the total number of RIM responses they elicit. Possible explanations for such a finding include less standardized behavior from male administrators or increased test structuring by females. Moreover, the role of adults as figures of authority may diminish the significance of administrator sex for children.

The specific effect of test administrator sex remains somewhat inconsistent among these RIM studies, but these data share a vision of the RIM as vulnerable to interpersonal factors. Moreover, the literature portrays the psychologist as a gendered force as opposed to some sort of neutral stimulus (Baughman, 1951). Perhaps a feminist perspective would further posit that 40 years ago, when these studies were conducted, female adults may have offered more RIM responses to male test administrators who were perceived as dominant. Research on the dynamics of gender, compliance, and the RIM is needed to capture the possible relevance of such a pattern in today’s gendered landscape.
The Effects of Sex Differences

In more contemporary research in the area of personality assessment, researchers considering the role of gender in personality assessment are often motivated by methodological concerns in their carefulness to look for and address possible gender differences in their construct of interest. Research on self-reported sex difference is prolific (see Chapter 5 by Krishnamurthy, this volume), but there are meta-analyses of over 50 different Rorschach variables, and none of them look at gender.

Thus it should not be surprising that, while limited in number, RIM studies that examine gender differences fairly consistently fail to capture significant gender differences. Whether analyzing responses using a complex Rorschach Performance Assessment System (Meyer, Giromini, Viglione, Reese, & Mihura, 2015; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011) or including a visual imagery reactivity task along with the RIM (Yanovski, Menduke, & Albertson, 1995), there is a literature demonstrating minimal differences on the RIM when men and women are compared. This result holds true even when gender differences were hypothesized, as was the case with Holmquist’s (2012) investigation of male and female juvenile offenders. Similarly, in their more general exploration of demographic variables and the RIM, Meyer et al. (2015) found no reliable connection between RIM response and gender. Notably, this finding held true across their rather large sample of youth (n = 241) and adults (n = 889), as well as across both clinical (n = 490) and nonclinical (n = 640) populations. These results were aligned with the authors’ hypothesis, which pulled from Exner’s 1991 assertion (as cited in Meyer et al., 2015, p. 48) that gender differences on the RIM are trivial at best; they “are inconsequential” (p. 38). These authors note that while the RIM does not produce significant gender differences, gendered personality differences do seem to emerge in studies wherein people have to self-describe, suggesting a gender difference in self-perception, not character. As such, these authors argue that there are not reliable, gendered patterns on the RIM, but rather the male and female RIM response are similar if not indistinguishable.

While these larger studies reach consensus that significant gender difference fail to emerge on the RIM, it is worth noting that limited, smaller studies provide contradictory findings. Cassella and Viglione (2009) looked at the extent to which the number of Texture responses on the RIM can predict attachment style. They found that women tended to produce more texture responses than men, and that in fact a large proportion of men produce RIM protocols with no Texture responses. The authors do not suggest potential meanings of this finding as it is not central to their study, yet they do otherwise conclude that their findings support the standard interpretation of texture provided by the Exner Comprehensive System (2003), in which the Texture response is interpreted as a need for interpersonal contact.

Cassella and Viglione’s (2009) finding on the number of Texture responses as a function of gender replicates a finding by Ivanouw in 2007, in which women
had a higher number of Texture responses than men in a sample of Danish non-patient adults. Ivanouw also found other differences in RIM responses on the basis of gender; specifically, that responses given by men had a significantly lower Form Level than responses given by women. Men also provided more answers using the White Space, and more Space answers with minus Form Quality. Protocols of men also featured a higher number of reflection answers and those that merited scores of MOR, or morbidity. Men produced a greater percentage of protocols lacking human responses altogether, but also a greater percentage of protocols with humans interacting in a cooperative way in more than two images (COP>2). Finally, the protocols of male participants had more nature and cloud content and a higher isolation index.

Findings Using Nonstandard Scales

Other recent studies have considered gender differences among factors outside of the standard scoring system. In a study by Singh and Singh (2000), the RIM was administered to adolescents, and Murstein’s (1965) hostility scale was applied to the responses. The authors found that boys scored higher than girls on this Rorschach measure of hostility. Looking at differential correlations between this variable and other measures in their study, they found that hostility in boys and girls predicted different personality profiles. As such, the authors suggest that gender should be taken into account when looking at hostility on the Rorschach.

Ephraim et al. (1993) found multiple differences between male and female RIM protocols in a Venezuelan sample. These authors looked at differences in scores obtained on the Affective Inferences Scoring System–Revised (AISSR) developed by De Vos in 1952. They found that women were more likely than men to have protocols that contained one response from the following categories on that instrument: internal organs, sexual female anatomy, oral anatomy, childish, and rejection and denial. Men were more likely than women to give responses that fit into the categories of explosion, pretentious, and science. The authors suggest that some of these differences can be explained in terms of gender-role socialization. In particular, the use of oral anatomy, childish (diminutive) terms, and the fusion of typically separate percepts may relate to the nurturance and dependency that can be encouraged for women, while male subjects may experience greater encouragement to express aggression.

Another means of assessing whether gender differences on the RIM can be ascertained in a meaningful way considers the use of scales that were constructed to measure one or more specific psychodynamic constructs. Two of these scales that have generated the most empirically validated research have been the Mutuality of Autonomy (MOA) Scale (Urist, 1977; Tuber, 1983) and the Oral Dependency Scale (Bornstein & Masling, 2005).

The MOA scale has been widely used in studies with children and adults and has received ample validation as a reliably scored measure of object relations.
In two significant meta-analyses of the measure, Monroe, Diener, Fowler, Sexton, and Hilsenroth (2013) and Graceffo, Mihura, and Meyer (2014) confirm that the MOA vividly captures the degree to which individuals represent self and others on the RIM. Strikingly, and in keeping with the tendency to control for gender differences rather than examine them, these two major reviews of multiple studies provide no data on whether there are gender differences using the measure. Tuber (1989, 1992) reported on gender differences in a study of 40 children (21 girls, 19 boys) ages 6–13 from a nonclinical sample. He found that the girls had a significantly more benign mean MOA score, a more adaptive single highest score, and a less malevolent single worst score. However, three subsequent studies using the MOA scale have not found any statistically significant differences in response on the basis of gender when examining both male and female adult participants (Fowler et al., 2004; Harder et al., 1984) and elementary-school children as well (Ryan et al., 1985).

The Rorschach Oral Dependency Scale (ROD) was developed to assess interpersonal dependency and orality in children, adolescents, and adults (Bornstein & Masling, 2005). Men and women typically obtain comparable results on the ROD. In a meta-analysis of sex differences on objective and projective dependency measures, Bornstein (1996) found that the ROD exhibited a modest difference, with men obtaining slightly higher scores than women. Two aspects of this finding should be noted. First, on objective measures of dependency, men tended to score lower than women, so their higher scores on the ROD represents a reversal with potentially notable theoretical implications. Second, the effect was observed in adults but not in children. These two findings provide conflicting support for social role theory. On the one hand, men seem to exhibit higher rates of implicit dependency but lower rates of self-reported dependency, which would be in keeping with social role theory. On the other hand, men appear to develop greater levels of implicit dependency as they mature, a finding that social role theory is ill-equipped to explain.

The RIM and Social Expectation

One other aspect of the RIM that we have not spoken about centers around the idea that the RIM is a culturally relevant social task. To consider the role of gender on the RIM, it is critical to emphasize that, by definition, the RIM is an interpersonal experience. The context of the test’s administration, in which an examiner is writing down verbatim responses so that they may be judged to generate some sort of statement about mental functioning, is undeniably evaluative in nature. This framework thereby forces the participant to filter mental associations through the prism of an evaluative process, making the RIM pull for a combination of implicit and explicit responses, as discussed above. This filtering process may be automatic, seamless, and comfortable for individuals whose unconscious associations are not experienced as malevolent or unraveling. For
those who feel less safe and secure with their sense of identity, such processes may be more laborious, dysregulating, or even impossible. Indeed, it is often argued that the healthier we are, the better we are at organizing and translating our associations with ease, whereas the more problematic or frightening our unconscious is, the harder it is for us to mold it into socially acceptable content. Regardless of the facility of this task, it is clear that the RIM generates a combination of unconscious and conscious processes. While the unconscious is stimulated by the inkblots, the culture in which we live asks us to make some sort of adjustment so that our responses make sense within a current cultural reality. Given the RIM is an inherently social and evaluative experience, the interpersonal aspect of this measure is responsible for the way in which unconscious content must become culturally filtered.

As discussed, definitions of gender and associations around this construct are highly culturally specific and susceptible to change. In understanding the RIM as holding a similar vulnerability to cultural content, the dual nature of the literature on the RIM and gender is further explained: On the one hand, there are examples wherein cultural moments of what gender is are echoed by the RIM, and on the other hand, the RIM captures no gendered patterns, defying the gender binary. As our gender norms change and expand, perhaps a future of more fluid gender response on the RIM will unfold; as our cultural lens shifts around gender, perhaps a percept will not appear so feminine or so masculine, but rather it may capture a comfort with something in between. Certainly, cultural determinations around what is comfortable in terms of gender norms will be reflected in what our unconscious deems acceptable.

Practical Points

• In the assessment of personality, performance-based techniques like the RIM provide an opportunity to deepen the psychological profile generated by self-report measures through the addition of information about the subject’s unconscious and social functioning.
• Gender is a complex, multidimensional, and culturally shaped construct, notable especially for the simultaneous ease with which it is perceived and difficulty with which it is defined. The RIM, in which stable percepts emerge from ambiguous stimuli without much conscious thought, lends unique characteristics to the assessor’s toolkit that may offer new possibilities to the continued study of gender identity and gender roles.
• In any review of the history of psychological assessment, it is likely that some knowledge once upheld as scientific fact will be reframed as the evidence of a distorted bygone worldview. As such, it behooves us to understand our place in the history of assessment, not as the endpoint to a process in which scientific veracity has finally been achieved, but simply as another moment in the evolution of our ever-changing—and hopefully ever-improving—understanding of human nature.
Annotated Bibliography


*Comment:* The authors of this article conducted a meta-analysis of all published studies since 1950, looking at sex differences in scores on various tests, including performance-based techniques. The authors looked at 97 studies in total, finding that women obtain higher dependency scores than men on objective tests while the reverse is true on projective dependency tests.


*Comment:* Mayman's classic article is an excellent introduction to the theory underlying personality assessment using the RIM.


*Comment:* This article examined the role of gender, ethnicity, age, and education on the RIM scores of children and adults in both clinical and nonclinical populations. Their analyses determined that age and education may each have a subtle effect on RIM scores in certain populations. However, their gender hypothesis was confirmed: In both the clinical and nonclinical samples, no significant correlations between RIM scores and gender could be made.


*Comment:* This concise review places the use of four major projective methods in historical context and argues persuasively for the inclusion of such methods in any in-depth psychological assessment process.

References


Gender, Sex, and Rorschach


Various methods of personality assessment have developed over many decades, represented by self-report instruments such as the Minnesota Multiphasic Personality Inventory (MMPI-2; Butcher, Graham, et al., 2001) and projective or performance-based instruments such as the Rorschach (Weiner, 2003). Although the Rorschach remains preeminent among projective methods, instruments such as the Thematic Apperception Test (TAT; Murray, 1943) and various forms of figure drawing tests also are in common albeit less frequent use. Among the performance-based instruments, objective scoring systems with demonstrable reliability exist mainly for the Rorschach and to a certain extent for the TAT (Jenkins, 2008). Narrative or idiographic approaches to clinical interpretation have been used for most projective/performance-based tests, but their role in interpretation has not been firmly established.

I discuss the use of narrative approaches and the data they yield in a specific context of understanding gender and sexuality. I begin with a discussion of two test instruments that yield narrative data—the TAT and human figure drawings (HFD)—emphasizing their development as psychological tests based on narrative verbalizations, followed by a review of research findings on gender variables or male/female comparisons using these test methods. I then will attempt to demonstrate the utility of narrative methods for providing valuable and sometimes decisive clinical information, by considering clinical examples of narrative data using TAT, HFD, and Rorschach verbalizations from five patients. My intent will be to show how narrative data lead to...
hypothesis-generating propositions concerning gender and sexuality in relation to personality.

Combining nomothetic and idiographic approaches to interpreting psychological tests of personality requires a judicious use of both methods. Though some clinicians rely largely or exclusively on nomothetic interpretive approaches, hardly any use only idiographic approaches. Most attempt to combine both approaches, particularly when the objective of an assessment entails gaining a characterologically rich, in-depth understanding of an individual. Schafer (1954, 1967) attempted to understand narrative data by applying a disciplined clinical sensibility using rules of evidence, seeking to find a way to integrate how individuals reconcile the world of external reality, such as problem solving and managing relationships with other people, with the world of inner life that plumbs the depths of psychological experience. Rapaport, Gill, and Schafer (1968), while emphasizing formal scoring methods for understanding personality, also viewed the idiographic or narrative approach to interpreting TAT stories as another unique window for apprehending people’s experience of their inner life.

Integrating nomothetic and idiographic or narrative approaches can seem like walking in a minefield because the rules for deriving inferences from thematic content or narrative test material are not easily articulated, despite Schafer’s (1954) and later Lerner’s (1991) efforts to formulate a systematic approach for clinical interpretation. As a result, examiners are of different minds about how and when to integrate empirical and narrative psychological assessment data. Clinicians combine both sources of data in various ways, sometimes looking for areas of confirmation or agreement but also trying to understand disparities in respect to which source of data to rely on and how to understand what divergences signify in the individual case.

While clinicians rely on self-report instruments and/or reliable Rorschach coding scores for grounding clinical interpretation, frequently they also incorporate impressions derived from thematic content of Rorschach responses and tests that do not usually yield formal scores, such as tests of figure drawings—sometimes known as the House-Tree-Person Test (Hammer, 1986) or Draw-a-Person Test (Handler, 1996)—and the TAT. Despite there being a number of empirical scoring procedures for some tests such as the TAT (Cramer, 1991; Jenkins, 2008) and figure drawings (Handler, 1996), hardly any are in widespread clinical use. Consequently, clinicians utilizing such test methods rely primarily, if not exclusively, on narrative story responses or post-drawing inquiries based on verbalizations concerning the figures that were drawn.

In addition to the issue of balancing empirically based and narrative approaches for interpretation, other areas of clinical interest could benefit from further study of augmenting empirically driven interpretation with attention to response verbalizations. One other area concerns the interrelationships among gender roles, organization and expression of sexuality, and personality functioning. This is not an area of psychological experience that has been studied
extensively in the field of personality assessment. Examining narrative verbalizations may usefully contribute to understanding how individuals perceive themselves and others from the standpoint of gender roles or expectations. It also may shed light about how women experience themselves as women and how men experience themselves as men, how people relate to others of the same and opposite sex, and how individuals’ sexuality is organized and consequently how people relate to one another as sexual objects or in their intimate relationships. Such areas of interest or concern may arise as clinical questions in a personality assessment, or they may emerge as aspects of people’s functioning incidental to more pressing clinical concerns. Aspects of sexuality or gender roles, however, remain infrequently addressed in many assessments unless there is a specific clinical question.

**Personality Assessment Instruments Using Narrative Data**

**Thematic Apperception Test (TAT)**

Dana (1996) and Holt (1978) considered TAT interpretation as capitalizing on clinicians’ trained intuition and disciplined creative thinking, relying on systematic and normatively relevant use of predominant story themes and extensive experience using this test instrument. They, like Schafer (1967) previously, emphasized its value in a hypothesis-testing frame of reference, cross-referencing across stories for interrelated themes and representation of conflicts. Bellak and Abrams (1997) also stressed the integrative function of interpreting TAT stories, using analysis of narrative, thematic material as a foundation for understanding ego functions such as integrity of defenses and impulse control, superego functions, and adaptation as an organizing framework for conceptualizing personality organization.

**Gender Differences.** The theoretical and clinical TAT literature has typically emphasized influences of card stimulus characteristics or preferred cards for use with men or women. However, relying on particular cards or using an entire TAT card set for evaluating gender roles, sexual orientation, and the organization of sexuality has not been a major interest of TAT theorists or practitioners (Handler, 1996). The TAT literature on gender or sexuality in recent decades has largely been limited to incidental references to these topics or to individual case studies, excerpt for May’s (1980) and Cramer’s (1996) studies of deprivation/enhancement fantasy patterns using the TAT, and McAdams et al.’s (1988) studies of intimacy motivation, which also were based on TAT narrative data. The study of examiner-patient interaction or response characteristics has not attracted particular interest in respect to gender variables on TAT performance or interpretation (Handler, 1996).

The empirical TAT literature contains few recent studies of gender and sexuality, although a greater level of intimacy needs or motivation among women seems to be a relatively consistent finding in several studies. Schultheiss and
Human Figure Drawings (HFD)

Figure drawings—whether of humans (HFD), animals, or inanimate objects such as a house or tree—have intrigued cultures since antiquity, and the representations of life forms expressed through drawings has long held symbolic significance for understanding thoughts and affect states. The clinical study of HFD probably originated with Goodenough (1926), who used them as an indication of intelligence in children. Subsequently, Machover (1949), Hammer (1986), and Handler (1996) came to regard drawings as indications of personality in both children and adults. Unlike the TAT, however, there has not been a systematic method of administering the HFD.

Many clinicians rely primarily on drawings of people (HFD)—typically with the nonspecific instruction to draw a whole person, after which a drawing of a person of the opposite sex is elicited—while others obtain drawings of a house and tree in addition to human figures. Handler (1996) pointed out that some clinicians also ask patients to draw their own family with each person engaged in an activity (Kinetic Family Drawing), or to draw specific scenarios such as a person in the rain. Often, but not always, clinicians conduct an inquiry following completion of HFD, employing the verbalizations thus elicited as an interpretive adjunct complementing the information derived from evaluating the quality and major characteristics of the drawings. Scoring methods have been developed for evaluating drawing features, but such scores have mainly been used for assessing developmental maturity or intelligence in children. Like the TAT, there exists no predominant HFD scoring method in widespread clinical use.

Figure drawings, particularly in young children (Koppitz, 1983), are typically interpreted as developmental signposts, and interpretation is frequently based on developmental quality of the figures, whether or not verbalizations about the figures are also obtained. When an inquiry is conducted, the HFD is generally interpreted from the standpoint of what drawings may signify as representations of the self. Kissen (1986) proposed an object relations theoretical perspective for HFD, particularly self and object representations. Besides Kissen’s (1986)
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and Handler’s (1996) use of narratives accompanying figure drawings, most of the clinical and theoretical literature on figure drawings emphasizes analysis of graphic characteristics of drawings.

Handler and Reyher (1965) reviewed a large number of studies examining particular features of the HFD, such as size and relative proportion of body features, distortion, heaviness of lines, and erasures. Their findings were equivocal regarding evidence for the importance of traditional elements of figures, but they concluded that anxiety appeared to lead to minimizing effort and completing and quickly getting away from the task at hand. Hammer (1968), discussing dissociation in respect to drawing features and the verbalizations describing them, emphasized interpreting incongruities between quality of drawings and the narrative verbalizations elaborating on the drawings.

**Gender Differences.** Much of the empirical literature investigating HFD has addressed gender identification, usually by examining whether same- or opposite-sex figures are drawn, either when only one drawing is requested or by examining which gender is drawn first when two drawings are obtained. Houston and Terwilliger (1995) and Aronoff and McCormick (1990) observed that most adults draw a person of the same sex as themselves as the initial figure. Houston and Terwilliger also reported that more males drew opposite-sex figures than did females. Dickson, Saylor, and Finch (1990), studying a psychiatric inpatient sample of children and adolescents and using a design that obtained only one human figure drawing, also found that drawing of a same-sexed figure was normative. Dickson et al. also reported no differences as a function of personality variables (aggression and locus of control) or family constellation (growing up in an intact family vs. growing up in a single-parent family or in a foster home).

There also have been reports on individuals with gender identification concerns. Fleming, Koocher, and Nathans (1979) reported that male and female gender-dysphoric adults drew opposite-sex figures more often than gender-matched controls. Zucker, Finegan, Doering, and Bradley (1983) studied a sample of children whose gender identities did not match their assigned genders, reporting that these children were more likely to draw an opposite-sex figure compared with sibling, psychiatric, and nonpatient controls. Moreover, the children drawing the opposite-sex figure were more likely to prefer toys and clothing suitable for the opposite sex than those children with gender identification concerns who drew a same-sexed figure. Brems, Adams, and Skillman (1993) studied a sample of 31 biologically male transsexuals who were candidates for sex reassignment surgery. They reported few and relatively small differences between these patients and psychiatric and nonpatient controls. Their most robust finding was a greater degree of femininity expressed in the drawings of a female for transsexuals compared to both control groups.

There also have been studies of sex role identification as assessed by the Bem Sex Role Inventory (BSRI; Bem, 1981). Aronoff and McCormick (1990) reported that androgynous persons of either gender showed no preference between drawing a same- or opposite-sex figure first. However, greater degree
of differentiation in the female drawings was associated with lower level of masculinity. Zaback and Waehler (1994) found that individuals categorized as masculine or androgynous on the BSRI, regardless of gender, more typically drew a male figure, and individuals categorized as feminine, regardless of gender, more typically drew a female figure. Nevertheless, no significant HFD preferences remained when men and women were analyzed separately.

Other studies have examined aspects of psychopathology besides the gender of HFD figures. Marsh, Linberg, and Smeltzer (1991) studied drawings from adjudicated adolescents, reporting that boys showed lower impulse control than girls and that the boys in their sample also had greater somatization, depression, and withdrawal compared to adjudicated girls. Nonadjudicated boys also showed lower levels of self-esteem and social acceptability compared to nonadjudicated girls. Rierdan, Koff, and Heller (1982) found that more men's than women's drawings received elevated anxiety and aggression scores. They also reported that the men and women in their sample drew male figures that received higher ratings for aggression and anxiety than did their drawings of female figures. Johnston and Johnston (1986) reported poorer quality of drawings and greater evidence of gender confusion among male molesters compared to nonmolester controls.

**Clinical Illustrations of Narrative Approaches**

The five clinical vignettes that follow—three women and two men ranging in age from 18 to 74—demonstrate a way of using narrative verbalizations from the TAT, HFD, and Rorschach to augment understanding of gender and/or sexuality. Most of these patients did not have gender or sexuality concerns as a primary clinical question. Nevertheless, the relationship between sexuality and personality or psychopathology emerged as a dynamic that might not otherwise have been particularly prominent.

**Ms. A.**

This first case illustrates how narrative projective test responses and the patient's reactions to some of her responses suggested either an immature sensibility concerning the other sex or compromised development of adult sexuality or sex role functioning. The patient, a 31-year-old single woman who was chief of surgical nursing at a medical school–based hospital, was seen for a diagnostic consultation as an inpatient following an agitated psychotic reaction with depersonalization and subjective feelings of emptiness.

After the brief psychotic reaction resolved, it became apparent that Ms. A. led a rather isolated existence outside of her work, having few friends and no particular interest in dating. Her TAT stories revealed a preoccupation with demands being made upon her, leaving her feeling that her autonomy was undermined. At such times, she appeared to regress into childlike behavior, expressing concerns about getting older, which seemed related to feeling
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pressured to take developmental steps into adult functional roles she tried to avoid, including mature sexuality.

Some of her verbalizations were striking for a quality that suggested that this patient could be thrown by situations that confused or overwhelmed her, appearing to leave her unable to find her way to provide a workable resolution. She seemed frozen in her tracks at such moments, and she withdrew from difficult situations she could not easily manage. For example, consider her story to TAT Card 13MF:

This is weird. A husband, for some reason can’t look at his wife because she’s undressed or possibly having sexual experiences he can’t deal with and can’t face her without her clothing on... He was told sex isn’t right, or he can’t perform as a man... She’s sleeping, or just waiting for him, but obviously he has his hand covering his face, like he doesn’t even want to face her... He just can’t deal with it, he walks out of the room.

This story was somewhat atypical being related by a woman, first for its being told entirely from the point of view of the man but mainly for its emphasis on the man’s difficulty with sexuality. Although Ms. A. seemed to emphasize the man’s feeling guilty, it also appeared to be a smokescreen to cover up his extreme and paralyzing discomfort with sexuality. The story emphasized the man’s inability to look at the woman in the picture, and the solution ultimately was to withdraw from the situation. Whether it was a man or a woman described in this patient’s story about a person who seemed to psychologically freeze up in a sexual situation, her story conveyed the difficulty she likely imagines when confronting mature emotional demands or expectations. Earlier stories similarly suggested identification with figures who seemed stuck or unable to take a developmental step, appearing to reflect a compromised capacity to assume mature adult functioning.

After first drawing the figure of a woman and then providing a plausible description of the figure she drew, Ms. A. then drew a male figure as requested, but she was again flummoxed, so it seemed, when asked to imagine what kind of person she drew. She said, “I don’t know. Maybe thinking of things to do around the house. It’s hard for me to put myself in a man’s position or this picture. I’m just having a hard time with this. I don’t know.” Ms. A. was unable to say anything further about the drawing of the male figure. She seemed nearly immobilized by indecisiveness that she could not resolve. Like the man she described in TAT Card 13MF, Ms. A. struggled to picture what a man might think or feel, ultimately caving in to a mental state that seemed to overwhelm her and from which she could not effectively recover.

In striking contrast, she described the female figure as “together,” and thinking it was a depiction of herself, “getting hold of my stressors or what’s bothering me, what I once was... wanting to go back to my apartment, having fun
again and not overachieving. People trying to decide for her . . . I’m satisfied with what I am but others don’t see it like that.” Although emphasizing feeling pressured to achieve and to resist others’ threats to a sense of autonomy, Ms. A. still managed to resolve the dilemma she described and attempt to stand up to what felt like other people’s demands on her. Ms. A. could not, however, seem to get anywhere psychologically with her characterization of the male drawing; she seemed stuck, actually even more than stuck—frozen. Her verbalization suggested how regressed she could become in relation to men and what they were all about. It was as if a woman’s motivations were knowable, regardless of the conflicts or struggles women faced in life, but a man’s makeup and motivations seemed incomprehensible to her. This dynamic reflects an observation by Piotrowski (1950) about TAT interpretation, in which he pointed out that stories about characters quite different from oneself or difficulty producing such stories may refer to psychological experiences about a person that may be disavowed or repressed.

Her Rorschach revealed this patient’s faltering adaptive functioning, dominated by a coping style centered around escaping from and ignoring problems through fantasy, which partially influenced the psychotic distortions she showed on admission. Ms. A. felt threatened when she experienced her dependent or i-entation to the world eroding.

After rejecting Card IX, unable to come up with any response at all, she hesitated at the outset of Card X and finally responded, “Part of a woman’s body, the vaginal area,” and later on in the inquiry, “Where you have sex. The place where you carry life, have kids.” This, from someone who was the head nurse on a major university renal transplant unit! After delivering her initial response, Ms. A. then said, “I don’t know what I’m supposed to be looking for.” She proceeded to give as her final response, “These blue things, like something I’d look at under a microscope, like when I was in biology.” During the inquiry, Ms. A. added, “Things I’ve seen under a microscope, in textbooks.” For someone who had so much trouble getting to first base by imagining what men were all about and who appeared paralyzed and almost childlike when confronting sexuality, she seemed much more confident with what she could see with a microscope or in textbooks.

**Ms. B.**

The following example shows how conflicting gender role expectations may appear in a series of TAT responses. This 74-year-old woman, a homemaker for most of her adult life with brief periods of part-time work as a bookkeeper, was seen for an evaluation of mild but progressive forgetfulness, an evaluation that also included a personality assessment because her family was concerned about a possible underlying depression. The main test findings revealed cognitive functions to be largely intact; there also were no appreciable signs of depression. What was surprising was her reaction to some of the TAT cards and the stories
she told. This case illustrates how gender role stereotypes defining most of this woman's life and the cultural context of her formative developmental years appeared to reveal resentments about forsaken opportunities that eluded her, which she may not have been aware she felt so strongly.

This patient’s verbalizations about the human figures she drew called attention to their unassuming or practical nature and a conventional attitude to life represented by carrying out role expectations and living one's life “the correct way and that’s the way things should be.” Some of Ms. B.'s TAT stories revealed tension between what protagonists tentatively wished for and parental figures in the background setting them straight. A few of her stories concerned sad, unhappy figures proceeding with their lives in the face of pressures to do what others expected of them, occasionally prefacing her stories with comments such as “Oh, my!” and “I can’t stand all this tragedy.” Sometimes, however, the protagonists thought about acting in ways that were uncharacteristically bold or assertive. For example, the boy with a violin (Card 1) was preoccupied with doing the right thing by pleasing his parents while questioning whether his parents were right to insist that he study the violin. Although the boy resolved the dilemma by acceding to his parent’s wishes, he also seemed to harbor a feeling of sadness and lingering doubt whether doing what they wanted was something he also wanted for himself. This theme appeared to continue on Card 2, which Ms. B. described as:

A schoolgirl looking back over her life on the farm and trying to decide if it’s the right future for her. She became educated and saw more of the world and pondering, “Is this for me?” She sees her mother in her situation and not going anywhere. She feels she should strive for better things. She feels like her mother resigned herself to it, and she doesn’t think it’s the thing for her. The family feels she should stay there because she’s so sad and pensive. She's trying to decide if this is the life for her because she wouldn’t be content to just accept it like her mother. It’s the only life her mother knew and feels it’s what her daughter should do.

Ms. B.’s story on Card 2 seemed to capture feeling conflicted about striving for something more than she was socialized to expect for herself, not having a role model to help her take what must have seemed to be a bold step. She struggled against acceding to the mother’s expectations about what constituted an acceptable life and the social expectations common at the time for young women. When asked to imagine an outcome, Ms. B. said, “she goes on for more schooling,” but she seemed to show some difficulty settling on an outcome, as most of her narrative focused on the back-and-forth struggle between the mother’s worldview about the right course of action and her own impulse to follow a different path. I wondered whether Ms. B. was also conveying a veiled sense of a mother who was not attuned to Ms. B.’s strivings,
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unable to comprehend that her daughter might contemplate a different life than the mother's and thus overlooking Ms. B.'s "sad and pensive" uncertainty, mistaking it for not following a prescribed way of life for a young woman of her generation.

I chose this example from a series of TAT responses because it illustrates a possible interpretation to entertain concerning ingrained but conflicted gender role expectations. It remains as a hypothesis to consider and examine further in attempting to understand this patient's current problems, much like a trial interpretation in psychotherapy. Of course, it is not possible to know for sure whether underlying resentment or wistful looking back on lost opportunities emerged at various points in Ms. B.'s life, as she undoubtedly grew into middle life seeing women around her living out hopes and achieving greater autonomy and self-determination than she may have been allowed or permitted herself to experience. One of the values of personality assessment is that narrative verbalizations on tests such as the HFD, TAT, and Rorschach may provide an avenue for patients to articulate subtleties of experience that can give rise to hunches or possibilities about interpretations that may not emerge in other ways. As long as a proper degree of caution is conveyed, narratives such as Ms. B.'s—that come as a surprise in consideration of the rest of the assessment protocol—may offer clues about an unexposed but vulnerable place in a patient's psychological makeup that otherwise remains closely or tightly concealed.

Mr. C.

The next case example demonstrates a narcissistic orientation to relationships with people played out in romantic and sexual relationships. Mr. C. was at age 24 working part time in a family business while playing guitar and singing much of the rest of his time. He described himself as manipulative and stated that he could fake his way through much of life, observing that "I could do almost anything I wanted to do." He quickly gave up on various self-aggrandizing pursuits, such as performing, which he found "hollow," and studying music, which he found disillusioning, preferring now to play music on his own. He recently began psychotherapy because he felt aimless and not knowing himself well, as he put it. The assessment unsurprisingly confirmed this young man's need to be the best or most unique person compared to others, shunning the ordinary or commonplace to go out of his way to come up with what he thought would be creative responses to impress this examiner. More often than not, however, he would come up short and his efforts backfired, which he seemed not to recognize. Narcissistic on the surface but empty and depleted in his depths, Mr. C. went from one attempt to find recognition after another, frequently becoming discouraged and bored.

It should also come as no surprise that Mr. C., a handsome and strapping young man, fell for especially attractive women who desired him and sought him out, probably feeling much like the peacock he described on the Rorschach
He would quickly tire of the women he appeared to conquer, moving on to another source of admiration—not unlike his peacock, which he described as “never having to touch ground.” Mr. C. also appeared to turn to women for soothing when he would feel injured or crushed. His sense of closeness at such moments was usually eroticized, and it was dominated by a fantasy of being invited in which soon left him needing to escape out of a fear that intimacy would require more than he wanted to give.

Mr. C. drew a male figure that he described as an “explorer . . . a TV superhero.” He added that the figure “propels into everything a sense of self-esteem and pride . . . to a degree he writes the play.” Elaborating on his drawing of a woman, he commented that “she’s her own person with her own wants for fulfillment of self-esteem . . . she’s exposed and confident and uninhibited, she’ll bare her breasts.” Although Mr. C. seemed to emphasize a confident, prideful image about both figures, note his response to TAT Card 13MF:

He had too much to drink last night, and so did his friend whatever her name might be. He woke up experiencing a new companion, and not fully sure how he got there. He feels it might be best to write her a cordial note of misunderstanding and apology for leaving her apartment while she’s still sleeping. He feels like a heel, to a degree, but now he’s got a slight grin of male pride. It evaporates all his concerns for her emotional feelings.

It did not take long at all for his “cordial note” to “evaporate” and turn to callous disregard, which seemed to characterize this man’s hedonistic orientation to the world around him—not an easy story for an examiner to feel sympathetic about, and not making Mr. C. a particularly likeable person, either. His story to TAT Card 1, like many people’s story to this card, concerned a boy who is given the violin to play but does not want to and tries to find a way out. Perhaps not surprisingly, considering his narcissistic personality, Mr. C. represented his lack of interest as stemming from a poor choice by his parents for him to demonstrate his artistic abilities. A particularly idiosyncratic turn was how he considered getting out of it: He might either “inflict injury to the violin or on his own arm and neck—if he doesn’t have his arm or neck he can’t play.” Judging from his story to Card 13MF, where his concern about the woman “evaporates,” one could easily bet how he would resolve the dilemma.

Most of Mr. C.’s TAT stories contained a theme about a romantic interest, though more often than not it remained in the background. After mentioning the romantic element, this patient often would launch into a secondary theme that ultimately became the dominant theme of his stories. Sometimes, the second, predominant theme concerned a disturbed relationship with a parent. For example, he began his story to Card 2 by saying that the girl in the foreground was in love with the man working the farm, admiring his ability to communicate with the earth and his strength. The girl then practically disappeared as
Mr. C. developed his story, emphasizing that the man’s mother watched over him with pride—“his strong back and fine attitude is her godly product she’s offered the world.” This patient spoke about how the man was “his mother’s boy created to take care of her and the land . . . the mother has no interest in the world outside their farm and feels it can infect the purity of their fine son.” He concluded with the girl taking one last look because the man “is his mother’s boy.”

On Card 6BM, Mr. C. told a story of putting his mother in a nursing home, telling her that she had already lived her life and now it was his turn. The protagonist wanted to sell the mother’s house so he would then have what he would need to be able to marry his girlfriend. The son acknowledged that the mother is pained by his actions, wondering what she did wrong after “everything she created in her son about good morals and ethics has obviously fallen to the sides.” To Card 7BM, his story was about a father apparently consoling his son after the son learned that his girlfriend wanted to date other men. The son described the girlfriend as having “that special something that drives him wild with physical anguish . . . he wants to impress her and be her everything.”

On Card 3BM, Mr. C. related a story about a woman whose boyfriend had suddenly dropped her and “regardless of the pain she’s feeling, it doesn’t matter.” The woman was then seen as giving a “dramatic performance . . . to some way hopefully understand that pain she felt, by doing it like they do in the movies.” Mr. C. concluded his story by saying that the fictional performance would be enough to help her get over her sorrow and continue a friendship with the boy.

Most of his stories seemed to reprise a theme of callous indifference to the feelings of women being hurt or taken advantage of by men. Grandiosity and entitlement abound, with little more than a passing awareness of feeling like a “heel,” readily giving way to disregard for another’s feelings as any sense of guilt or wrongdoing simply “evaporates.” Indeed, not only did Mr. C.’s “love ’em and leave ’em” inclination seem to leave behind a battlefield of rejected girlfriends he expected to recover on their own, but he also appeared to hope that they would stay in his corner to be there for him when he was narcissistically injured and needed them for support.

His abundant capacity for callous indifference and very likely sadistic treatment of people appeared to dominate this young man’s relationships, including romantic involvements with women. It is not difficult to imagine that the women with whom he became involved soon were pushed to the periphery of his self-aggrandizing needs when they were no longer needed for that purpose or when they failed to provide what he needed to sustain the level of self-esteem he seemed to feel was his for the asking.

Ms. D.

The case that follows provides another illustration of narcissistic entitlement, but here self-absorbed grandiosity covers over a more vulnerable and potentially
fragile personality organization. Sexual orientation, while one area of concern that this patient, Ms. D., appeared to toy with, could easily be mistaken as an important problem for this young woman. However, I will attempt to show that sexuality cannot be considered apart from the psychopathology, and it might well take a back seat to more pressing concerns about Ms. D’s level of functioning, particularly as she was about to enter young adulthood.

Ms. D., an Hispanic 18-year-old who was raised as a young child in France while her father was stationed there for his work and was now beginning her first year in college, was referred for psychological evaluation after reporting paranoid ideation. Ms. D. was becoming particularly cautious while speaking on the telephone and preoccupied that people could overhear what she was saying. She had a history of agitated depression since age 13, and she also was preoccupied during adolescence with fantasies about the occult and vampires. This young woman appeared unconcerned about these symptoms, trying to avoid talking about problems that had led up to this consultation, preferring instead to talk about how she felt school was pointless, about a novel she had written while in high school, and about speaking freely and without concern about forces influencing her actions, such as an Islamic archangel telling her in advance that Michael Jackson would soon die. She described friendships going awry as she felt she was “losing an audience.” Ms. D. also reported idiosyncratic interests, which she considered normal, such as looking at pinup girls and burlesque stars.

Although Ms. D. was highly intelligent and verbally adept, she seemed inclined to go over the top with highly abstract verbalizations and ideation that mainly appeared to distance her from people. She seemed to flaunt her intelligence by denigrating others whom she felt were inferior because they could not match what she believed to be her superior intellectual powers. It was often difficult to draw the line between extremes of intellectual overproductivity—which sometimes missed its intended mark—and overt thought disorder. Using her intellect this way also seemed to insulate her from what she probably experienced as narcissistic injuries as people pulled away from her or tired of her unrelenting wittiness stemming from a need to constantly not let people forget how brilliant or creative she could be. It seemed that a guiding principle for her was outwitting others to exert power over people before they might undermine her self-esteem. Pride in her unsentimentality appeared to conceal a deep insecurity about self-worth in an effort to protect herself from further humiliation or rejection. This young woman’s real affect life seemed strangely submerged as she spoke about events that most people would find deeply disturbing.

Ms. D. seemed to particularly disparage men, whom she enjoyed seeing in flawed or ridiculed positions, and I had the impression that she may have taken a kind of perverse pleasure in sensing my discomfort about listening to or trying to record her lengthy verbalizations on the projective test protocols. There was not a single Rorschach response that was a simple, straightforward bat or butterfly anywhere in her record. Any examiner would easily be annoyed by how difficult it was to follow her train of thought while attempting to write down
all that she said and simultaneously pondering how to conduct what unsurpris-
ingly turned out to be a tedious and difficult inquiry—something no examiner
would relish, which I thought Ms. D. sensed and played for all it was worth to
see if she could undo my composure or make me feel foolish in the process. Her
verbalizations concerning women were not as denigrating as those concerning
male figures, although there were several indications suggesting a distrust of
women and keeping women at a cautious distance.

She also seemed to enjoy playing with a superficially facile, pseudosophisti-
cated appearance of casualness regarding sexuality, frequently alluding to homo-
sexuality. Closer analysis seemed to suggest that sexuality, much like the rest
of her personality, was largely organized around narcissistic needs, distrusting
others, and disregarding their needs as a result.

Here is this patient’s verbalization following her first drawing, which looked
like a nude woman with male genitals:

It has both sides of human sexuality, somewhat androgynous. I left
it more female because they’re more graceful. I made it curvaceous
because even though society’s emphasis is on thin, I think all types
should be represented. I included the navel as it is a sign of one’s birth.

When I asked Ms. D. to describe the person she drew, directing her attention
to what the person was like on the inside, she said:

Very competent, they’d still want to hide something of themselves
because everyone has something to hide. They accept themselves but
are unsure what the world has to say, but at the same time they don’t
care. They’re most likely asexual, indifferent as to what gender or creed
as to who they love. Somewhat pure-hearted.

Ms. D. proceeded to talk about abstract qualities such as divisions in politics
and immortality when I asked her to describe what would make the person
she drew anxious or depressed. She appeared to conceal as much about the
person as she noted in her verbalization above, speaking in platitudes con-
cerning the unfairness of people or vague, quasi-philosophical meanderings.

Her drawing of a person of the other sex, which looked more like a nude
male, although without male genitalia, was described thus:

I already drew that. I don’t necessarily believe in binary genders, so this
is difficult for me. Again, I made them gender-neutral. I gave him/her
what seems to be labia and a vagina because I believe that whoever
they choose to be, they should be able to procreate. I gave this a more
masculine shape with broader shoulders and a wider chest, but I gave
them longer hair and a more squarish face. But I did want to include
female characteristics because I believe there’s both in everyone.
In much the same way as she related her clinical history, in her drawings, Ms. D. dealt with material that would typically engender anxiety or discomfort in a matter-of-fact, coolly distanced or intellectualized manner. I have no way of knowing how her sexuality was organized because there were so many layers of defensive, guarded language that was difficult to penetrate—a word I am using here fully aware of its multiple meanings. Ms. D. stood her defensive ground steadfastly, regardless of how many different ways I tried to pose inquiry questions bearing on affect states or motivations. Her unyielding though vulnerable defensive veneer managed to contain what almost certainly concealed an underlying brittleness of her psychological makeup, considering the presenting symptom picture. Despite attempting to appear capricious if not cavalier about sexuality or sexual identification, Ms. D.’s narrative about her drawings was hardly convincing as a depiction of someone as comfortable with or indifferent about sexuality as she made it sound. Few high school students are anyway, and this patient was no more persuasive in this regard than she was when speaking about how she began to “embrace death as another phase of life,” when she described fearing her mortality, or when she described feeling sad as “more of a mourning for my childhood when I was happy and completely nocturnal . . . and seeing how miserable adults look.”

Her TAT stories and Rorschach verbalizations continued in the same vein, displaying a superficially facile but ultimately confounding or defensive portrayal of this patient’s gender identification or sexuality. Her stories seemed to belie a pseudosophistication about experiences she probably did not know very much about. For example, on Card 3BM she told a story about a young woman who moved to a city, went to an office Christmas party, and became involved with a male co-worker, getting into a drunken argument with him. The woman then left the man’s apartment, quit her job, and became an activist for abusive lovers. I must confess that I could not tell whether Ms. D. was serious about the story she told or whether she was playing me for a fool, which I suspect is how she comes on to the people around her. The people in her life probably never quite knew whether Ms. D. was being serious, trying to convey something about herself, acting in a pseudomature or pseudosophisticated manner, or toying with her “audience” by making people feel foolish.

And so it continued throughout the rest of the TAT. On Card 7GF, she told a story about a girl becoming disenchanted with her baby doll and rejecting a domestic homemaker life for herself. The girl then gave the doll to her brother to show that a boy could have a feminine side. The girl grew up, cut off her hair, and dressed and lived as a man—a “drag king”—while being praised by her company for her progressive ideas as she strove to live outside societal norms. Even Ms. D.’s story to Card 1 was not simply about a boy looking at a violin; hers was a story about a French aristocrat playing a Stradivarius violin.
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There is always a possibility that Ms. D.’s stories might be interpreted as those emanating from a bright young woman with a sharp mind imagining being grown up and sophisticated, or as someone struggling to find a way to experience sides of herself that others would regard as unconventional. Indeed, some graduate students regarded her responses thus when I would use this case as a teaching example. For this reason, it deserves reemphasizing the reason for referral for the psychologicals—to evaluate a psychotic process or thought disorder—in the context of Ms. D.’s presenting symptoms. The nearly nonstop bluster throughout most of her narrative stories and Rorschach verbalization would leave most examiners hard pressed to sustain such a benign interpretation for very long. Consider, for example, the following sequence of responses to Cards II and III on this patient’s Rorschach, which I cite for its relevance to the narrative verbalizations in respect to sexuality.

On Card II, Ms. D.’s first response was “someone’s first period, very messy, it’s kind of shaped as the downstairs region . . . the way the color’s splattered just shows the confusion of a first period.” Something more overtly painful may have slipped through her defensive veneer, something she could not easily turn into an intellectualized or playful, sophisticated trifling as she typically did in most of her verbalizations. Ms. D. seemed to recover her composure somewhat in her second response to Card II, which she described in her characteristically over-the-top manner as “two Eskimos kissing, the way they rub their noses; each one is holding half of a heart, some kind of Valentine’s Day kitsch. And pigeons. Their love is underappreciated, it’s being ruined by bitchy pigeons tearing them apart.” Ms. D. delivered a third response to this card—“rabbits hit by a car, like a trauma, the way the blood comes out.” Her psychological recovery did not seem to last very long, as it was difficult for her to sustain her unsentimental, cynical “kitsch . . . bitchy pigeons” defensive position as the compelling imagery of blood and trauma appeared to grab hold of her again. It appeared to leave her at least for the moment reexposed to a psychological position that was probably not easy for her to deal with in her unsentimental, arm’s-length manner. Sexuality or possibly a hint of affection was fused with some of the imagery about blood Ms. D. saw on this card, and it seemed to catch her off guard and trying to distance herself from the anxiety Card II may have evoked, albeit not particularly successfully.

She did begin Card III, however, with a response of French burlesque dancers surrounding a rich man wearing a big red bow tie, but Ms. D. followed this response with one of a frog in “mid-dissection . . . it was dissected soon after its death, the blood’s still fresh.” I could easily imagine that the distress of the raw nerve triggered by the red color on Cards II and III was indeed “still fresh” for her. What was particularly interesting about the red color and her references to blood on both of these cards was that they seemed intertwined with subtle or innocent intimations of sexuality—such as her defensive or fanciful images (Eskimos kissing, Valentine’s Day kitsch, underappreciated love, burlesque dancers surrounding a rich man with a funny-looking bow tie)—but also more
frightening or violent imagery (rabbits bleeding as a result of a traumatic injury, frogs being dissected), which also contained a reference to emerging sexuality (‘‘the downstairs region’’ representing a confusing first period).

It was not entirely clear whether this patient was teetering between a destabilizing breakdown of psychological functioning and a smoothly functioning defensive organization built around isolation and distancing. Nor were the hints or provocative glimpses into her sexual organization well clarified by the personality assessment. It may not have become clearer, perhaps because it remained unformed in this young woman now at the threshold of young adulthood, and she may have been loudly trying things on for size without fully recognizing what anything meant for her. Ms. D’s vulnerable personality organization was probably too unsettled and fragile for sexuality or gender identification to have stabilized.

That may be the main point of the interpretation of this personality assessment protocol, and as a result it may be prudent to wait and see what emerges over time rather than place much credence in the content of the narrative stories she related about sexuality or the allusions she entertained in her narratives. Like troubled adolescents and young adults who go on to settle into a relatively stable albeit chaotic borderline personality organization, the dramatic fluctuations comprising the precursors of borderline personality in adolescence sometimes need time to become more firmly established for just what they are. Regarding Ms. D., it still may be too premature to know what to make of the pattern of psychopathology she showed, including her gender role functioning and the organization of her sexuality. We can tell that it may be confused, possibly chaotic, and very likely troubling for her, but it may be too soon to know at present what form or level of stability the organization of her sexual functioning and gender role development will take as she enters adulthood and has to navigate the difficulties that lie ahead of her.

Mr. E.

The final case illustrates how sexual functioning and its influence on sex role identification was impacted by acquired cerebral dysfunction. Not unlike Ms. D. above, this patient’s sense of himself as a sexual being was integrally related to his personality organization.

Mr. E., age 48, had sustained appreciable brain damage following an episode of cerebral anoxia, causing him to give up his position as an executive at a company he had run for the past 10 years. This represented a significant loss to Mr. E., creating appreciable disappointment and frustration for him. Because the personality issues seemed to be as relevant to assisting this patient with adapting to a considerably changed life with a guarded prognosis for neurocognitive recovery, an assessment of personality was included with a neuropsychological evaluation of the extent of cognitive dysfunction.

Mr. E. was an assertive and hard-driving individual who seemed hard-wired to persevere and fight back against adversity. He went back and forth as he took
the measure of where he was and where he was going in his life, sometimes imagining himself as animated and vigorous but also preparing to say goodbye to a world he no longer fully inhabited. He was struggling against trading in a life of successful accomplishment for one dominated by a quality of bittersweet psychological experience of being alive but accomplishing little.

He had not yet given up on making his way in life to try to reestablish what still held meaning for him, but increasingly it was sinking in that the likely permanent impairment of cognitive capacities was to be an inevitable consequence of his future. He seemed to feel the way he described his final response on the Rorschach protocol: “a bug that had a bad day and got squooshed. The head is here and the body pancaked. There’s blood coming out and organs falling out. Someone stepped on it.” Like his bug that had a bad day, Mr. E.’s days had indeed become very bad.

However, Mr. E. also was nothing if not persevering and pushing himself to the limit, and he was not about to readily give in to becoming anything like the bug he described above that had “pancaked.” He still was going to try to pick himself up and recover if he could. For example, on Card IV, Mr. E.’s response of a “poor excuse for an image” referring to a dark road was followed by a response of “shoulder pads for an athlete, but a little far-fetched to me.” The diminished, despairing dark road followed by an image of something worn by an athlete conveyed both the uncertainty of what he faced alongside a viable self-image he could still imagine somewhere within himself—far-fetched or not.

His TAT stories also reflected Mr. E.’s determination to persevere. The boy with the violin was a story of “his trials and tribulations learning his violin . . . he’s frustrated and bewildered . . . he continued and it became a big enjoyment for the balance of his life.” The girl on the farm was “very diligent to improve her life . . . she works hard and aspires to the success she planned for herself . . . she becomes very successful.” The young man standing next to the older woman became a story about a man “who just lost his job . . . he assures his mother that he’ll find a job and he gets a better job than he had before.”

Despite these optimistic outcomes, the TAT demonstrated how difficult it would be for Mr. E. to come to terms with channeling his strong sense of drive and perseverance into something far more modest and possibly unsuccessful. He was still in both places in his life, going back and forth as he tried to balance what he was with what he imagined to be in store for him as he looked metaphorically over a dark, uncertain horizon he could not entirely comprehend—an image he himself described in two of his Rorschach responses.

Particularly interesting was Mr. E.’s story to the picture of a person in silhouette sitting by a window: “this man couldn’t sleep and looks up at the moon, he shared with the moon his concerns and plans for the future. He discussed with the moon his life, as if it were his best friend. The moon slowly set and, feeling comfort, he went to bed and got a fresh start in the morning. He looked inside himself for the strength to continue on.” I regarded this story about turning to the moon as a comforting friend to represent a good test indication of a
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companionate, alter-ego or twinship self-object function, to use Kohut’s (1984) characterization.

For someone as injured as Mr. E., struggling to reconstruct a life following the debilitating cognitive and functional adaptive deficits he faced, it should not be surprising that the effect of Mr. E.’s injuries on sexual functioning and his changing view of himself as a man also might play on his mind. For example, returning to his Rorschach, in between the “poor excuse for an image” and the athlete’s shoulder pads on Card IV was a response of “a woman’s ovaries or something like that . . . vagina, the pelvis area, her ovaries . . . to me it’s just a meaningless blotch. It doesn’t stimulate anything. I have a pretty good imagination but this is pretty dry stuff.” Mr. E. was probably indicating that his capacity for sexuality also had suffered in consequence of his injuries, as he attempted to reconcile what now may have felt like “pretty dry stuff” with thoughts or memories of sex as stimulating. Perhaps still trying to hold on to an image of himself as an “athlete,” dealing with a “poor excuse for an image” may also indicate how he struggled to come to terms with a change in his sexual capacity.

This patient also gave a response on Card X of “fireworks, some are going off and others are dissipating, they’re exploding and the redness of the smoke dissipating. The dark areas are like the smoke that dissipated in the sky . . . The aftermath of the fireworks display.” This response of an exciting fireworks explosion dissipating seemed to be a variation of Mr. E.’s earlier response of a woman’s sexual organs as “pretty dry stuff . . . it doesn’t stimulate anything” on the same card as his responses of an athlete’s shoulder pads and the “poor excuse for an image.” It seemed that Mr. E. was really saying much the same thing in all of these responses, and it would not seem too much of a stretch to regard this sequence of responses as representing a portrayal of his sense of himself as a sexual being in addition to its depicting how devitalized this man could feel as he struggled to rebuild what he could of his vulnerable self-esteem.

An Approach to the Clinical Interpretation of Narrative Verbalizations

As examiners, we frequently search for the unique characteristics of response verbalizations to deepen interpretations as we strive to make sense of individuals’ symptoms, personality dysfunctions, self-esteem disturbances, and problems of work, intimate relationships, and everyday interactions with others. By insightfully making the best of what various tests offer, a judicious but still probing analysis of HFD and TAT verbalizations helps to augment what may be learned from structural data on tests such as the Rorschach to anchor clinical interpretation, as I and others have emphasized (Schafer, 1967; Silverstein, 2013).

Looked at from this standpoint, the HFD offers a phenomenological picture about how people perceive themselves and present themselves to the world. It is not uncommon for an HFD narrative to yield a depiction of a person’s sense of himself or herself as invigorated or depleted, confident or diminished, or
what one regards as lacking or incomplete within. It also is not unusual for the HFD to offer a glimpse about what a person needs or is searching for to buoy self-esteem. However, it must be emphasized that not a great many people can generate a rich, vivid characterization of themselves or others, thus it frequently falls to examiners to help people generate as rich or complete a narrative as they are able to develop. Consequently, the greatest value of narrative verbalizations accompanying the HFD—and equally on the TAT—inevitably must rely on examiners inquiring in a way that gets close enough to reaching the level of depth we are looking for people to find within themselves.

For example, someone might say that a person they drew looked sad or unsure about themselves. Typically, an examiner would probe further to try to discern why the person in the drawing seemed sad or what the figure was unsure about. A patient might then say that the person in the drawing was sad because she or he felt alone, or unsure about his or her ability to achieve a goal such as being able to pass a test. Such details tell a bit more but still do not go far enough toward more fully understanding a person’s inner life. Further inquiry directed at a deeper level may be necessary to understand what it signifies for the person as drawn to be alone or to not pass a test, because we need to meaningfully grasp the particular quality of loneliness (e.g., a momentary state from which one bounces back or a more debilitating sense of despair from which a person sees no way out) or of failure (e.g., being able to pick oneself up and try again or a sense of utter worthlessness leaving a person immobilized or irreparably damaged).

People also may reveal their degree of comfort with the level of psychological intensity such probing stimulates, including the defenses they need to protect themselves should they feel too threatened. Not only do we attempt to probe as deeply as a person can reach, but at the same time, we are looking to see whether people are able to maintain a coherent and logical narrative. This offers yet another indication concerning the resiliency of defenses and the level of intactness of the underlying ego integration. The same considerations apply as well to TAT narratives and Rorschach responses, although perhaps in a more limited or circumscribed way on the Rorschach.

In this way, by considering the HFD as an initial phenomenological indication of self-cohesion and ego integration, it is but a natural step to proceed to the structural data from the Rorschach to systematically examine quality of thinking, regulation of emotionality, and the capacities for modulating drives and satisfying their expression within the bounds of reality. Although the response content of Rorschach verbalizations provides the basis for the structural findings, it also provides a rich source of insight about predominant conflicts, defenses, and the interplay between drives and defenses. For example, while it is one thing to say that a person’s thinking becomes compromised as anxiety mounts or that one’s realistic appraisal of other people’s intentions interferes with judgment when a person feels suspicious or threatened, it is possible to add a layer of greater understanding if we also were able to infer
that the person whose thinking faltered became anxious when powerful figures
loomed overhead or undermined autonomy, or that a person’s compromised
judgment stemmed from a vulnerability to feeling overpowered or diminished.
Thus, Rorschach response content may augment the structural findings by put-
ting meat on the bones of the skeleton, so to speak.

Once these elements of the total picture come into clearer focus, it falls to
the TAT narratives to add still further detail and nuance by capturing how the
self and object world become expressed in important psychological situations or
with other people involving circumstances such as separation and individuation
(e.g., on TAT Cards 1 or 2) or managing affect states (e.g., Cards 3BM or 18GF).
Here again, as with the HFD, it behooves examiners to conduct thoughtfully
considered inquiries that bring a sophisticated understanding of psychodynamic
influences to guide thinking about what to ask during an inquiry. As a result, it
is important to conduct an inquiry that extends well beyond eliciting superficial
outcomes or obvious interpersonal interactions. The purpose of the inquiry,
after all, is not to stop once it is clear that a narrative has a beginning, middle,
and an end; a richly meaningful inquiry uses a well-developed understanding of
a theory of psychodynamics to try to explain, for example, how people struggle
to reconcile drives with reality or how they attempt to sustain self-cohesion in
the face of threat or injury.

In an approach to interpretation such as that described above, examiners
can make good clinical use of response content and narrative verbalizations to
build on self-report and structural findings and, in many instances, to generate
interpretive hypotheses that may not otherwise be readily discernable using
other methods. It represents an approach that takes good advantage of multiple
sources of data from psychological assessment instruments as guided by a sophis-
ticated, theory-driven understanding of mechanisms of personality organiza-
tion. In respect to comprehending the clinical meanings of sexuality or gender
role functions, richly developed narrative verbalizations enable examiners to
position sexuality and gender in a broad conceptualization of individuals’ per-
sonality and its development.

**Practical Points**

- Verbalizations accompanying figure drawings, obtained from an inquiry
  following completion of each drawing, and narrative stories on TAT cards
  may yield rich information concerning people’s experience of themselves
  and others augmenting clinical data obtained from empirically based
test-scoring methods.
- Rorschach verbalizations may also provide elaboration or embellishment
  of themes that are indicated in a broad, general way using mainly formal
codes.
- Narrative verbalizations obtained from projective test instruments may be
  particularly well suited for explicating gender role functions and sexuality.
Human Figure Drawings

Most test-based scores point to indications of problems in these areas; however, they do not necessarily provide specific information or elaboration of conflicts concerning gender and sexuality that may unfold more clearly with narrative data.

Annotated Bibliography

Comment: This chapter provides a comprehensive overview to interpreting figure drawings.

Comment: This text offers a sophisticated approach to using psychodynamic theory, specifically here object relations theory, in interpreting narrative test responses.

References


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PART III

Personality, Psychopathology, and Gender-Based Issues
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ASSESSING AND INTERPRETING ADULT ATTACHMENT WITH GENDER-NONCONFORMING CLIENTS

Hal S. Shorey

As a leading theory of personality, with measures that have predictive and discriminant validity in relation to personality, achievement, and clinical outcomes, attachment theory has been gaining increasing attention in the area of clinical personality assessment. The theory juxtaposes normal development with pathological developmental trajectories (Bowlby, 1988). As such, it is useful for understanding vulnerabilities underlying psychopathology and guiding case conceptualizations and treatment (Shorey & Snyder, 2006).

The theory emerged through John Bowlby’s (1969) clinical work with child clients, was refined and operationalized in the context of Mary Ainsworth’s (1973) observational research and development of the “Strange Situation” measurement system (Ainsworth, Blehar, Waters, & Wall, 1978), and was applied to adult functioning through the development of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), the more recently developed Adult Attachment Projective Picture System (AAP; George & West, 2012), and a host of self-report measures. These measurement systems ushered in more than two decades of research on adult attachment, personality, psychopathology, and treatment.

One problem with much of this research is a paucity of attention to issues of sex, gender, and gender identity. Gender differences in attachment are often found when self-reports are utilized (Schmitt et al., 2003), whereas research with the AAI has revealed no gender differences (van IJzendoorn & Bakermans-Kranenburg, 2010). This situation calls into question how assessment results relating to attachment styles and dimensions are interpreted and
applied at the level of the individual in clinical settings and with gender-non-conforming clients. My goals in this chapter are therefore: (a) to review the theoretical perspective and research on the relationships between gender, gender identity, and attachment; (b) to evaluate some of the most popular attachment-based assessments systems in terms of gender identity issues; and (c) to make recommendations for best practices in interpreting adult attachment findings in the context of clients’ family socialization experiences and present-day gender identity.

Theoretical Underpinnings

Bowlby (1969) proposed that factors present in the real external environment, as opposed internal drives or childhood fantasies, are the primary determinants of normal/healthy personality development or deviations in the direction of psychopathology. Bowlby’s (1969, 1988) propositions can be traced to his affinity for the natural sciences and the idea that young humans, similar to other animals, are biologically predisposed to maintain attachments to groups and more powerful others because maintaining such attachments has basic survival value.

The attachment system acts as a homeostatic mechanism that uses the person’s experience of anxiety to keep proximity seeking and exploration in balance. When the child strays too far from the parent in exploring the environment, anxiety becomes intolerably high and motivates the child to reestablish proximity. When children are young, security is attained through seeking real physical proximity to parents. As children mature, they build on these early experiences and form internal mental representations of themselves in relation to the parent (i.e., working models) so that they can maintain senses of proximity in the event of separation (Bowlby, 1988). These working models allow the developing person: (a) to anticipate how others and the environment are likely to respond under various conditions; (b) to learn how to regulate distressing emotions given the environmental context; and (c) to initiate behaviors that maximize the experience, if not the direct attainment, of security and proximity to attachment figures.

Because people tend to behave in ways that elicit reactions from others that are consistent with their working model (Allen, Coyne, & Huntoon, 1998), attachment dispositions are continually reinforced across the developmental years, carry forward into adulthood, and have profound influences on adult mental health and psychopathology (see Batgos & Leadbeater, 1994). As such, the attachment patterns and styles to be reviewed in the next section should be viewed as fully applicable to adult functioning, health, and psychopathology.

Attachment Patterns and Styles

Although clinical assessment systems and self-report measures are not highly related empirically (de Haas, Bakermans-Kranenburg, & van IJzendoorn, 1994),
they use similar labels for the attachment patterns (the term used in the AAI and AAP) and styles (the term used in self-reports), and draw on the same underlying theory. Throughout the remainder of this chapter, I will use the word “styles” to refer to the categories yielded by both systems.

People who were raised by parents who provided adequate reflective functioning, who were consistently warm, available, and responsive, and who also maintained high standards for their children’s behaviors tend to develop secure attachment styles (Bowlby, 1988). Confident in caregiver availability, secure children are free to focus their energies on exploring their interpersonal and natural environments and become increasingly efficacious individuals who believe that (a) they are lovable and worthy of support; (b) others are responsive and available to provide support when needed; and (c) the world is a safe and predictable place (see Bowlby, 1969; Brennan, Clark, & Shaver, 1998). Securely attached individuals comprise approximately 55% of participants in nonclinical samples (see Shorey & Snyder, 2006).

When parents, for whatever reason, are not able to provide their children with consistent warmth, availability, responsiveness, and high standards, children will naturally adapt to optimize their perceptions of security in relation to their parents. When parents are inconsistent (i.e., sometimes available and warm; sometimes rejecting and cold), children learn that they cannot take parental security for granted, and they become hypervigilant for rejection cues in order to head off feared abandonment (Bartholomew & Horowitz, 1991). Over time, they develop chronic high levels of attachment anxiety and become preoccupied with relationships.

Individuals who have preoccupied attachment styles are likely to be overly dependent on others (Brennan & Shaver, 1998) for problem solving and guidance, their good feelings, and their senses of self-worth. Preoccupied adults also tend to devalue the self while overvaluing others (Brennan, Clark, & Shaver, 1998), which leads them to engage in frequent reassurance seeking. Thus, they pull for the experience they fear the most—rejection (Bartholomew & Horowitz, 1991). By extension, they report high subjective levels of distress and psychopathology relative to their securely attached counterparts (see Shorey & Snyder, 2006).

In contrast to those with preoccupied attachment styles, people who develop avoidant/“dismissing” styles regulate their emotions through “deactivation” of the attachment system (Mikulincer & Shaver, 2003). When parents are consistently rejecting of the child’s neediness or negative emotional displays (e.g., crying or expressions of anger; see Connors, 1997; Main, 1990), children learn to forgo asking parents for attention, comfort, and support. In order to cope, the child is likely to selectively ignore negative social cues, suppress negative affective states, and deny needs for closeness and intimacy; hence, the dismissing label for this style connotes that the person is dismissing of intimacy. Adults with this style have difficulty describing their own emotional experiences (see Diamond, Hicks, & Otter-Henderson, 2006), report little in the way of psychiatric
symptomology, and tend not to value or perceive benefit from psychological interventions (Shorey, 2010).

The preoccupied and dismissing attachment styles are adaptive in that they facilitate organized emotional experiences and coping responses. People who develop the fourth style, which is variously labeled disorganized (Strange Situation label) unresolved (AAI and AAP label), and fearful (self-report label), are not able to cope consistently with social stressors or regulate emotions. In childhood, their parents were typically unresponsive, frightened, or frightening (Cassidy & Mohr, 2001). Contemporary theorists propose that severe failures of early attachment relationships, and specifically the abuse and neglect associated with disorganized attachment patterns, are likely to impair the right brain’s and limbic system’s regulatory stress and coping functions (Bowlby, 1988; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Schore, 2001; Siegel, 2002). These early distortions in the regulation of emotions and behaviors as experienced in the parent–child relationship are likely to lead to later emotional and interpersonal disturbances, which in turn feed back and consolidate insecure attachment patterns (Carlson, 1998).

Because the fearfully attached person is likely to view the world as unpredictable and threatening, he or she also is not likely to trust others and may infer malevolent intent. As such, she or he is likely to shy away from asking for the very support that is so much needed and desired. Because of their difficulties in affect regulation, social skills, and inconsistent behaviors/coping strategies, these fearfully attached individuals are likely to evidence deficits across multiple life areas. Of all four attachment styles, they have the worst mental–health outcomes (Brennan & Shaver, 1998). For example, in studying attachment and depression, Murphy and Bates (1997) found that although fearfully attached individuals made up only a small proportion of their overall sample, they represented nearly half of the depressed group.

**Measurement Systems**

Although the attachment patterns and style described in the preceding section are consistent across self-reports, clinical interviews, and narrative/projection picture systems, the research indicates that there are at best small relationships between the self-report measures on one side and the AAI (de Haas et al., 1994) and AAP (George & West, 2011) on the other. This situation begs the question as to whether each system taps the same underlying construct and whether research findings from one system should be incorporated into the feedback to a client assessed with a different system. Moreover, none of these systems was designed specifically for use in clinical contexts. Rather, most were developed for research, with social psychologists favoring self-report methodologies (Bartholomew & Horowitz, 1991; Brennan, et al., 1998; Hazan & Shaver, 1987) and clinical psychologists favoring the AAI (George, et al., 1985) and the more recently developed AAP (George & West, 2012). Moreover, none of these
Assessing and Interpreting Adult Attachment systems provides gender-specific norms or addresses issues of gender identity in the context of assessment and the need to provide meaningful feedback to a diverse range of clients.

The Adult Attachment Interview (AAI) and Adult Attachment Projective Picture System (AAP)

The AAI (George et al., 1985/1996) and AAP (George & West, 2012) were developed based on Bowlby’s view that early attachment relationships shape the cognitive organization and unconscious defensive processes of the developing person. The AAI is a quasi-clinical interview that codes people’s attachment-related narratives of childhood interactions with parents. In scoring the AAI, the direct content of the client’s narrative is less important than how well the client’s narrative provides balanced or biased views of attachment figures, adheres to or violates common rules of social discourse, and is coherent or internally consistent.

The secure style on the AAI is operationalized in terms of coherence between adjective and narrative descriptions of memories of interactions with the parent in childhood, evidence of parental love and care, and balanced perceptions of the parents’ behaviors. The preoccupied style is typified by unresolved anger toward the parent, excessively long conversational turns, childish or nonsensical verbalizations, and/or melding the past and present. The dismissing style is typified by general, positive, and glowing adjective descriptions of the parent without supporting autobiographical evidence, claiming a lack of memory for childhood events, a lack of the direct expression of warmth in memories of the parent, and a parental push for achievement. The unresolved classification relates to an overt revelation of loss or trauma in childhood, lapses in narrative discourses (long pauses in the middle of a narrative), intrusions of traumatic recollections into the narrative flow, or disorganized speech; all of these can be indications of dissociative processes and difficulty integrating traumatic memories into the personal attachment story (Hesse & Main, 2000; Liotti, 2004).

Although the AAI is accepted as the gold standard in attachment research, it can take an hour to administer and many more hours to score. Training to use the measure is also relatively expensive and requires an extensive time commitment (10 days of intensive training followed by a reliability check of scored protocols that can take up to a year to complete). As such, the AAI may be out of reach for many psychological assessors. To address this issue, George and West (2012) developed the AAP as a “user-friendly” alternative, wherein the processes of administration, transcription, and classification are expedited (25 minutes for an audiotaped administration). Coding by a trained judge takes from one-half to two hours. The AAP evaluates a client’s narrative in response to ambiguous drawings that pull for attachment-related themes. The AAP uses the three dimensions of Discourse, Content, and Defensive Processing to
designate the four adult attachment patterns (Secure, Dismissing, Preoccupied, and Unresolved).

As with the AAI, the temporal coherence of the client’s narrative occupies a central place in the coding of the AAP transcript. Both the AAI and AAP are closely aligned with more traditional clinical interviews and assessment tools such as the Thematic Apperception Test (TAT). Defensive exclusion of memories that are difficult to assimilate into existing schema results in inconsistent conscious access to autobiographical and affective memories, and the affective component guides the organization of the present narrative (George & West, 2012). The AAP does not pull for the revelation of autobiographical memories of childhood but, rather, for narration of presented ambiguous pictures. As such, the stimuli pull for the revelation of unconscious defensive processes.

Although not the primary focus of research, results to date on the AAI and AAP do not suggest the presence of gender differences in relation to attachment (van IJzendoorn & Bakermans-Kranenburg, 2010). This should not come as a surprise because research on memory, emotion regulation, and cognition do not suggest gender differences. Because the AAI and AAP tap unconscious processes, I contend that they should not be expected to yield differing results as a function of a person’s perception of themselves in relation to the present social environment. In other words, self-identity is a conscious process involving judgments and attributions for social behavior that may not have corollaries in unconscious structures. As such, there is no indication that gender should influence scoring or interpretation of these measures. Research on the self-report measures described next, however, does indicate the presence of gender differences. As such, there may be a discrepancy between how one’s consciousness is organized and how one perceives one’s self in relationships when it comes to assessment with those who are gender nonconforming.

### Self-Report Measures

As an alternative to using the AAI or AAP, there are highly reliable self-report instruments available in the published social psychology literature that can be administered and scored in the consulting room. Although administering and scoring these measures is simple and inexpensive, it should be noted that they do not yield the same results as the clinical assessment instruments. From a theoretical standpoint, the descriptions of the styles and their developmental antecedents are highly similar. From a statistical standpoint, however, the correspondence has been found to be moderate (Bartholomew & Horowitz, 1991; Shaver, Belsky, & Brennan, 2000) to minimal (e.g., Simpson, Rholes, Orina, & Grich, 2002).

The Experiences in Close Relationships Scale (ECR; Brennan et al., 1998) assesses how individuals perceive themselves to typically think, feel, and behave in their romantic relationships. It was created by factor analyzing items from all previously known adult attachment measures. As such, it is the latest evolution
of the self-report methodologies. It has two subscales that assess the continuous dimensions of attachment anxiety and avoidance, which are theorized to underlie most attachment theory conceptualizations (Brennan et al., 1998). Low scores on both attachment anxiety and avoidance correspond with a secure classification. Low scores on anxiety but high scores on avoidance are typical of dismissing attachment, and high scores on attachment anxiety but low scores on avoidance are typical of preoccupied attachment. High scores on both attachment anxiety and avoidance correspond with a classification of fearful.

Although statistical considerations have led researchers to recommend assessing only the dimensions, to the exclusion of styles, the dimensional approach will be difficult to apply in the context of psychological assessment. This is because no norms have been developed for what levels of avoidance and anxiety should be considered indicative of psychopathology, and the interaction of avoidance and anxiety is not considered. For example, a high score on the avoidance dimension could mean that the individual is likely to present as dismissing or fearful. Similarly, a high score on anxiety could mean that the person is preoccupied or fearful. Likewise, a secure style can only be inferred when both avoidance and anxiety are low. As such, the dimensions cannot be interpreted independently of one another.

For this reason, the style designations should be preferred in psychological assessment. Because self-reports are vulnerable to socially desirable responding and attitudinal influences, I recommend never interpreting one measure in isolation. A style classification from the ECR can be verified by using a secondary self-report measure that uses scales to assess attachment security, avoidance, and anxiety separately. The Attachment Style Questionnaire (ASQ; Feeney, Noller, & Hanrahan, 1994) is such a measure and is appropriate for administration to those with or without significant experience in romantic relationships. A high score on ASQ attachment security and an average to low score on ASQ attachment anxiety or avoidance (relative to nonclinical norms) should correspond with secure attachment on the ECR. A high ASQ score on avoidance and a low ASQ score on security and anxiety should correspond with the ECR dismissing style. A high score on ASQ anxiety and a low score on ASQ security or avoidance should correspond with the ECR preoccupied style. Finally, a high score on ASQ avoidance and anxiety and a low score on ASQ attachment security should correspond with the ECR fearful style.

In addition to providing confirmation (or not) of a dominant attachment style, the ASQ has the added benefit of referring to relationships in general as opposed to romantic relationships. Assessing attachment in relation to both general and romantic relationships should be particularly desirable when working with gender-nonconforming clients because these clients often experience increased and divergent stresses on both types of relationships relative to the cisgendered population.

Although anecdotal, in my private psychotherapy practice and in our university training clinic, where both the ECR and ASQ are administered as part of the intake process, I have noted a high degree of correspondence between
ECR and ASQ results. In such cases, the style designation can be confidently made, and the wealth of empirical findings for each style can be integrated into report writing and feedback. When there is no correspondence between the ECR and ASQ results, taking a Therapeutic Assessment approach to feedback, as exemplified in the following case example prior to finalizing an assessment report, should be considered (see Finn & Tonsager, 1997).

Case Example

Consider the case of Jane, a young professional who came to me for help in her long struggle with recurrent depression and difficulties in her professional relationships. Jane’s ECR indicated a prototypically secure style, but her ASQ yielded a low score on attachment security and high scores on both avoidance and security, which is indicative of a fearful style. I pondered this inconsistency in her data in the context of her clinical presentation. She was prone to being emotionally reactive and displayed defensive behaviors that lead to problematic interpersonal interactions at work. She had lost a highly valued job and was worried about losing another one. She experienced moments of extremely high anxiety wherein her thoughts raced and she acted out behaviorally at work. Subsequently, she engaged in self-loathing and felt hopeless and depressed. All of these indicators from my clinical evaluation pointed in the direction of the fearful style. At the same time, Jane related to me easily and demonstrated a capacity for close interpersonal relationships. She evidenced empathy and emotional insight, and we formed a strong therapeutic alliance. She also reported consistently loving and supportive parents and that she was sustaining a long-lasting and happy marriage. Her behavior with me during her sessions and the interactions she reported with her parents and partner seemed typical of someone with a secure attachment style.

Given these inconsistencies, I decided to engage Jane in helping me make sense of her data. Jane described having a stable, loving home and feeling peaceful and happy until puberty. At that time, she started developing secondary sex characteristics more common in men. Jane had begun to form a strong female gender identity, and she was embarrassed and ashamed of her secondary non-female sex characteristics. She also was teased, bullied mercilessly, and rejected by her peer group. This experience went on until she had medical procedures to correct the issue during her later years in high school, but Jane never recovered from the emotional scars she received from the peer rejection experience. She was hypervigilant for signs of peer rejection, especially from cisgendered females, inferred malevolent intent from others in ambiguous social situations, and experienced strong emotional activation and maladaptive cognitive processes in response. In effect, Jane had two discrete attachment schemata: one in relation to her attachment figures (her husband, parents, and me as her therapist) and one in relation to her peers. As such, the data Jane produced were not discrepant at all but, rather, a valid indication of her personality organization.
Jane’s case has many corollaries with what assessment psychologists may see with their gender-nonconforming clients. The initial attachments formed to parents in infancy may lead to secure working models, which could be maintained into adulthood or deviate in the direction of insecure attachment through later rejection or loss experiences. In this respect, gender-nonconforming individuals may undergo two levels of socialization during their developmental years. They may be socialized into the family of origin based in some measure on their biological sex. When it is discovered that their gender identity does not conform with the cisgendered expectations of the family of origin, or of the larger society, a secondary socialization process may ensue—one that affirms family support and acceptance or one that involves tacit or direct rejection of the gendered self.

**Gender, Gender Identity, and Attachment**

Although Bowlby’s early writings emphasized the child’s relationship with the “mother” as the primary determinant of personality development, he also was careful to stipulate that this was not because the mother was the source of food or, for that matter, the mother being a biological female. What he was emphasizing was the bonding process, viewing the “mother” or “mother surrogate” as the source of comfort and protection. Because of this, until recently attachment theory did not attend to, or hypothesize, differences as a function of the sex or gender identity. As stated previously, research on the AAI and AAP has not revealed gender differences in attachment. Research using self-report attachment measures, however, reveals gender differences such that men generally report higher levels of attachment avoidance relative to women, and women sometimes report higher levels of attachment anxiety relative to men (Bartholomew & Horowitz, 1991; Brassard et al., 2007; Scharfe & Bartholomew, 1994).

In one of the largest studies to date, Schmitt et al. (2003) used a series of single-item attachment scales (one item for each of the four styles) to assess attachment-related gender differences worldwide across 62 cultural regions. They found small to moderate differences, with higher levels of dismissing attachment among men relative to women across most cultures. Feeney (2008) suggested that findings that men are more avoidant and women are more anxious in relation to attachment is consistent with gender stereotypes of men being more self-reliant and autonomous and women being more relationally oriented.

Taylor et al. (2000) believed that women’s relational orientation was more related to evolutionary processes than to socialization and that gender differences in attachment would be accentuated when people were subjected to stress. Taylor et al. theorized that biological women enact affiliative and caring responses characteristic of secure attachment when under stress because of increased release of oxytocin; biological men were theorized to de-emphasize relationships and enact more competitive and task-oriented responses.
characteristic of dismissing attachment when under stress because of increased release of androgens such as testosterone.

In the context of the present discussion, it is not clear where Taylor et al. (2000), or for that matter any researcher heretofore having examined gender differences in attachment, would fit gender-nonconforming individuals in their conceptualizations. Research on gender differences in attachment typically rely on selecting from one of two options (female or male) on a demographic form. As such, what is selected is the respondent’s self-identification as male or female, which confounds gender category and biological sex. Taylor et al. (2000) appear to be discussing being biologically female because their theory is based on the hypothesis that hormones mediate the relationship between women’s stress levels and an orientation toward secure attachment. This issue could mean that individuals undergoing hormonal treatments (going from male to female, MtF) would become more secure in their present-day attachment orientations, whereas those going from female to male (FtM) would become more dismissing in their attachment orientations.

While no research had demonstrated that male hormones lead one to become more dismissing, findings by Colizzi, Costa, Pace, and Todarello (2013) indicate that hormone replacement does lead to a general decrease in insecure attachment. Colizzi et al. (2013) studied the relationship between attachment (assessed with the AAI) and stress levels (perceived stress and cortisol levels) in the context of hormonal replacement therapy among 70 transsexual patients (45 MtF; 25 FtM) and found that at the beginning of treatment, study participants evidenced higher levels of attachment insecurity, perceived stress, and cortisol, relative to population norms. At the beginning of treatment, the sample was 30% secure; 22% anxious, 46% dismissing, 2% (n=1) disorganized. In contrast, prevalence rates for secure attachment in clinical (46%) and nonclinical (56%) samples reported by Colizzi et al. (2013) were higher.

At the beginning of treatment, Colizzi et al. (2013) found that those with preoccupied styles evidenced higher cortisol levels relative to avoidant or secure participants. Hormone replacement therapy for both the MtF and FtM groups over 12 months was associated with significant decrease in cortisol and perceived stress levels to the extent that these levels fell within the normative range for the population by the end of treatment. By the end of treatment, there also were no differences in cortisol levels between the attachment style groups. Based on these results, it can be theorized that hormone therapy could result in greater alignment between the gender identity of a given individual and the secondary sex characteristics of that individual, resulting in a more cohesive sense of self.

It stands to reason that when gender identity and personality variables, such as adult attachment, fit with normative cultural expectations, the individual may not experience high levels of stress. In contrast, when one’s attachment style is out of sync with cultural or gender expectations, the disparity would lead to the experience of stress. According to Schmitt et al. (2003), gender differences in dismissing attachment appeared to become less pronounced under conditions of
cultural stress (e.g., low life expectancy, poor human development, and high fertility rates used as an index of reproductive stress) “presumably because women become more similar to men in short-term mating tendencies and express concomitantly higher levels of dismissing romantic attachment” (Schmitt et al., p. 327).

Searle and Meara (1999) came to a similar conclusion after finding that low-socioeconomic status (SES) adolescent mothers in their sample showed the strongest over-representation of dismissing attachment. Searle and Meara concluded that their data supported the “life history theory” prediction that individuals adopt a quantity-oriented reproductive strategy and a related dismissing attachment style in harsh environments. Because it can be assumed that people who do not ascribe to traditional gender norms may be under increased stress, the “life history theory” would suggest that gender-nonconforming individuals would tend to become more dismissing over time.

Recent findings of higher anxious attachment and lower avoidant attachment in gay men relative to lesbian women (Ridge & Feeney, 1998) contradict this proposition. Mohr et al. (2013) also found that lesbian women reported lower attachment anxiety relative to gay men and suggested that anxiety may be higher in gay men because their violation of social norms is likely to be met with greater resistance (than that encountered by lesbians) and create more distress, which activates and exaggerates attachment anxiety. It also could be that gay men experience greater social marginalization and rejection, particularly when their gender identity is more out of sync with their biological sex characteristics. Sandfort, Melendez, and Diaz (2007) conducted research with gay and bisexual Latino men and found that those who identified as more effeminate relative to those who did not identify as effeminate reported higher levels of mental distress and negative experiences of homophobia.

Peer victimization in the context of being gender-nonconforming also may be a primary social stressor that could lead attachment to deviate in the direction of insecurity (see D’Augelli, Pilkington, & Hershberger, 2002). Some studies find that as many as half of LGB youth have experienced verbal abuse and almost one-third reported physical assaults (Remafedi, 1987). D’Augelli et al. (2002) surveyed 350 LGB youth and found more than half had been verbally abused because of their sexual orientation, 24% were threatened with violence, 11% had things thrown at them, 11% were physically assaulted, 2% were threatened with weapons, and 5% had been sexually assaulted. Males were generally victimized more than females when it came to verbal and physical aggression.

It should come as no surprise, therefore, to find that half of D’Augelli’s sample reported being completely “closeted” during the high school years. Coming out can be a difficult event because it is ripe with opportunities for both peer and parental rejection, which could lead even an initially secure style to deviate in the direction of insecure attachment. Landolt, Bartholomew, Saffrey, Oram, and Perlman (2004) assessed gender nonconformity, a history of childhood rejection, and adult attachment in a sample of 191 gay and bisexual men.
and found that gender nonconformity predicted peer and parental rejection in childhood. Peer rejection and rejection from fathers (but not mothers), in turn, predicted attachment avoidance and anxiety in adulthood. As such, rejection mediated the relationship between gender nonconformity in childhood and attachment anxiety in adulthood. Gender nonconformity thus can be seen to influence the socialization and resultant attachment status of gay men.

Although attachment theory presumes that the parents’ own attachment history and personality dictate parental socialization behaviors vis-à-vis the child, the theory of “reciprocal determinism” (Bandura, 1986) suggests that the child’s behaviors also are likely to elicit behaviors from the parent, which in turn feed back to impact the child’s personality development. Gender nonconformity is not likely to be observed in infancy. A child who was forming a secure attachment to the parent could thus later deviate in the direction of insecure attachment if he or she experienced parental rejection because of his or her emerging gender identity.

Rejection is less likely in families wherein the parents’ attachment styles are secure. Therefore, young people can more readily take the risk to come out to their parents. Holtzen, Kenny, and Mahalik (1995), for example, found that secure attachment to parents was positively associated with disclosure to parents about sexual orientation. Carnelley, Hepper, Hicks, and Turner (2011) similarly found that secure attachment behaviors on the part of mothers predicted greater acceptance of their children’s sexual orientations and resulted in lower levels of attachment anxiety for natal men. Harkening back to the theory of reciprocal determination introduced in the last paragraph, Carnelley et al. posited that coming out to parents could affect the care received from parents and be experienced as a significant attachment-related event that could alter one’s attachment style. This proposition was supported by Mohr, Selteman, and Fassinger (2013), who found that when parents were perceived as being sensitively attuned in childhood, members of same-sex couples perceived those parents to be more supportive of their sexual orientations in adulthood, which in turn led to higher rates of secure attachment among the adult same-sex partners.

**Implications for Psychological Assessment**

Based on the research reviewed in the previous section, gender identity, particularly when it does not conform to gender stereotypes, does appear to impact attachment style formation. It may be that the gender identity shapes the parents’ behavior toward the child and what attachment style is formed. For example, if a biological male experiences consistent parental availability, warmth, and responsiveness in early childhood, but then finds that his parents are not accepting of his nonconforming gender identity as he approaches adolescence, he could be expected to develop an anxious attachment style. Anxious attachment styles form when parents are inconsistent in their responses to the child. I propose that such inconsistency does not necessarily have to relate to the passage of time but
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could also relate to inconsistencies between overt and covert statements. In the case of the gender-nonconforming child, the parent may accept one aspect of the child but reject another, which sets up an irresolvable conflict in the assessed individual and a need to continually seek reassurance and validation in order to feel secure.

In conducting psychological assessments, the assessor should inquire about (a) early socialization experiences and (b) parental and peer reaction to, and acceptance of, the individuals coming out and revealing a heretofore closeted gender identity. Later rejection experiences could potentially explain inconsistencies between attachment measures (secure on the ECR and Anxious or Fearful on the ASQ) or between clinical presentations and self-report data. In the aforementioned case example of Jane, who had different attachment styles to her parents and to her peers, both of these factors were observed and helped in developing a deeper understanding of her personality and interpersonal functioning. One could expect that there would be a larger discrepancy between parent and peer attachment among gender-nonconforming individuals than among cisgendered people. Thus, results of attachment assessments should be interpreted more cautiously and not without Therapeutic Assessment. Assessors should engage in a fairly robust biopsychosocial interview prior to the assessment and give interactive feedback with the client prior to finalizing the assessment report. Assessors also should not infer that the fearful attachment style resulted from attachment to the parent, given the many relational traumas that may have been experienced by gender-nonconforming clients.

Prior to giving feedback about attachment styles, we as assessors should also know our own attachment styles (Shorey, 2010). Therapists’ attachment styles have been shown to impact their responsiveness to clients. The unaware therapist could thus inadvertently recapitulate the client’s core conflict. For example, dismissing assessors, along with their discomfort for closeness, may be less likely to probe about sexual orientation. A dismissing cisgendered male assessor also may respond with shorter and more directive statements to a preoccupied gay man. The gay man could then experience this response as a rejection of his gendered self, which could impact his ability to accept more difficult psychological feedback.

The assessor using self-report measures also should realize that preoccupied attachment is more normative among gay men and that dismissing attachment is more normative among lesbian women. This is important because the impact of the attachment style on relationship commitment and satisfaction will likely differ as a function of same-sex or opposite-sex couples status. Research also indicates that, for couples, data on outcomes for heterosexual couples may not generalize to gay or lesbian couples. For gay and bisexual men, for example, attachment anxiety was more related than attachment avoidance to negative relationship outcomes, whereas among heterosexual couples attachment avoidance is typically related to negative relationship outcome (Feeney, 2008). Mohr et al. (2013) found that attachment avoidance did not predict lower levels of
relationship commitment among same-sex couples as it did for heterosexual couples. Mohr et al. went on to propose that nonmonogamy should not necessarily be taken as a sign of relationship problems among same-sex couples, although it is likely to be more distressing for those with high levels of attachment anxiety.

The assessor also should evaluate the client’s attitudes toward his or her own sexual orientation. For example, internalized homophobia should be associated with negative perceptions of self and, by extension, either a preoccupied or a fearful attachment style. This is one more reason that gay men might report higher levels of anxious attachment. Lesbian women, in contrast, may not have internalized homophobia to the extent of gay men and may not have experienced the same degree of social marginalization and, by extension, may have more positive self-evaluations in relationships.

Longitudinal research is needed to see if the concordance rates between gender-nonconforming clients’ infant to adult attachment classifications are similar to the concordance rates for cisgendered clients. Such research is often conducted using the Strange Situation in early childhood and the AAI in early adulthood. If trauma and loss are indeed associated with deviations from attachment security in the direction of insecure attachment, and we consider the fact that gender-nonconforming individuals are faced with an increased likelihood of such events, then we would expect to see differences in concordance rates. It also should be noted that the gender-nonconforming population is likely to have been included in all normative client population data. As such, differences between gender-nonconforming samples and population norms are likely to be underestimated. If anything, this latter observation, along with the research reviewed and recommendations made in the present chapter, should serve as a call for additional research on the assessment of attachment and gender identity as we continue to strive to deliver the highest quality of assessment services to all of our clients.

Practical Points

• In assessing attachment using self-reports, always use measures of both romantic and peer attachment.
• If using the AAI or AAP for assessment, assume that they will not correspond with self-report measures. Understand that the AAI and AAP measure preconscious processes, whereas the self-report measures consciously held attitudes.
• Never make final conclusions relating to the client’s attachment style until you engage in interactive feedback that would put any assessed inconsistencies in their proper context.
• Do not attempt to generalize research on attachment styles and outcomes for heterosexual couples to LGBTQ couples. Given the many negative experiences that could potentially be experienced historically by these
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individuals, insecure attachment may be more normative than in the general population.

- Because of the negative social interactions that may have been experienced by LGBTQ individuals, clinicians should take care to avoid overpathologizing insecure attachment styles in this population.

Annotated Bibliography

Comment: For the best overall review of attachment theory and how it relates to personality dynamics, this article teaches you about perception, emotion regulation, and behavioral strategies associated with each of the attachment styles.

Comment: This article provides an excellent pragmatic overview of most contemporary attachment measures, although those who are interested in each measure’s psychometric properties should look to each measure’s original validation study.

Comment: This book chapter provides guidelines for how to customize clinical interventions in terms of the client’s attachment style.

References


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Kenny, a 22-year-old Vietnamese American man, sought psychological assessment to determine the presence of Attention Deficit Hyperactivity Disorder (ADHD) versus a learning disorder. Early in the assessment process, it became clear that—cognitive challenges notwithstanding—Kenny suffered from pervasive depressive symptoms that impaired his concentration as well as his ability to complete complex tasks. Much of his depressive ideation involved severely self-critical beliefs, largely those connected to his appearance, sexuality, and intimacy needs. Kenny identified as exclusively homosexual but felt like he did not fit in with most gay men his age since he did not desire casual sexual encounters, which he believed was expected within the male homosexual community. He was critical of what he perceived to be a promiscuous lifestyle and denied wanting a same-sex romantic relationship, often making comments suggesting he could never be a worthwhile partner because of his physical unattractiveness. Although Kenny remained self-disparaging of his looks, he was in fact an especially handsome young man. Kenny had a handful of friends but also described those relationships as relatively burdensome, particularly those involving his female friends, whom he found overly demanding and excessively dramatic in their emotionality.

Throughout the assessment, Kenny’s self-presentation and self-report test scores reflected a counterdependent personality style, where he routinely dismissed having needs for intimacy, warmth, or support. Although Kenny scored high on the MMPI-2 Masculinity-Femininity (Mf) scale, suggesting nontraditional gender role related experiences and beliefs, he scored low on the MMPI-2 Dependency (Dy) scale. His pattern of scores on
the Relationship Profile Test (RPT) was consistent with these other results, as Kenny obtained elevated scores on Dysfunctional Detachment, and low scores on Destructive Overdependence and Healthy Dependency. These patterns were particularly noteworthy given Kenny’s cultural background; individuals raised in more sociocentric societies typically score relatively high on self-report indices of dependency, especially when compared to standard Western norms.

A very different pattern emerged in Kenny’s performance-based test results. He scored high on the Rorschach Oral Dependent Language (ODL) scale and produced a high number of Texture responses as well. The marked discontinuity between Kenny’s self-presentation and his performance-based test patterns—consistent with a counterdependent personality orientation—was quite revealing in another way: Evidence suggests that the sort of counterdependent profile Kenny produced is associated with increased risk for depression, which was an instrumental finding in this assessment and helpful in understanding the factors that contributed to Kenny’s cognitive difficulties. Perhaps more important, the divergent patterns in Kenny’s self-report and performance-based test scores provided an opportunity to discuss discrepancies between his stated desire for independence and his strong underlying dependency needs. Much of the early portion of treatment was spent exploring how Kenny’s harshly self-critical beliefs, repudiated dependency strivings, and internalized homophobia contributed to his counterdependent profile, exacerbated his depression, and created difficulties in his social, sexual, and professional relationships.

If there is a single challenge that characterizes all of psychology’s diverse subfields, that challenge is assessment. Regardless of whether the construct in question involves observable behaviors, hidden mental states, or changes in traits, symptoms, skills, and abilities over time (e.g., as a result of maturation or in response to psychological treatment), assessment forms the core of psychological science and clinical practice.

As psychometricians have noted, psychological assessment is challenging under the best of circumstances, but especially so when an individual difference variable is being contrasted in different segments of the population (see Messick, 1995; Strauss & Smith, 2009). In such situations the psychologist must not only assess the construct in question (e.g., narcissism, impulsivity, aggressiveness) using measures that yield valid and reliable scores, but must also find ways to identify ecologically meaningful subgroups so that variations in scores across groups can be compared. Segmenting the population according to certain criteria (e.g., age) is comparatively straightforward; other criteria (e.g., gender, ethnicity) present more complex challenges.

This chapter discusses the relationship of sex and gender to personality and personality pathology and the assessment issues that arise in examining these patterns. In line with current thinking we consider sex to refer to a biological state of being male, female, or—less commonly—intersex (i.e., a person born with sexual anatomy, reproductive organs, and/or chromosome patterns that do not conform to the traditional definition of female or male; see Office of the UN Commissioner for Human Rights, 2013). We use the term gender to
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encompass both gender roles (i.e., culture-based norms that define what behaviors are considered appropriate for women and men; Range & Jenkins, 2010) and gender identity (i.e., individuals’ subjective experience of gender, including the degree to which they regard themselves as belonging to a particular gender category; Lev, 2004). We discuss sex and gender issues from the perspective of the patient and from that of the assessor as well.

We begin by defining personality and personality pathology and then review research on sex and gender differences in personality traits and personality disorders, including differences in prevalence rates, expressed behaviors, and symptom patterns. We offer alternative conceptualizations of these findings, which allow psychologists to distinguish genuine sex and gender differences from spurious group differences that result, in whole or in part, from flawed assessment tools, variations in patients’ ability (or willingness) to describe themselves accurately, and limitations in psychologists’ ability to perceive their patients in an unbiased way as a result of social learning, culture-based assumptions, and stereotypes regarding sex and gender. Finally, we discuss clinical and empirical implications of research in this area.

Personality and Personality Pathology

One widely used undergraduate text defines personality as “the dynamic and organized set of characteristics possessed by a person that uniquely influences his or her cognitions, motivations, and behaviors in various situations” (Ryckman, 2013, p. 4). A similar but more nuanced definition is offered by the Psychodynamic Diagnostic Manual (PDM; Alliance of Psychoanalytic Organizations, 2006, p. 17), which defines personality as “relatively stable ways of thinking, feeling, behaving, and relating to others” and goes on to note that “each of us has a set of individual assumptions by which we try to understand our experience, a set of values and characteristic ways of pursuing what we see as valuable, a personal repertoire of familiar emotions and typical ways of handling them, and some characteristic ways of behaving, especially in our personal relationships.” Other definitions vary in the details (e.g., Mischel, Shoda, & Smith, 2004), but virtually all agree that personality is a complex, multifaceted construct encompassing an array of underlying psychological processes (e.g., cognitions, motivations, affect patterns) and expressed behaviors that interact synergistically to determine each person’s unique way of adapting to life’s opportunities and challenges.

Like personality, personality pathology is not easy to define. The most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5 (American Psychiatric Association, 2013), defines personality disorder (PD) as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (APA, 2013, p. 645). As is true for most definitions of personality, the DSM-5 definition of PD acknowledges the importance of
inner experience (e.g., motives, beliefs, emotions) as well as surface behavior, an emphasis that carries over to the symptom descriptors as well. When Bornstein, Bianucci, Fishman, and Biars (2014) categorized the DSM-5 PD symptom criteria according to the psychological processes tapped by each, they found that just over half of these criteria reflect internal states, including difficulties involving cognition (30%), affectivity (18%), and impulse control (6%).

The DSM-5’s emphasis on both internal states and expressed behaviors helps enhance diagnostic accuracy insofar as it enables clinicians to go beyond surface symptoms and render diagnoses based in part on underlying psychological processes that characterize different PDs (see Bornstein, 2011; Huprich, 2011). Also on the positive side, the DSM-5 definition of PD makes clear that personality pathology is defined in part in terms of a “mismatch” between an individual’s experience and behavior and the expectations of his or her culture (see Leising, 2008, for a detailed discussion of this issue). Understanding that personality pathology stems in part from a divergence of individual behavior from prevailing cultural norms helps explain why mental health professionals in more sociocentric cultures (e.g., India) find the concept of dependent PD problematic (Bornstein, 2005), why behavior that would be classified as histrionic in northern Europe is normative in some Latin American and Caribbean societies (Castillo, 1997), and why symptoms of avoidant PD tend to be exacerbated in interactions with figures of authority in Japan but are expressed more commonly in interactions with peers than authority figures in the United States (Ono et al., 1996).2

No single theoretical framework can account for the complexity of personality pathology, and as a number of clinical researchers have noted (e.g., Lenzenweger & Clarkin, 2005; Millon, 2011), most PDs reflect a combination of biological (sometimes genetic) influences, social learning (including that related to gender and culture), self-defeating thought patterns (e.g., problematic beliefs, assumptions, and attributions), and psychodynamic factors (e.g., maladaptive defense and coping patterns, distorted mental representations of self and significant others). To be sure, some PDs are more strongly influenced by one array of factors than another (e.g., schizotypal PD is rooted in information processing deficits with identifiable neurological precursors, whereas narcissistic PD is influenced predominantly by psychodynamics and social learning). To explain the etiology and development of personality and personality pathology, an integrative approach that draws upon multiple theoretical perspectives is needed.

Sex and Gender Differences in Personality and PDs

Just as contemporary models of personality and personality pathology have become increasingly integrative, most present-day conceptualizations of sex and gender appreciate the complex influences of biology, social learning, and culture on the beliefs and behaviors of women and men. This integrative approach was not always the norm: As Shields and Bhatia (2009) noted, early efforts at
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explaining sex differences (e.g., Darwin, 1871; Galton, 1907; Thorndike, 1914) typically sought an evolutionary mechanism to justify a priori beliefs regarding women and men, with little empirical evidence to support these beliefs.

An important innovation in understanding sex- and gender-linked behaviors was the introduction of the concepts of masculinity, femininity, and androgyny (Bem, 1974; Spence, Helmreich, & Stapp, 1975). As research in this area evolved, it became clear that gender role is a multifaceted concept encompassing an array of cognitive, affective, and behavioral features, each of which evolves over time in response to changing life experience. Moreover, it is clear that both gender role and gender identity are best conceptualized as continuous dimensions rather than dichotomous categories; this reasoning is echoed in recent conceptualizations of biological sex as being more continuous—less dichotomous—than once thought (Carothers & Reis, 2013; Reis & Carothers, 2014). Thus, even though most people can be reliably categorized as being male or female, people in both categories share many common biological and psychological characteristics (Hyde, 2005).

With these evolving conceptualizations in mind, in many ways it is easier to assess sex and gender differences in personality pathology than in personality more broadly defined. Regardless of whether one uses as a starting point the DSM, PDM, or ICD, there are a limited number of PD categories in the diagnostic manuals. In contrast, hundreds of personality traits and predispositions have been studied empirically over the years, many of which overlap to varying degrees with other conceptually similar constructs (e.g., agency and self-efficacy, avoidance and detachment). Despite these contrasting challenges, similar patterns of sex and gender differences have emerged in studies of personality and personality pathology. Three conclusions capture these similarities and help explain the epidemiology of personality traits and PDs with respect to sex and gender—namely, that both sex differences and gender differences in personality and personality disorders tend to be modest in magnitude, and that assessment modality matters.

**Sex Differences in Personality and PDs Tend to Be Modest in Magnitude**

Maccoby and Jacklin’s (1974) review confirmed that identifiable sex differences in temperament and interpersonal behavior are present early in life and persist through adulthood. Feingold (1993, 1994, 1998) and others (e.g., Costa, Terracciano, & McCrae, 2001; McCrae & Terracciano, 2005) extended these patterns to the domain of personality using data from widely used measures such as the NEO Personality Inventory–Revised (NEO-PI-R; Costa & McCrae, 1992). In their large-scale study involving participants from multiple countries, Costa et al. (2001) found that women reported higher levels of agreeableness, warmth, and openness to feelings, whereas men reported higher levels of assertiveness and openness to ideas. Researchers have continued to investigate sex differences
in personality using the Five Factor Model (FFM) and other conceptual frameworks (e.g., the interpersonal circumplex), finding that many patterns of sex differences are replicable across cultures (see, e.g., McCrae & Terracciano, 2005), though these sex differences typically account for a relatively small portion of the variance in personality. When Schmitt, Realo, Voracek, and Allik (2008) contrasted FFM sex difference data across 55 nations, they confirmed that in most nations sex differences in core personality traits were in the small to medium range (Cohen, 1991), with the magnitudes of these differences being somewhat greater in wealthier, more egalitarian societies.

As Grant et al. (2004) and Torgersen (2005) noted, large-scale epidemiological surveys of PDs in the community typically find that a higher percentage of men than women qualify for PD diagnoses, although findings vary somewhat as a function of sample, setting, and measure, with some investigations reporting significantly elevated PD rates in men (e.g., Jackson & Burgess, 2000) and others reporting nonsignificant sex differences (e.g., Torgersen et al., 2001); meta-analyses have not yet been conducted to systematically examine potential moderators of these patterns. Beyond overall differences in PD prevalence rates, certain PDs tend to be diagnosed more frequently in one sex or the other, with schizoid, paranoid, antisocial, and narcissistic PDs more common in men, and dependent, borderline, and histrionic PDs more common in women (Corbitt & Widiger, 1995; Cosgrove & Riddle, 2004). Complicating the situation, certain PDs show significant sex differences in some cultures but not others (e.g., borderline PD appears more frequently in women than in men in the United States, but it is diagnosed in equal rates in women and men in Japan; Calliess et al., 2008).

Like Sex Differences, Gender Differences in Personality and PDs Tend to Be Modest in Magnitude

Most studies examining the relationship of gender to personality and personality pathology have operationalized gender role using the Bem Sex Role Inventory (BSRI; Bem, 1974), which yields separate scores for masculinity, femininity, and androgyny. Paralleling the results of studies examining sex differences, studies examining the relationship of gender to personality have generally found that gender role–personality links are modest in magnitude. For example, when researchers examined links between gender role and individual difference variables such as aggression, communication and coping skills, and support seeking, they typically found the expected associations between gender role and personality, with small effect sizes in most domains (Hirokawa, Yagi, & Miyata, 2004; Tenenbaum & Leaper, 2002).

The relationship between gender role and personality pathology is complex and varies across PD category. For example, when Klonsky, Jane, Turkheimer, and Oltmanns (2002) examined links between gender role and PD symptoms in a large, mixed-sex sample of college students, they found that for
both women and men, dependent traits were associated with higher femininity and lower masculinity, whereas antisocial traits were associated with high masculinity and low femininity (see also Bornstein, Bowers, & Bonner, 1996, and Lilienfeld & Fowler, 2006, for related findings). In addition, men and women in Klonsky et al.’s sample who had “sex consistent” gender role (i.e., feminine women and masculine men) reported more narcissistic and histrionic features, whereas women and men with “sex inconsistent” gender role reported more symptoms of paranoid, schizoid, and schizotypal PDs. Somewhat similar results were obtained by Blais (1995), who found that female psychiatric inpatients who scored as masculine on the MMPI-2 Masculinity–Femininity (Mf) scale also obtained elevated scores on the MCMI-II narcissistic, antisocial, paranoid, and aggressive/sadistic PD scales. Similar patterns emerge in other investigations of personality pathology and gender role, regardless of whether these links are assessed in nonclinical (i.e., college student or community adult) or clinical populations (Oltmanns & Powers, 2013).

In contrast to gender role, which has been fairly widely studied in relation to personality and PDs, there have been comparatively few investigations of personality and PD correlates of gender identity; all of these studies contrasted individuals with gender dysphoria (GD) and non–GD control participants on salient personality and PD dimensions. For example, Bodlund and Armelius (1994) contrasted PD patterns in 11 GD adolescents and a comparison group of 18 adolescents with similar demographic features, finding that GD participants scored higher on borderline, avoidant, dependent, and obsessive-compulsive symptoms. In contrast, Hepp et al. (2005) found that PD prevalence rates in 31 GD participants were no higher than those of the SCID-II outpatient norms; similar findings were reported by Haraldsen and Dahl (2000) in Norwegian adults.

**Assessment Modality Matters**

The vast majority of studies examining sex and gender differences in personality and PDs (including the aforementioned investigations) used questionnaires or interviews to quantify personality and personality pathology. As a number of writers have noted (e.g., Bornstein, 2002, 2009; Meyer et al., 2001), because questionnaires and interviews rely on participant self-reports, they are affected by respondents’ self-perceptions (which may or may not be accurate) and by self-presentation confounds as well (e.g., participants’ willingness to acknowledge various traits, symptoms, and experiences). Certain self-perception and self-presentation effects (detailed in the following sections) are rooted in people’s beliefs regarding which attitudes and behaviors are appropriate for their sex and gender. Thus, it is likely that observed sex and gender differences for many personality traits and PDs are greater when questionnaire and interview measures are used than when measures with low face validity (e.g., the Rorschach Inkblot Method [RIM]) are employed (see Meyer, Giromini, Viglione, Reese, & Mihura, 2014).
Findings confirm these assessment modality differences. For example, when Bornstein (1995) used meta-analytic techniques to synthesize findings regarding sex differences in interpersonal dependency and dependent PD, he found that women scored higher than men on every questionnaire and interview measure, with an overall sex difference $d$ of 0.41. There were no significant sex differences on any performance-based measure of dependency; for these measures, the overall sex difference $d$ was -0.11 (in other words, men scored higher than women by about one-ninth standard deviation). When Bornstein et al. (1996) assessed the relationship between gender role and dependency in a mixed-sex sample of college students, they found that in both women and men, self-report dependency scores were positively correlated with BSRI femininity scores ($r$'s were .30 and .37, respectively) and negatively correlated with BSRI masculinity scores ($r$'s were -.64 for women and -.55 for men). Gender role was unrelated to Rorschach-derived dependency, with $r$'s ranging from -.12 to .03.

These contrasting patterns not only confirm the moderating impact of face validity on assessment results when different types of measures are used, but they can also help clinicians and researchers illuminate personality dynamics not amenable to assessment using measures within a single modality. For example, Bornstein (1998) used self-report and performance-based measures of interpersonal dependency to explore the personality dynamics of college students who scored above threshold on the Personality Diagnostic Questionnaire—Revised (PDQ–R; Hyler et al., 1990) histrionic PD and dependent PD subscales. A large sample of undergraduates was screened to obtain a group of 28 “pure” dependent PD participants (i.e., participants who scored above threshold for dependent PD but no other PDs) and 24 pure histrionic PD participants. Separate groups of “Other PD” and “No PD” participants were included as controls. All participants completed a well-established measure of self-reported dependency and the Rorschach Oral Dependency (ROD) scale (Masling, Rabie, & Blondheim, 1967), a widely used measure of performance-based dependency.

Results of this comparison were clear and unambiguous: As expected, participants in the dependent PD group showed high levels of both implicit and self-reported dependency, while those in the histrionic PD group scored high on implicit—but not self-reported—dependency. Participants in the other two groups scored comparatively low on both dependency measures. This study provided the first direct evidence that dependent PD is associated with high levels of underlying and expressed dependency, whereas histrionic PD is associated with high levels of underlying dependency but not self-reported (or “self-attributed”) dependency. Cogswell, Alloy, Karpinsky, and Grant (2010) similarly found that divergences between implicit and self-attributed dependency scores were associated with predictable patterns of personality, self-concept, and interpersonal behavior in college students. In the case of Kenny, discussed at the start of this chapter, divergences between self-reported dependency (assessed via the MMPI-2 and RPT) and performance-based dependency (assessed via the Rorschach ODL scale) not only helped illuminate some core personality
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dynamics but also provided a tentative framework for conceptualizing Kenny's
cognitive difficulties.

**Processes, Pathways, and Variations in Experience and Expression**

Beyond differences in prevalence rates, personality traits and PDs are sometimes expressed differently by women and men and as a function of gender role. These variations are due in part to sex and gender differences in the subjective experience of pathology and in part to the ways in which gender role and other individual difference variables (e.g., cultural background) affect the individual's self-concept, the “idiom of distress” that is used to express intra- and interpersonal conflict and dysfunction, and the defense and coping mechanisms evoked in response (Dadlani, Overtree, & Perry-Jenkins, 2012).

For example, in the realm of personality it was long assumed that men were more aggressive than women. However, more recent findings suggest that these global aggressiveness differences were largely a product of the way aggression was operationalized and assessed, using measures that emphasized the types of aggressive behaviors most commonly exhibited by men (e.g., physical aggression). When more nuanced assessment methods are used, it is clear that in certain respects women are as aggressive as men—sometimes more so—but that women’s aggression tends to be expressed differently (e.g., as relationship-focused aggression, sometimes called *social aggression*) and in response to different environmental cues and contingencies (Kistner et al., 2010). Kaplan (1983) and others (e.g., Cadbury, 1991) have made a parallel argument regarding interpersonal dependency and dependent PD, pointing out that the behaviors tapped by most dependency scales tend to emphasize dependency as it is traditionally expressed by women but ignore men’s more indirect expressions of dependency (e.g., reliance on others to carry out activities like managing the home and child- and eldercare).

The same is true of other personality and PD domains. For example, virtually all extant research on histrionicity and histrionic PD has focused on women, and it is not at all clear that the DSM-5 histrionic PD symptom criteria can be applied to men in a heuristic and clinically useful way (Bornstein, Denckla, & Chung, 2014). The reverse problem characterizes contemporary research on antisocial PD, the vast majority of which has been conducted on men. In fact, Cale and Lilienfeld (2002) conjectured that histrionic PD and antisocial PD may actually be differential sex- and gender-linked expressions of underlying psychopathy, with histrionic PD reflecting psychopathy in women, manifested in accordance with the traditional female gender role, and antisocial PD reflecting psychopathy in men, manifested in more masculine ways. Thus, although both PDs are associated with manipulativeness, as well as deficits in empathy, these behaviors take a somewhat different form in antisocial PD (which is characterized by instrumental manipulativeness and overt disregard for the feelings
of others) than in histrionic PD (wherein manipulativeness often takes the form of theatrical flirtatiousness and pseudosexuality, and diminished empathy is more strongly rooted in reliance on the defense mechanism of denial).

Distinguishing Fact From Artifact in Sex and Gender Difference Research

Although research has documented sex and gender differences in a number of personality and PD domains, the magnitudes of these differences are generally small. The causes of these sex and gender differences remain open to debate and vary as a function of the personality trait or PD being assessed, as well as the method used to assess personality and personality pathology (e.g., larger sex and gender differences are typically obtained when self-report measures are used than when performance-based tests are employed). Elucidating the causes of observed sex and gender differences requires that researchers identify potential confounds (e.g., variations in patients’ ability and willingness to describe themselves accurately) and examine empirically the impact of these confounds on psychological test results. To the extent that the impact of confounding variables can be ruled out, it becomes increasingly likely that observed group differences stem from processes that are genuinely related to sex and gender.

Although clinicians have occasionally attributed sex differences in personality pathology to sampling artifacts (e.g., a higher portion of women than men in many clinical samples), these arguments are unpersuasive; when preexisting base-rate differences are taken into account, sex differences for many PDs persist. As a result, researchers have sought alternative explanations for potential measurement confounds, including biased PD symptoms, assessor/diagnostician effects, and patient self-presentation effects.

Biased PD Symptoms

When Landrine (1989) provided undergraduates with prototypic descriptions of five DSM-III PDs and asked them to judge whether the behaviors in the description better described women or men (in general), she found that those PDs that are diagnosed more commonly in women (i.e., dependent and histrionic) were also judged to be more “characteristically female.” Those PDs diagnosed more commonly in men (i.e., antisocial, schizoid, and obsessive-compulsive) were seen as more “characteristically male.” Several investigations have replicated these patterns using DSM-IV and DSM-5 PD criteria, suggesting that at least some PD symptoms tap sex- and gender-linked traits and behaviors in addition to (or in lieu of) genuine personality pathology (see Morey, Warner, & Boggs, 2002; Oltmanns & Powers, 2013).

Along somewhat different lines, if PD symptom criteria are minimally affected by sex and gender, they should tap similar underlying processes in women and men and show comparable relationships with salient
outcome criteria. To test this hypothesis, Lindsay, Sankis, and Widiger (2000) administered widely used PD scales to 82 outpatients and found that a number of test items (38 in all) were more strongly predictive of overall psychological dysfunction in one sex or the other; the majority of these items came from narcissistic PD subscales. Somewhat different results were obtained by Boggs et al. (2009), who found that differential PD–dysfunction links across sex were stronger for borderline PD than other PDs. Similar differential PD–dysfunction patterns have emerged for histrionic PD and antisocial PD in other investigations (Caplan & Cosgrove, 2004; Jane, Oltmanns, South, & Turkheimer, 2007). Thus, although the specific PDs that yield the strongest differential patterns vary across studies, most likely as a function of the samples examined and measures used, these findings taken together suggest that observed sex and gender differences in PD prevalence rates are due, at least in part, to bias inherent in the diagnostic criteria.

Assessor/Diagnostician Effects

Even the most well-trained, well-intentioned clinician holds certain stereotypes regarding sex, gender, and other individual difference variables, and these stereotypes shape the clinician’s inferences regarding patients and their problems (see Brabender & Whitehead, 2011; Garb, 1998). Several analogue studies have shown that patient sex influences clinicians’ judgments regarding the presence and type of personality pathology. For example, when Becker and Lamb (1994) asked clinicians to assign diagnoses to a case vignette wherein the patient displayed symptoms of borderline PD as well as symptoms from other, similar syndromes (e.g., posttraumatic stress disorder), clinicians were more likely to assign borderline PD diagnoses when the patient was female; similar findings were subsequently obtained by Woodward, Taft, Gordon, and Meis (2009) using DSM-IV PD symptom criteria. Samuel and Widiger (2009) found that when a hypothetical patient described in a case vignette was identified as a woman, the proportion of histrionic PD diagnoses increased; when the patient was described as a man, antisocial PD diagnoses increased.

To identify potential moderators of the impact of patient sex on PD diagnoses, Crosby and Sprock (2004) administered case vignettes describing a patient with an array of PD features to a national sample of clinicians, systematically varying the sex of the patient. Consistent with other studies in this area (e.g., Boggs et al., 2009), Crosby and Sprock found that when the patient in the vignette was a woman, the proportion of borderline PD diagnoses increased significantly. In addition, they found that clinicians’ gender role (assessed via the BSRI) moderated the types of diagnoses rendered, with feminine clinicians tending to assign antisocial and narcissistic PD diagnoses more readily than did clinicians with other gender role patterns. No other studies have assessed directly the impact of clinicians’ gender role on PD assessments and diagnoses, however, and greater attention to this understudied issue is clearly warranted.
Patient Self-Presentation Effects

A third potential source of bias is rooted in how people perceive and describe themselves. As several writers have noted (e.g., Morey, Alexander, & Boggs, 2005; Oltmanns & Powers, 2013), it may be that women and men are more willing to acknowledge symptoms that seem consistent with their sex than symptoms that do not. This hypothesis is supported by Bornstein’s (1995) meta-analytic results regarding interpersonal dependency and dependent PD and by similar findings obtained for other PDs (e.g., narcissism, histrionicity), wherein larger sex differences are found when the construct in question is assessed via a scale with high face validity than when one with lower face validity (e.g., the RIM) is used (see Huprich, 2006, for reviews of research in this area). These patterns are not only obtained in studies contrasting self-report and performance-based test scores in different participant samples but also when the same participants are asked to complete both types of measures within a single session (e.g., Bornstein et al., 1996).

Clearly, self-presentation confounds are at least partially responsible for observed sex differences in some personality and PD domains. Additional research is needed to ascertain the degree to which these self-presentation effects represent mindful, deliberate efforts on the part of patients to present themselves in sex- and gender-consistent ways, or whether these patterns reflect deeply ingrained responses that are exhibited automatically and “mindlessly.” As Bargh and Williams (2006) and others have shown, many self-presentation effects—most notably those related to gender, ethnicity, and age—occur reflexively in response to subtle environmental cues, with minimal conscious awareness on the part of respondents.

Clinical and Empirical Implications

Several conclusions emerge from the present review. First, it is clear that there are genuine sex and gender differences in certain domains of personality and personality pathology. These differences are of modest magnitude, however, and have been more widely studied (and more firmly established) for sex than gender. It is also clear that certain confounding variables—most importantly bias in item content, respondent self-presentation, and observer inference—may exaggerate obtained sex differences for certain forms of personality pathology; these patterns have been documented most extensively for antisocial, histrionic, and borderline PDs.

The present review also identifies some noteworthy gaps in the literature. For example, very few studies have examined the relationship of gender identity to personality and personality pathology; greater attention to this issue is warranted. There has been surprisingly little research examining the impact of clinician sex and gender role on judgments of personality and personality pathology (cf., Crosby & Sprock, 2004), despite the fact that salient features of
an observer’s self-concept have been shown to influence information processing and judgment in myriad ways.

Beyond these general conclusions, the present review has implications for how sex and gender differences in personality and PDs should be conceptualized, examined empirically, and used to enhance assessment within the clinical setting. Three implications stand out.

**Deconstructing Sex and Gender Effects: From Surface Presentation to Underlying Dynamics**

Traditionally, sex and gender differences have been assessed by contrasting participants’ responses to self-report and interview measures of personality and PDs; less commonly, performance-based test patterns have been contrasted across groups differentiated on the basis of sex and/or gender. Although these studies provide compelling evidence regarding sex and gender differences in test scores, they cannot illuminate the causes of these differences. As Bornstein (2002, 2009) pointed out, to delineate the processes that underlie observed sex and gender differences in personality and personality pathology, researchers must employ multi-method assessment strategies and focus on meaningful test score divergences—inconsistencies in patterns obtained when self-report and performance-based instruments are used. Only by understanding the psychological processes engaged by different types of tests can test score convergences and divergences be interpreted meaningfully.

Although a comprehensive analysis of psychological processes that underlie the broad spectrum of tests in use today has yet to be written, Meyer and Kurtz (2006) and others (e.g., Cogswell, 2008) contrasted the processes engaged by two of the more widely used types of measures: self-report and performance-based. As Bornstein (2009) noted, when people engage a typical self-report test item (e.g., “I would rather be a follower than a leader,” “I often feel depleted”), three processes occur in sequence. First, respondents engage in introspection, turning their attention inward to determine if the statement captures some aspect of their feelings, thoughts, motives, or behaviors. Second, a retrospective memory search occurs, as respondents attempt to retrieve instances wherein they experienced or exhibited the response(s) described in the test item. Finally, respondents may engage in deliberate self-presentation, deciding whether, given the context and setting in which they are being evaluated, it is better to answer honestly or modify their response to depict themselves in a particular way.

Contrast this set of psychological processes with those that occur as people respond to stimuli from a performance-based measure like the RIM. Unlike a self-report test, here the fundamental challenge is to create meaning in a stimulus that can be interpreted in multiple ways. To do this, respondents must direct their attention outward (rather than inward) and focus on the stimulus (not the self); they then attribute meaning to the stimulus based on properties
of the inkblot and the associations primed by these stimulus properties. Once a series of potential percepts (or *stimulus attributions*) is formed, respondents typically sort through these possible responses, selecting some and rejecting others before providing their description (see Meyer, Viglione, Mihura, Erard, & Erdberg, 2011).

With these processes in mind, it is not surprising that patients often yield contrasting patterns when self-report and performance-based measures are used (Bornstein, 2002; Mihura, Meyer, Dumitrascu, & Bombel, 2013) and that the correlation (r) of scores on self-report and performance-based indices of the same construct is typically quite small. For example, in their large-scale meta-analysis, Mihura et al. (2013) found that overall the correlation between scores on performance-based and self-report indices of a given construct was .08. Other studies have yielded correlations between self-report and performance-based test scores in the range of .20 to .30 (Bornstein, 2002; Cogswell, 2008; Meyer et al., 2001). Zeigler-Hill, Fulton, and McLemore (2012) found that the correlation between scores on measures of implicit and self-attributed self-esteem was .11 in college students.

**Beyond Epidemiology: Using Experimental Methods to Alter Salient Processes**

Ruling out potential confounds goes a long way toward demonstrating that observed group differences in personality and PDs are genuine, but to make a compelling case for robust sex and gender differences in personality and personality pathology, it is also important to show that sex- and gender-related factors, which are expected to moderate these patterns, do in fact produce the expected outcomes. Such studies have typically been conducted in vivo, with regression and other modeling techniques used to estimate the impact of sex and gender on personality and PD patterns beyond that of other variables. In recent years, experimental methods (e.g., lexical priming, mindset priming) have been used to activate schemas related to perceptions of self and others and to assess the impact of these manipulations on personality and PD-related behaviors (see Bornstein et al., 2005; Horvath & Morf, 2009).

No studies have employed this paradigm to examine the impact of activating sex- and gender-related schemas on patients’ responses to personality and PD test items, but such studies could go a long way toward documenting the impact of salient attitudes and beliefs on personality patterns and PD diagnoses. In this context, it is worth noting that studies of stereotype threat (e.g., the fear of inadvertently confirming a negative stereotype regarding oneself) have documented the impact of priming sex and gender stereotypes on intelligence, aptitude, and achievement test performance (e.g., Spencer et al., 1999). These manipulations could be employed in the context of established paradigms examining the impact of schema priming on personality and PD-related
behavior (e.g., Bornstein et al., 2005) to elucidate the role of sex and gender schemas in personality traits and PDs (see also Range & Jenkins, 2010, for a review of evidence in this area).

**In the Eye of the Beholder: Considering the Psychological Processes of the Assessor as Well as the Person Being Assessed**

Humans are, by nature, imperfect processors of information. This is especially true of information obtained in interpersonal settings, including psychological assessments. In such situations, the clinician engages in multiple tasks simultaneously: In addition to administering the various tests that comprise the assessment battery and maintaining rapport with the patient, the clinician must devote cognitive resources to self-monitoring, to tracking the patient’s subtle verbal and nonverbal cues, and to other ancillary tasks (e.g., time management). The cognitive capacity devoted to these competing tasks diminishes the clinician’s ability to modify or inhibit reflexive responses and increases the likelihood that unacknowledged attitudes and beliefs regarding sex and gender may inadvertently taint perceptions of and inferences regarding the patient. Even the most conscientious assessor is susceptible to the biasing effects of unacknowledged—often unconscious—attitudes and beliefs, especially when cognitive control mechanisms are diminished by multitasking.

Beyond inherent limitations in our capacity to monitor our reflexive responses and perceive our patients accurately, an additional source of bias comes from the assessor’s own self-concept and the ways in which features of the self-concept alter the assessment situation. In this context, Dadlani et al. (2012) noted that every interaction between psychologist and patient is shaped by the complex sexual, ethnic, religious, and cultural identities of both, with certain identities more salient in some interactions than others (e.g., the psychologist’s gender identity may be more influential in interactions with a transgender or intersex patient than with one whose sexuality is closer to the prevailing cultural norm).

To the extent that the assessor is anxious or conflicted regarding one or more identities that are salient in the context of a particular clinical assessment, unresolved issues related to these identities may inadvertently bias his or her inferences regarding the client’s test data. In this regard, clinicians and patients are more alike than different: We all use defenses and other coping mechanisms to moderate anxiety aroused by threats to the self, and these self-protective strategies are invariably associated with some degree of distortion in our perception of self, others, and self–other interactions. Just as the increased self-awareness that comes from personal therapy is crucial for clinicians to engage in productive therapeutic work, awareness of subtle, heretofore unrecognized aspects of one’s identities as they bear on sex and gender is crucial in order to conduct effective psychological assessment and use these assessment results to enhance treatment.
Practical Points

- Sex and gender differences in most personality and PD domains are modest in magnitude and account for a small portion of the variance in personality and personality pathology.
- Because different assessment methods engage different psychological processes in the respondent, multi-method assessment is necessary to obtain a more complete and accurate picture of a patient’s personality.
- Understanding sex and gender differences in personality and personality pathology requires that clinicians and clinical researchers go beyond epidemiology and focus on underlying psychological processes that differ across sex and gender.
- The impact of sex and gender on personality and PD assessment is not limited to the patient but also reflects the sex- and gender-related attitudes, feelings, beliefs, and behaviors of the assessor.

Annotated Bibliography

Comment: This edited volume includes chapters discussing sources of bias in various areas of psychiatric diagnosis (including chapters on PDs, as well as symptom disorders), along with discussions of societal and clinician-based sources of bias.

Comment: The third edition of Millon’s comprehensive review of personality pathology, this volume includes detailed discussions of historical context and research evidence related to each DSM-5 PD, along with information regarding diagnosis, assessment, and treatment.

Comment: This chapter reviews research on sex and gender differences in personality and PDs, including discussions of seminal studies and frameworks for conceptualizing and interpreting observed sex and gender differences.

Comment: Written by two of the leading authorities in this area, this article reviews empirical evidence on sex differences in various individual difference domains (e.g., empathy, sociosexuality), concluding that many sex differences are best conceptualized as continua rather than as discrete/dichotomous differences between women and men.

Notes

1 There has been considerable research examining sex differences in personality traits and personality disorders across culture. Unless otherwise noted, evidence discussed in this review was collected from participants in the United States.
These strengths notwithstanding, the DSM-5 contention that PDs “onset in adolescence or early adulthood” is inconsistent with a plethora of studies from developmental and clinical psychology, which converge to confirm that identifiable precursors of most PDs are present by mid-childhood—sometimes earlier—and it is rare to find an adult with significant personality pathology whose early years were not marked by interpersonal difficulties, distortions in the perception of self and significant others, and a pattern of dysfunctional, self-defeating behavior (Millon, 2011; Triebwasser et al., 2013). With these findings in mind, some clinical researchers have argued that personality pathology typically onsets early in life and should, when associated with clinically significant distress or impairment, be formally diagnosed in childhood and early adolescence (see Freeman & Reinecke, 2007).

The ROD scale (Masling et al., 1967) has been updated in Meyer et al.’s (2011) Rorschach Performance Assessment System (R-PAS) and is now included as the Oral Dependent Language (ODL) scale.

References


Robert F. Bornstein & Barbara A. McLeod


Sex, Gender, and Personality Disorders


Sex, Gender, and Personality Disorders


Clinical assessment and diagnosis of psychotic conditions requires use of multiple methods, including clinical interviews, psychological testing, and, when possible, appropriate symptom rating scales (Kleiger & Khadivi, 2015). However, competent assessment of serious mental health disorders, like psychoses, requires attention to contextual factors and comorbid conditions. In terms of context, assessors must always remain aware of factors such as age, ethnicity, and culture. Sex differences in the diagnosis and prognosis of psychosis is an equally important intervening variable that assessors need to take into consideration when evaluating patients who are referred with questions of psychosis. The issues of comorbidity and differential diagnosis are also critical factors, which challenge diagnosticians to determine which issues are primary and which are secondary and, in certain situations, whether one condition may be a consequence of another more significant disturbance.

Assessing psychosis in the context of sex, gender identity, and sexual orientation requires knowledge about psychotic dimensions, the continuum of psychotic phenomena, and contemporary diagnostic categories, along with keen sensitivity to sex- and gender-related variations that, if ignored, may not only complicate the assessment process but eventually lead to misdiagnosis and poor treatment outcomes. Individuals with nonconforming gender identity or sexual orientation also face social and, possibly, self-stigmatization, just as individuals who are diagnosed as suffering from psychoses face similar forms of self- and societal stigma. The potential for a diagnostic assessment to be stigmatizing is compounded when an individual carries both labels (e.g., psychotic and homosexual or transgender). Conversely, a patient struggling with gender identity dysphoria may be further stigmatized by being mislabeled as psychotic, just as the psychotic individual with sexually related
delusions may be stigmatized further by being labeled as having a cross-gen-
der identity, as well.

Consider the case examples provided by Mizock and Fleming (2011), which illustrate the complexity in teasing apart gender variance in the context of psychosis. For example, the authors presented the case of N.W., a female-to-male transgender individual, who was admitted to the hospital following a suicide attempt and then revealed symptoms of a psychotic-level depression with visual and auditory hallucinations. A subsequent clinical interview and collateral information confirmed that he had passed as a male in his community for a number of years and had been saving money to continue sexual reassignment surgery. With treatment, his depression, suicidality, and psychotic symptoms remitted, and N.W. continued his life with his wife and child as a transgender man.

In contrast, Mizock and Fleming (2011) described the patient, C. F., a female-bodied individual who presented as male during manic psychotic episodes, during which times she dressed as a man and believed she was the reincarnation of a Greek god. Her treatment team focused on her delusional symptoms, and with medication and therapeutic support, her positive symptoms lessened, and she reported no further beliefs that she was a man following the remission of her psychosis. Thus, the interface between psychotic and gender-related phenomena is complex, easily leading to erroneous assumptions and misdiagnosis.

There are a number of ways to consider the interface between psychosis, sex, and gender. Whether one is conducting an evaluation or treatment, it is important to understand the relationships that exist between psychotic vulnerability and sexual and gender variations.

**Perspectives on Sex, Gender, and Psychotic Phenomena**

Understanding the psychological assessment of psychosis in the context of sex and gender begins first with a general discussion of sexual issues in psychosis, with attention to how evaluators often fail to ascertain information related to a psychotic individual’s sexual functioning. Second, a comprehensive review includes understanding sex differences in onset of illness, symptom presentations, diagnoses, and prognostic factors. Assessors should become acquainted with the substantial literature regarding sex-based differences in psychosis. Armed with an understanding of such differences, assessors can think about how males and females with psychotic symptoms or disorders may perform differently on psychological tests. Third, it is important to review the relationship between gender and sexual orientation dissonance and psychosis. Here, assessors must be aware of the occurrence of comorbid mental health conditions, in this case psychosis or psychotic features, among members of the LGBT community who present for evaluation and treatment. Finally, and often most challenging for diagnosticians, is the issue of differential diagnosis. For example, when are the assertions of the nonconforming gender identity patient mistakenly viewed
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through the lens of a psychotic diagnosis; and conversely, when are these same assertions not seen as a delusional symptom in a truly psychotic individual? Here, the question becomes somewhat political and broach the controversy over whether or not psychosis should be an exclusionary condition for making the diagnosis of a Gender Identity Disorder, or Gender Dysphoria, as it is called in DSM-5 (American Psychiatric Association, 2013), given that the very nature of psychosis involves a distorted reality. The current diagnostic practice clearly states that, “Schizophrenia (or other psychotic disorders) and gender dysphoria may co-occur” (American Psychiatric Association, 2013, p. 458).

Sexuality and Psychosis

Too often assessors and therapists pay less attention to sexual issues in their psychotic patients than to difficulties having to do with primitive object relations, disorganized attachment, or deficits in ego functioning. Skodlar and Zunter Nagy (2009) framed this issue of neglect of sexuality in evaluating and treating patients with psychoses, pointing out the mismatch between many patients’ desires to talk about sexual problems and gender or orientation uncertainty and clinicians’ neglect of their patient’s sexual concerns, confusions, behavior, and identities. Neglect to explore sexual aspects of a psychotic patient’s experience may be a product of an assessor’s discomfort, ignorance, or part-object orientation. Skodlar and Zunter Nagy point out how some clinicians may avoid asking about sexual functioning because they consider sexuality of their psychotic patient to be “bizarre, inaccessible, and uncontrollable” (p. 115). As indicated above, others may neglect sexuality while paying more attention to disturbed attachment and impaired ego functioning. Finally, especially when performing psychological evaluations, assessors may err in reducing patients with psychoses to a set of intriguing symptoms, while failing to see the patient as a person desperately trying to find solutions to common human problems in establishing a cohesive sense of self and in regulating emotions and closeness with others.

Although based on anecdotal data, the authors identified several categories of manifestations of sexuality in their experience working as therapists with psychotic individuals. Chief among these were concerns about avoidance of sexual activities, gender identity and homosexuality, masturbation, and more rarely, impulsive sexual behavior. Skodlar and Zunter Nagy (2009) interpreted their patients’ absence of sexual activity as avoidance of intimacy due to difficulties in regulating closeness. Regarding concerns about gender identity and sexual orientation, the authors interpreted these issues as byproducts of primary difficulties in establishing a stable sense of identity and less in terms of transgender identity or same-sex object preference. Although their explanation that transgender and sexual orientation concerns in their psychotic patients are often epiphenomena of a lack of self-cohesion makes some sense, it is important not to ignore the coexistence of these conditions. An individual may struggle with psychosis, while also being a member of the LGBT community.
As noted by Mizock and Fleming (2011), when working with gender-variant patients, “either-or” diagnostic thinking may occasionally be appropriate, as was the case with patient C. F., whose cross-gender presentation only occurred during psychotic episodes. However, often a “both-and” mindset conforms more closely to reality. Such is true with patients like N. W., whose psychotic symptoms occurred separate from his long-standing, ego-syntonic cross-gender identity.

Psychosis and sex-related issues can also be viewed demographically, in terms of sex differences in the occurrence of psychotic phenomena. The following section explores base rates of sex differences in premorbid factors, symptom dimensions, and diagnoses of psychosis.

**Sex-Based Differences in Psychosis**

Regardless of assessment method, it is important to know about base rates in the occurrence of psychotic phenomena among men and women. Understanding base rates helps ground our inferences about the implications of our findings. In other words, knowing that a particular psychotic symptom or diagnosis is more common in women than in men, or vice versa, adds meaning to the significance of this symptom when it occurs in one sex versus the other.

Studies of sex- and gender-based differences have focused on (a) premorbid factors, age at onset of psychosis, course of illness, recovery, and prognosis, (b) symptom dimensions, and (c) diagnostic categories.

### Sex Differences in Premorbid, Prodromal, Onset, and Recovery Factors

A number of studies have demonstrated sex differences in premorbid factors, age of onset, symptoms features, long-term functioning, and social support for patients with psychotic spectrum disorders (Angermeyer, Kühn, & Goldstein, 1990; DeLisi et al., 1989; Goldstein & Link, 1988; McGlashan & Bardenstein, 1990; Shtasel et al., 1992; Grossman et al., 2008). Independent of diagnosis, several studies have shown sex differences in various premorbid factors prior to first psychotic episode. For example, in their sample of patients treated at an early psychosis prevention center, Cotton and colleagues (2009) found that females had a higher rate of depression and suicide attempts, while males had a higher level of substance abuse and general psychopathology. Additionally, the researchers demonstrated that, prior to admission for their first psychotic episode, males had lower Global Assessment of Functioning (GAF) levels, were more frequently unemployed, found to be living at home, and noncompliant with treatment. Women have also been shown to have suffered a longer duration of illness before treatment and to have exhibited more affective symptoms, while men were more socially isolated and had more negative symptoms (Koster et al., 2008).
Sex differences in prodromal symptoms have been investigated in retrospective (Moukas et al., 2010) and prospective (Amminger et al., 2006; Willhite et al., 2008) studies. With structured clinical interviews, Moukas and colleagues recorded prodromal symptoms reported by patients after symptoms of acute psychosis had cleared. Although all symptoms appeared in both sexes, females showed a greater prodromal frequency of magical thinking, overelaborate speech, and painful sensitivity to sounds (hyperacusia). In contrast, males demonstrated a higher frequency of peculiar behavior and aggressiveness.

Prospective studies of ultra-high-risk groups have also demonstrated sex differences in prodromal symptoms. Amminger et al. (2006) found that female sex, along with decline in functioning, were significant predictors of conversion to affective psychosis two years after identification, while early age of onset (prior to age 18) of psychiatric symptoms significantly predicted nonaffective psychosis. In their study of young adults diagnosed with schizotypal disorder, Nordentoft et al. (2006) found that males had a four-fold risk for conversion to schizophrenia compared to females, within one year of assessment.

Willhite and colleagues (2008) suggested that sex-based differences in symptom presentation and functional outcome might predate conversion to psychosis. Although they found no gender differences in demographic variables, functional level, or symptoms at baseline, they showed that males presented significantly higher levels of negative symptoms and marginally lower levels of functioning when baseline and follow-up time points were collapsed and considered collectively. They also found that female subjects reported greater social support at baseline.

Barajas et al. (2010) conducted a longitudinal study of 53 patients between the ages of 7 and 65 with a non-diagnostic-specific first psychotic episode. Although they did not find that males functioned more poorly prior to onset of psychosis, age ended up being a key distinguishing variable. In general, almost across the board, males under the age of 18 fared more poorly prior to the onset of their illness. Similarly, males in this younger age group also had higher levels of cannabis usage and demonstrated more soft neurological signs than did females.

Typically, studies have demonstrated that males have an earlier onset of schizophrenia compared to females, independent of culture or diagnostic classification system (Faraone et al., 1994; Gureje & Bamidele, 1998). More specifically, when looking at individual illness types, Kolvin et al. (1971) suggested that the predominance of males in the early-onset schizophrenia group is a distinguishing feature of this disorder. Similarly, males (along with childhood history of antisocial behavior) seem to have an earlier onset of mania and bipolar disorder than do females (Kennedy et al., 2005).

Researchers identified three peaks in the age of onset of schizophrenia, which included different distributions between males and females (Castle, Wessely, & Murray, 1993). The early peak was prominent in males, whereas a middle peak was found to be more frequent in females. The last onset peak was shown to be
even more heavily dominated by females. However, not all studies have agreed with this three-tiered onset model or have found such clear differences in age of onset between the sexes (Addington & Addington, 1996; Barajas et al., 2010).

Long-term follow-up studies have shown that women generally fare better than men (Grossman et al., 2006, 2008; McGlashan & Bardenstein, 1990). Females with schizophrenia and other psychotic disorders demonstrated better functioning at various follow-up assessments over a 15-year period (Grossman et al., 2006). Better outcome was operationalized in terms of fewer and briefer hospitalizations and longer periods of recovery. In a subsequent study (Grossman et al., 2008), this group of researchers concluded that, after 20 years, women had a significant improvement and a lower level of psychotic symptomatology when compared to men. Szymanski et al. (1995) also reported that women responded to treatment more rapidly and required lower doses of antipsychotic medication.

**Sex Differences in Symptom Dimensions**

Assessing psychosis involves both dimensional and categorical perspectives. Although some proclaim the dimensional model to be the most valid approach to assessing psychosis (Bentall, 2003; Carpenter et al., 2009), it is still considered standard practice to assess psychoses according to both empirically derived symptom dimensions, as well as familiar diagnostic categories (American Psychiatric Association, 2013; van Os et al., 1999; van Os & Kapur, 2009). The DSM-5, for example, advocates an assessment of eight dimensions, including (1) Hallucinations, (2) Delusions, (3) Disorganized speech, (4) Abnormal behavior, (5) Negative symptoms, (6) Impaired cognition, (7) Depression, and (8) Mania. In addition, there are separate categories for schizophrenia spectrum and other psychotic disorders, bipolar, and depressive disorders with psychotic features (American Psychiatric Association, 2013).

**General Psychosis Dimension.** Some have proposed that a single-dimension model, consisting of a general psychosis factor, accounts for most diagnostic variance (Berrios & Beer, 1994). A consistent finding has been that, independent of diagnostic categories, psychosis in males is associated with a greater prevalence of negative symptoms, more severe illness course, and poorer outcome (Grossman et al., 2008; Maric et al., 2003; Morgan et al., 2009). These studies showed that women had higher rates of positive symptoms, which disappeared after adjustment for depression, and more benign course of illness, lower levels of disability, and better integration into the community.

**Hallucinations.** A number of studies have shown no difference with respect to positive psychotic symptoms (Addington & Addington, 1996; Shtasel et al., 1992). However, several have found auditory hallucinations to be more frequent in women (Barajas et al., 2010; Goldstein et al., 1990; Rector & See- man, 1992; Shama et al., 1999). However, once again, in the Barajas et al. study, age was a significant intervening variable, with younger women showing more frequent hallucinations than men and older women. Analyzing
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phenomenological differences in hallucinations by social class and sex, Suhail (2000) found that men reportedly heard more threatening voices commenting critically on their behavior. Regarding thematic content of visual hallucinations, men visualized more real images of people, whereas a greater proportion of women and people from lower socioeconomic classes reported seeing more spirits and demons.

**Delusions.** Several studies found that paranoia and persecutory delusions were more frequent in women with psychosis (Goldstein et al., 1990; Shtasel et al., 1992). Regarding delusional content, one study noted differences in how males and females experienced persecutory delusions (Walston et al., 1998). This retrospective analysis of a small sample of patients revealed that a higher proportion of male patients tended to identify physically violent strangers as their persecutors, while females identified more social exclusion and verbal aggression perpetrated by familiar females. When delusions are studied as the syndrome, versus symptom level, females tend to have delusions with affective qualities with erotic and heterosexual themes, whereas males tend to have delusions with a homosexual theme (Rudden & Sweeney, 1983).

**Thought Disorder.** In their study of sex differences in prodromal symptoms, the Barajas study (2010) showed that for patients whose first psychotic episode occurred after the age of 18 years old, males demonstrated more dysfunctional language than did females. Examining thought disturbances among males and females with schizophrenia, Perry and colleagues (1995) found no differences with conventional instruments like the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) or the Scale for the Assessment of Positive Symptoms (SAPS; Andreasen, 1984). However, male patients showed a greater degree of thought impairment on the Rorschach Ego Impairment Index (EII), a broad measure of thought disorganization, developed by Perry and Viglione (1991). In a study with a slightly younger group of people with schizophrenia, Danielsson, Flyckt, and Edman (2001) found a trend for women to score higher than men on the EII, but their small sample size would have required a very large effect size to be statistically significant (Resende, Viglione, & Argimon, 2009). Resende and colleagues (2009) also found that the Rorschach could identify sex differences in disordered thinking, as their male participants, between the ages of 20 and 55, produced a significantly higher number of scores signifying disturbed and illogical thinking than did women participants.

**Negative Symptoms.** Higher levels of negative symptomatology in males have been a consistent finding in the research (Goldstein, et al., 1990; Shtasel et al., 1992; Szymanski et al., 1995). Barajas et al. (2010), like others, found more negative symptoms in males younger than age 18. In the older than 18 group, there was a difference in excitation, with males showing higher scores as well. Finally, when age was taken into account, awareness of illness was difference between the sexes. In the earlier-onset group, males showed less insight and awareness than did females. Interestingly, this trend was reversed in the older group, with women showing less awareness of illness than did males.
**Cognitive Impairment.** The literature has been inconsistent regarding sex differences in neuropsychological impairment among men and women with psychosis. The Barajas (2010) study of gender differences in incipient psychoses found no differences in executive functions, attention, and working memory. However, other investigations found that males had greater impairment in working memory, sustained attention, verbal memory, and language processing (Goldstein et al., 1994). Haas et al. (1991) found no neurocognitive differences in early phase of schizophrenia, but over the course of the illness, males demonstrated greater impairment.

**Affective Symptoms.** Men tend to manifest more excitative symptoms and women more dysphoria (Barajas et al., 2010; Goldstein et al., 1990). Manic symptoms in males are characterized by a higher level of motor activity, grandiosity, contact, and humor, whereas females demonstrate more mood lability, depression, guilt, anxiety, and suicidality (Bhattacharya et al., 2010).

**Sex Differences in Diagnostic Categories**

**Schizophrenia Spectrum.** Although prevalence between the sexes is similar, there are sex-based differences in schizophrenia. In addition to differences in age of onset and severity of premorbid adjustment, females seem to demonstrate less deterioration and a more benign illness course than do males. In general, males have an earlier age of onset and demonstrate poorer premorbid adjustment than do females. However, studies show that women are over-represented in both late-onset, or geriatric, schizophrenia (Jeste & McClure, 1997; Shultz, 2001) and schizophreniform and brief psychotic disorders (Maneros & Pillmann, 2007).

Explanations of sex differences in premorbid factors, symptoms, clinical course, and outcome have included structural brain differences, birth complications, hormonal, and psychosocial factors. It has been hypothesized that estrogen may play a protective role in women with schizophrenia and account for some of the differences between men and women (Cancuso & Pandina, 2007).

**Schizoaffective Disorder.** Females are over-represented among individuals diagnosed with schizoaffective disorder (Angst, Felder, & Lohmeyer, 1980; Lenz et al., 1991). However, Abrams and Arciniegas (2007) argue that these gender differences may be due to the more general presence of clinically significant emotional disturbances in women compared to men.

**Delusional Disorder.** In contrast to the equal distribution among the sexes in schizophrenia, delusional disorders are slightly more common in women than men. According to Manschrek (2007), individuals with delusional disorders tend to be older women, who are more socially and educationally disadvantaged. However, being female and married, in addition to having an acute and earlier onset, predicts a more favorable outcome. As noted above, women’s delusions may reflect more affect and include erotic and heterosexual themes, while men may have delusions with themes involving homosexuality (Rudden & Sweeney, 1983).
**Bipolar Psychosis.** No sex-related differences are reported in the prevalence of bipolar psychoses (Baldwin et al., 2005); instead, women were over-represented in the bipolar-II category (Hendrick et al., 2000). However, women were hospitalized more often for mania and found to have had higher rates of alcohol abuse than did men, who had higher rates of drug abuse. Findings have been somewhat inconsistent regarding whether women or men with bipolar disorder experience more positive symptoms. There is also some evidence of a link between postpartum psychosis and bipolar disorder, given similarities in family history, symptomatology, and outcome measures (Chaudron & Pies, 2003). Approximately one-third of women diagnosed with bipolar disorder also meet criteria for postpartum psychosis.

**Psychotic Depression.** It is not surprising that depression is more common in women than it is in men. This sex-based difference has also been found in psychotic depression. Studies have found that well over half of the subjects with psychotic depression were female (Johnson et al., 1991; Ohayon & Schatzberg, 2002).

**Drug-Induced Psychoses.** Most studies have shown that a greater proportion of cannabis-induced psychotic symptoms have been observed in males (Gonzalez et al., 2000). This may be due to not only the higher base rate of consumption in males but also possibly the protective function of female hormones. There is also evidence that men are far more likely to develop cocaine-induced psychoses (Brady et al., 1991).

**Sexual Orientation and Psychosis**

Awareness of the possible existence of psychotic phenomena in individuals presenting with sexual- and gender-related concerns informs psychological assessment and guards against binary conclusions, which reduce the diversity and complexity of experience in the individuals we evaluate. With any patient who presents for a psychological consultation, assessment of personality functioning, including ruling out psychotic phenomena, is a standard of clinical practice. Especially when the results of psychological assessments have consequences for medical decision-making, nowhere is this issue more compelling than the case of evaluating transgender individuals for sexual reassignment surgery. Finally, although sexual trauma can shift the frame of reference from subjectivity of identity and object choice to traumagenic etiology, it is also appropriate to consider the relationship between sexual abuse and psychosis when surveying the nexus between sex, gender, and psychotic phenomena.

**Sexual Orientation and Psychosis**

Several studies have identified higher rates of mental health disorders among sexual minorities (Bostwick et al., 2011; King et al., 2008; Mays & Cochran, 2001; Wang et al., 2007). Most have focused on increased rates of anxiety,
depression, self-harm, and substance abuse disorders in lesbian, gay, and bisexual individuals. However, a few have also looked at prevalence of psychosis in sexual minorities and found an increased risk of psychotic symptoms in LGB patients (Chakraborty et al., 2011; Gevonden et al., 2013). Cumulative incidence of psychotic symptomatology was found to be elevated in the LGB subjects compared with heterosexuals (Gevonden et al., 2013). The researchers proposed that, as with any ethnic minority status, being in the sexual minority increases the risk for a range of mental health problems, including psychotic symptoms, as a result of social stresses, which can include discrimination, exclusion, and defeat.

Psychosis can also be associated with anxieties regarding one’s sexual orientation. The concept of “homosexual panic” has been recognized and described as an acute, brief reactive psychosis, occurring in vulnerable individuals who have been subjected to unwanted sexual advances (Chuang & Addington, 1988). However, psychodiagnosticians, especially when performing forensic evaluations, need to be aware that this is a controversial concept, which has led to legal and clinical arguments about whether “homosexual panic” constitutes a bona fide defense in the courtroom for violent crimes (Chuang & Addington, 1988; Lee, 2013).

A final way to discuss the assessment of psychotic symptoms among members of the LGB community is to study the prevalence of psychosis in individuals suffering from HIV infections. In addition to identifying areas of cognitive impairment, neuropsychologists may encounter an increased frequency of psychotic phenomena in late-stage HIV patients. Psychotic symptoms secondary to HIV typically include delusions with persecutory, grandiose, or somatic features. However, bizarre behavior, disordered thinking, and hallucinations are also reported, primarily in males infected with AIDS (Reading & Little, 2007).

Coexistence of Transgender Identities and Psychotic Phenomena

The relationship between transgender identity, transsexualism, or cross-gender identification, as it is sometimes referred, and psychotic disorders can be thought about both in terms of prevalence of coexisting psychotic diagnoses that may occur in this population and underlying psychopathology that might make some individuals with gender dysphoria more vulnerable to psychotic phenomena. Regarding the latter, the underlying personality organizations of gender-confused and gender-dysphoric patients, which might make them more susceptible to psychosis, have been studied.

More than is true with the LGB community, individuals with transgender issues have been the focus of psychological evaluations aimed at identifying psychiatric disorders that might make an individual unsuitable for sexual reassignment surgery. The incongruence between experienced gender and biological sex has not only puzzled clinicians but may also lead some transgender
Sex, Gender Identity, and Psychosis

individuals to question their self-cohesion and perception of reality. This fundamental schism between the body and mind, or between dueling realities, may be why some transgender individuals experience more severe confusion and distress, and consequently, develop severe gender dysphoria.

The question whether transgenderism, without dysphoria or confusion, signals the presence of underlying psychopathology has largely been settled, as contemporary ways of conceptualizing gender variations view transgenderism as an alternative form of identity (American Psychological Association, 2009; American Psychiatric Association, 2013). Those who disagree and continue to view transgenderism as psychopathological lie outside of the mainstream. However, there is no doubt that transgenderism may lead to secondary psychopathology as a consequence of minority stress. Confusion and distress regarding one’s gender identity may also produce a range of psychosocial symptoms and psychiatric disorders.

Some studies have shown that, despite the incongruence between assigned sex and experienced gender, transgender individuals do not have a high level of co-occurring psychopathology (Cole et al., 1997; Hoshiai et al., 2010; de Vries et al., 2011). When a higher incidence of mood, substance abuse, personality, and psychotic disorders has been found in individuals with gender identity issues (Campo et al., 2003; Hepp et al., 2005), these conditions may be secondary to the stress of discrimination and stigmatization.

When psychological assessment has played a role in evaluating patients who present with gender-related concerns or dysphoria for psychotherapy or for medical treatment, such as hormone injections and sexual reassignment surgery, one clear diagnostic concern has been ruling out the presence of complicating or disqualifying conditions, such as severe personality disorders and psychoses. Historically, psychologists have employed popular instruments, such as the MMPI (Hathaway & McKinley, 1940) or MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), or multi-method approaches in order to identify those transgender individuals who may also have psychotic symptoms, which would interfere with treatment and recovery.

Lothstein (1984) reviewed a sizable number of studies in the 1970s and 1980s, which sought to describe the underlying psychological characteristics of transgender patients. Among the most commonly used instruments were the MMPI and Draw-a-Person Test. Lothstein was appropriately critical about the test-centered, single-method, “hit or miss” nature of these studies and concluded that many were methodologically flawed. However, Lothstein, like others, suggested that individuals with transgender confusion suffer from borderline psychopathology, with disturbances in thought organization, reality testing, and object relations, which made them more vulnerable to psychotic-like experiences (Karmel, 1988; Murray, 1985; Person & Ovesey, 1974, Volkan, 1979).

Using the Rorschach, a number of small sample research and case studies concluded that patients with gender confusion or gender identity disorder
produced more thought-disordered responses that reflected fluid boundaries between fantasy and reality (Coates & Tuber, 1988; Ipp, 1986; Karmel, 1988; Kolers, 1986). Mid-level thought disorder responses, such as incongruous combinations (INCOMs), fabulized combinations (FABCOMs), and deviant responses (DRs), have been interpreted as test signs of primitive defenses and psychotic-like phenomena.

However, such findings deserve further thought, lest a whole class of individuals with gender confusion is overly pathologized based on findings from these studies. We must consider the fact that the transgender individual's internal psychological experience is confusingly incongruous with biological reality. Life for the transgender person is an incongruous combination of critical details that are incompatible. Thus, we might view the Rorschach INCOMs, FABCOMs, or DRs given by these individuals as reflections of the discontinuities in self-experience, as opposed to impairments in thinking or reality testing. Viewing incongruous combinations on the Rorschach, in special groups of people, as something other than signs of thought disorder harkens back to formulations about the nature of thought disorder responses in the Rorschachs of post-traumatic patients. Trauma researchers typically reject the traditional explanation that such responses reflect the “breakthrough of primary process” material or signal the possibility of borderline-level or psychotic predispositions. For example, Levin and Reis (1996) suggested that the presence of such incongruous combinations in traumatized patients may be a metaphor for the incongruity of the survivor’s traumatic experiences. According to Armstrong (1994b), the trauma-laden confabulatory quality of some responses, which contain self-reference and graphically primitive imagery, is almost seen as a Rorschach equivalent of a flashback experience. According to the traumatologist's argument, these INCOMs, FABCOMs, and DRs may represent the unmetabolized reexperiencing of the traumatic event and implausibility of the survivor’s experience captured by an actual witnessing of a scene of violence and death. Thus, in a similar way, it may be possible to reconceptualize Rorschach thought disorder scores in the records of gender-dysphoric patients as something other than manifestations of psychosis proneness.

Miach and her colleagues (2000) narrowed their focus to the usefulness of the MMPI-2 in assessing gender-dysphoric patients. They reviewed a number of MMPI studies, which suggested that transgender individuals had severe underlying borderline or psychotic pathology and pointed out the methodological problems in these studies with sample sizes, classification standards, and representative nature of the subjects. In their own investigation of male candidates requesting sexual reassignment surgery, they distinguished between the MMPI-2s and psychiatric evaluations of two groups of patients, one classified as transsexual and the other gender identity disorder of adolescence and adult, non-transsexual type (GIDAANT), which the DSM-III-R (American Psychiatric Association, 1987) had defined as the two subtypes within the gender
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identity disorder spectrum. The distinguishing feature between the two groups was that the GIDAANT patients did not have a persistent desire to get rid of their sexual characteristics and acquire the characteristics of the other sex. Based on the MMPI-2 and psychiatric evaluations, the majority of the transsexual patients did not show evidence of severe psychopathology, whereas nearly one-half of the GIDAANT group did. Miach et al. concluded that their findings offered no support for the contention that severe borderline or psychotic phenomena were necessary conditions for developing transgender dysphoria and requesting sexual reassignment.

Disentangling Transgender Identities and Psychosis

In contrast to the previous sections that describe research into whether one group may be more prone to suffer from additional symptoms, disorders, or underlying psychopathology than another, a more radical and potentially controversial question would be, “Is this individual claiming a transgender identity actually psychotic?” In other words, can the belief about the incongruity between one’s felt gender and biological sex itself be a symptom of a psychotic disorder? This seemed to have been the case with Mizock and Fleming’s (2011) patient C. F., whose belief that she was male, and a Greek god no less, disappeared after the psychosis was successfully treated. The literature reveals a number of similar case reports where the patients’ transgender identities were actually manifestations of delusional thinking (Campo et al., 2001; Caspar, Sittinger, & Lang, 1999; Hashimoto, 1992; Urban, 2009). Clearly, some studies conclude that most people with cross-gender identities, in the process of sexual reassignment, do not suffer from severe psychopathology (e.g., Gómez-Gil, Vidal-Hagemeijer, & Salamero, 2008).

Historically, with psychological and psychiatric evaluators, there has been a continuum of viewpoints ranging from those who have viewed cross-gender identity or transsexualism as a valid phenomenon, in some cases warranting medical and surgical interventions, all the way to those who continue to believe that the mere existence of a cross-gender identity is indicative of a delusion. To quote McHugh (1995), “the scalpel should not be used to reconcile fantasy with reality” (p. 111). According to this extreme point of view, acceptance of the validity of cross-gendered identification or providing medical or surgical intervention is akin to supporting a psychotic delusion (Socarides, 1978). These writers represent an anachronistic position, which is no longer in accordance with current conceptual and diagnostic practice.

Campo and colleagues (2001, 2003) are among a number of researcher-clinicians who raise concerns about risks for false positives in assessing and making medical/surgical recommendations for individuals presenting with gender identity issues. In particular, they discuss reports of cases in which cross-gender identification disappeared when the patients were treated with neuroleptic medication. Likewise, there are reports of patients whose cross-gender identification
switched back after antipsychotic medication was stopped (Puri & Singh, 1996). As a result of these case reports and their survey findings, Campo et al. (2003) concluded that contemporary DSM criteria (in this case, those of the DSM-IV) were not strict enough and that persistent transgender identification may be all too common in psychotic patients. They conclude that, in a number of cases, confusion or conviction regarding cross-gender identification may be attributable to misperception of reality that is symptomatic of psychosis. As such, they argued in favor of using stricter exclusion criteria before accepting the individual’s transgender identity as such—namely, ruling out the presence of a psychotic disorder before concluding that an individual had a nonpathological cross-gendered identity.

The Value of Psychological Assessment

As noted throughout this chapter, the relationship between psychotic phenomena, sexual orientation, and gender identity can take several forms. Apart from psychological assessment’s role in identifying an individual’s psychological resources and vulnerabilities and in clarifying dynamic issues that the individual cannot tell us directly, it can idiographically aid in disentangling the relationship between psychotic symptoms, sexual orientation, and gender identity. For example, an individual may suffer from psychosis and also have a nonconforming gender identity and/or sexual orientation. A careful psychological assessment can help clarify where the major sources of distress lie, along with the impact that they are having on the individual’s personality and adaptive functioning. Assessment can help elucidate which issues are most in need of treatment and which are not. Clearly, the actively psychotic individual has symptoms that will take precedence in a treatment plan, and the gender- or sexual-related issues may or may not become a focus of treatment. However, assessment and treatment must encompass those individuals for whom questions, anxieties, and beliefs about sexual orientation and gender identity are deeply embedded within their psychosis and, like Skodlar and Zunter Nagy (2009) suggested, may reflect more profound confusion about their identities and sense of self. Again, psychological assessment, which includes a thorough review of history, along with a clinical interview, and appropriate self-report and performance measures, can help decipher the meaning that sexual and gender identity concerns may have for the individual who is in the throes of a psychotic episode.

Practical Points

- Most evidence points to a greater incidence of positive symptoms, in particular hallucinations, in females. To assess the presence of hallucinations and delusions, clinicians will find the clinical interview and
selected empirically supported rating scales, such as the Beliefs About Voices Questionnaire–Revised (BAVQ–R), Characteristics of Auditory Hallucinations Questionnaire (CAHQ), or Psychotic Symptoms Rating Scales (PSYRATS), to be useful instruments (Chadwick, Lees, & Birchwood, 2000; Haddock et al., 1999; Trygstad, 2002). Multiple scales and subscales of popular personality inventories like the MMPI–2 (Butcher et al., 1989; Nichols, 2011), MMPI–2–RF (Ben-Porath & Tellegen, 2008), and PAI (Morey, 1991) also may signal the presence of hallucinations and/or delusions. To assess disordered thinking, there is no more useful instrument than the Rorschach (Rorschach, 1942/1921; Exner, 2003; Meyer et al., 2011).

- Keeping in mind sex-based differences in psychotic symptoms, assessors should pay attention to how negative symptoms may look like depression on psychological tests. Negative symptoms, in particular, are more common in males. In assessing males suspected of psychosis, it is important not to mistake negative symptoms for depression. Emotional and ideational constriction and impoverishment seen in testing protocols might reflect the psychological impact or either depression or negative symptoms. Typically, negative symptoms are associated with less dysphoria, regret, guilt, or self-loathing and more with social detachment, anhedonia, and poverty of thoughts and speech.

- Two extreme points of view may undermine effective psychodiagnosis of individuals presenting with transgender identities. The first view, which has been largely rejected, holds that the presence of cross–gender identification is not a legitimate variation in identity formation but is pathognomonic of significant psychopathology, perhaps of psychotic proportions. By contrast, the contemporary position is that an individual's claim regarding transgenderism represents an alternate form of identity, which, in the absence of discomfort or maladjustment, is not representative of underlying psychopathology. While this position is accepted as true, it should also not constrain our curiosity and prevent us from seeking to understand the psychological underpinnings of identity, just as we would with the cisgendered person. In other words, the first position is anachronistic, painting all transgender people with a broad brush, ignoring individual differences, confusing comfort and distress, and assuming that if someone presents with cross–gender identification, then he or she must be disturbed, borderline at best, and possibly psychotic. The current approach, although far more acceptable, may constrain the diagnostician from developing a more comprehensive understanding of the individual's internal world and the nature of his or her identity. Here, the concern about being politically correct may prevent a psychologist from trying to understand the struggles of the individual who has the identity, regardless of whether that identity is transgendered or cisgendered.
The role of psychological assessment has been important in the process of evaluating patients presenting for treatment with gender dysphoria or requesting sexual reassignment surgery. The essential question in evaluating cross-gender patients presenting for medical and surgical treatment is whether the individual's experiences can be better explained by the presence of a psychotic disorder. This is why a comprehensive evaluation, which includes a careful background history, clinical interview, and multi-method psychological assessment, is critical. Use of single instruments, whether they be personality inventories like the MMPI-2 or performance methods like the Rorschach, fall below the standard of carrying out multi-pronged evaluations.

When there is clear evidence of a psychotic condition, regardless of the patient's gender identity, the psychotic symptoms should be addressed first before further decisions are made regarding medical or surgical treatment of the individual's gender identity concerns.

The high incidence of trauma, and sexual abuse in particular, in the backgrounds of individuals with psychosis indicates that assessing chronic forms of PTSD is important when evaluating transgender individuals who appear to have comorbid psychotic symptoms.

**Annotated Bibliography**


*Comment:* This article captures the complexity that clinicians encounter in evaluating and treating patients presenting with psychotic phenomena and concomitant sexual orientation and/or gender identity issues.


*Comment:* The authors describe reasons that clinicians often fail to ask about sexual issues in patients presenting with psychosis. Although their conclusions about sexual orientation and/or gender identity issues among their psychotic patients are overly narrow, the authors address an important and frequently overlooked issue relating to sexuality in patients with psychoses.

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SEX, GENDER, AND SEXUAL ORIENTATION IN THE ASSESSMENT OF AFFECTIVE DISORDERS

Pavel S. Blagov and Joshua A. Goodman

The late-20th-century specialized literature on affective disorders (ADs) was largely uninformative with regard to sex, gender, gender identity, and sexual orientation. Authoritative handbooks barely mentioned sex ratios in depression and made no mention of gender or sexual minority status (Paykel, 1992), or they contained index entries about gender that did not correspond to actual text (Blatt, 2004). Similarly, early reviews on the neuropsychology of ADs hardly mentioned sex or gender variance (Veiel, 1997). This inattention to sex and gender variance is of concern because psychologists are expected to be mindful of the ways sex, gender roles, and sexual orientation may relate to diagnostic practices or to unique challenges vis-à-vis morbidity in diverse groups (American Psychological Association, 2000, 2007). The goal of this chapter is to inform clinicians who practice differential diagnosis and psychological assessment with adults of the ways research on sex, gender, and sexual orientation may inform their thinking about the ADs. We divided this chapter into three parts corresponding to epidemiology, assessment, and practical implications. In the epidemiology section, we discuss base rates, presentation, and risk factors for affective disorders based upon sex, gender, and sexual orientation; in the assessment portion, we discuss diagnostic interviewing, questionnaires and rating scales, and neurocognitive tasks. Finally, we provide guidance and implications for clinicians performing differential diagnosis of ADs. We wrote this chapter from a general clinical science perspective without assuming any theoretical approach to conceptualization (readers may refer to the following sources of theoretical review and innovation: Diflorio & Jones, 2010; Parker & Brotchie, 2010; Vigod & Stewart, 2009).
Affective Disorders

Epidemiological Considerations

Depression’s well-characterized parameters (Joiner, Walker, Pettit, Perez, & Cukrowicz, 2005) can be distinguished from general distress, demoralization, and sadness. The syndromal operationalization of major depressive disorder (MDD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APtA], 2013) includes the two core symptoms of dysphoria and anhedonia (at least one is required for diagnosis), as well as changes in appetite or weight, dyssomnia, objective psychomotor agitation/retardation, fatigue/loss of energy, inappropriate guilt/feelings of worthlessness, indecisiveness/reduced concentration, and morbid ideation and/or suicidality (APtA, 2013). The International Classification of Disorders (ICD-10; World Health Organization [WHO], 2000) includes fatigue/loss of energy among the core symptoms (Bebbington, 2004). Several types of depression have received varying degrees of empirical support in adults (Joiner et al., 2005): melancholic, atypical, seasonal-affective, persistent, and premenstrual (APtA, 2013).

The manic phase of bipolar disorder (BD) is defined by the two core symptoms of elevated, expansive, or irritable mood and an increase in goal-directed activity or energy; the additional symptoms are grandiosity, decreased need for sleep, increased talkativeness/pressure of speech, racing thoughts/flight of ideas, distractibility, psychomotor agitation/increased goal-directed activity, and excessive risk-taking (APtA, 2013). BD-I is characterized by manic episodes resulting in marked functional impairment (e.g., in social, occupational, or academic functioning, often requiring hospitalization), in addition to MDD episodes, whereas the BD-II diagnosis denotes a history of hypomanic (no marked functional impairment; only some difficulty with work, school, or relationships, and not requiring hospitalization) and depressive phases (APtA, 2013).

Depression represents a major cause of disability worldwide and has a high economic burden (Luppa, Heinrich, Angermeyer, Konig, & Riedel-Heller, 2007); although less common, BD is highly morbid and disabling and carries a great cost (Kleine-Budde et al., 2014). A moderate effect size links neurocognitive performance and everyday functioning in patients with BD (Depp et al., 2012), and this is likely also true of depression, whose severest forms resemble dementia (McCintosh, Husain, Greer, & Cullum, 2010). Both disorders are associated with certain neurocognitive impairments during active episodes and in remission (Andersson, Lovdahl, & Malt, 2010; Kurtz & Gerraty, 2009), even more so when accompanied by psychosis (Hill et al., 2009). Thus, a high standard of care may require psychological assessment when the differential is difficult because of co-occurring psychiatric or general medical conditions. Furthermore, assessment for nearly any purpose is likely to involve screening for ADs.
Base Rates and Symptom Presentation

Awareness of the base rates of disorders in the populations with which they work can allow clinicians to adjust their decision-making to increase its validity. MDD has a 7% annual prevalence in the U.S. (APtA, 2013) and a lifetime prevalence of 2–19%, with considerable international variability (Bebbington, 2004). The point prevalence of MDD is about 1% in children, 6% in adolescents, and 3% in adults, with up to 20% of adults and 50% of children and adolescents reporting subsyndromal symptoms; 10% report seasonal variation, and 1% meet criteria for seasonal AD. The majority of women with depressive symptoms report some changes with the menstrual cycle, but only 5% meet criteria for premenstrual depression. The cumulative probability of a depressive disorder over the lifespan is 25% but may involve major cohort effects (related to significant socioeconomic and sociopolitical developments). BD’s annual prevalence is about 0.6% (APtA, 2013). The estimates above may be uninformative if sex and sexual orientation are not taken into account.

Depression typically evidences a lifetime prevalence female/male ratio of 2:1 and a point prevalence ratio of 1:7 (Van de Velde, Bracke, & Levecque, 2010). Some sources report lifetime prevalence sex ratios as low as 1:5 and as high as 3:0 (Bebbington, 2004). The ratio starts around 1:0 in childhood, grows in adolescence, continues to do so during adulthood, and declines toward baseline in old age; the pattern is attributable to acceleration in onset incidence in adolescence that is much higher for girls than boys (Nolen-Hoeksema, 2002). Cross-sectional research suggests that women and men do not evidence different age of onset, episode duration, or recurrence, whereas longitudinal research finds a more chronic and recurrent course in women (Kornstein et al., 2000). The sex ratio cannot be accounted for by postpartum depression. (Unlike postpartum blues, which is very common, postpartum depression has a 10–15% prevalence and can be highly debilitating, although it likely is indistinct from MDD; Nolen-Hoeksema, 2002). Overall, the different prevalence rates appear to be due to a higher rate of first onset in women.

The sex ratios in depression prevalence appear to be population dependent and vary with global geography and cohort. For example, the sex difference may not replicate in medical students (Brewin & Firth-Cozens, 1997) and Old Order Amish adults (Goodwin & Jamison, 1990). Southern and Eastern European nations (which have lower socioeconomic indicators and more sexism and gender inequality) yield greater sex ratios relative to Western and Northern European nations (Marcus et al., 2005). The depression sex ratio’s decrease over cohorts appears to parallel the decrease in female gender role traditionality (Seedat et al., 2009).

Heterosexual men and women may differ in the ways they express distress, and these differences may yet vary across cultures (Andermann, 2010). Men and women with depression, in particular, may present somewhat differently. Women seeking outpatient treatment for depression are more likely to present...
with a history of prior psycho- or pharmacotherapy. Relative to men, women may report more subjective distress (e.g., feelings of failure and remorse), low energy, appetite and weight increase, anxiety, sympathetic arousal, gastrointestinal problems, and interpersonal sensitivity (Kornstein et al., 2000), whereas men may be somewhat more likely to present with double depression (dysthymia between MDD episodes), weight decrease, and suicidal ideation. Men may be more likely to evidence psychomotor retardation and alexithymia, whereas women are more likely to evidence agitation and to endorse crying (Carleton et al., 2013; Chuick et al., 2009; Sobin & Sackeim, 1997). Women may be somewhat more likely to report greater marital and physical health impairment, whereas men may be more likely to complain of impairment at work. Among community patients seeking treatment for depression, women may be somewhat more likely to endorse having attempted suicide (Marcus et al., 2005). Interestingly, sex does not seem to be associated with global severity in MDD (Mojtabai, 2001) or with symptom severity, functional impairment, hospitalization, or electroconvulsive therapy history (Frank, Carpenter, & Kupfer, 1988).

Despite the mean-level differences cited above, the most rigorous studies have found few sex differences in MDD symptomology. For example, the DSM-III-R criteria for MDD in a large twin sample evidenced identical factor structure for men and women (Aggen, Kendler, Kubarych, & Neale, 2011). Although women scored higher on the depression factor, the effect of sex disappeared after taking into account its interaction with age. Overall, women were somewhat more likely to endorse “depressed mood” in comparison to men with similar levels of the construct, and this explained why they were more likely to meet the diagnostic cutoff. Men tended to endorse “loss of interest” more often than did women with the same depression levels, but this difference decreased with age. “Depressed mood” and “feelings of worthlessness” had an age by sex interaction, whereby the sex difference decreased with age.

Beyond sex, gender roles may be linked to depression levels and symptom expression quality. Whereas femininity and androgyny may not be predictive of affective symptoms, masculinity appears to be related to lower self-reported levels of depression (Kopper & Epperson, 1996). Some authors have argued that the diagnostic criteria for depression ignore such typical male gender-role-specific expressions of distress as anger expression, aggression, risk-taking, and substance abuse (Rice, Fallon, Aucote, & Moller-Leimkuhler, 2013). The argument is that gender roles may color symptom expression, as masculinity is linked to the verbal and physical forms of anger expression, whereas femininity is linked negatively to all of its forms (Kopper & Epperson, 1996). Hence, on the basis of studies suggesting that including items that tap the male gender role in the diagnostic criteria for depression resulted in more men being identified as depressed, Pollack (1998) proposed a male depressive subtype characterized by workaholism, help avoidance, angry outbursts, and denial of sadness. Respectively, the Male Depression Inventory (Zierau, Bille, Rutz, & Bech, 2002) was developed to capture male gender-role-specific expression of distress, but its psychometrics
and utility received criticism (Rice et al., 2013). Rice and colleagues have proposed a Male Depression Risk Scale, which does not contain typical depression items but measures domains (i.e., emotional suppression, drug use, alcohol use, anger and aggression, somatic symptoms, and risk taking) that, in theory, ought to predict male depression. However, anger has been studied as a potential depression symptom and, albeit common, lacks diagnostic sensitivity (McGlinchey, Zimmerman, Young, & Chelminski, 2006). We wonder whether research into the Male Depression Risk Scale will yield similar results, perhaps revealing that it captures general psychopathology rather than depression in men.

**Bipolar Disorder**

BD has a male:female ratio of 1:1, yet, in the community, male sex is somewhat more strongly associated with the diagnosis, suggesting that BD may be missed or diagnosed as MDD in women (Schaffer et al., 2010). Perhaps BD-I has about the same prevalence or a slightly higher prevalence in men, whereas BD-II has a replicable higher prevalence in women (Diflorio & Jones, 2010; Parker & Fletcher, 2014). Early in life (ages 16–25), the incidence of BD may be higher in men, whereas it may be higher in women later in life (Kennedy et al., 2005). As with depression, postpartum BD episodes do not appear to differ in clinical features, functioning, or severity from other episodes (Colom et al., 2010), and sex does not appear to be linked to functional impairment in BD or to rapid cycling (Diflorio & Jones, 2010; Martinez-Aran et al., 2007). However, the lifetime prevalence of manic episodes (rather than BD per se) may be up to double in men than it is in women (Diflorio & Jones, 2010).

As with depression, some research suggests that BD may present somewhat differently in men and women. Although there may be no sex differences in the overall severity, symptom levels, and polarity of onset of BD (Diflorio & Jones, 2010; Kessing, 2004), women may recall greater appetite and weight change, and insomnia during past depressive episodes, whereas men may report greater suicidal ideation, hallucinations, and delusions; during manic episodes, men tend to score higher than women on grandiosity, hypersexuality, problem behaviors, excitement, and inability to converse, whereas women may score higher on mood lability, depressive symptoms, and hallucinations (Diflorio & Jones, 2010). Women with BD may be somewhat less likely than men to receive inpatient treatment, but their hospital stays may involve more mixed episodes and longer stays. Gender roles in BD do not appear to have been studied directly.

**Research With Nonheterosexual Adults and Adolescents**

Research over the past two decades has revealed increased rates of depression, anxiety, substance use, and suicidality in sexual minority populations. In a population-based health survey by the Centers for Disease Control and Prevention, nonheterosexual men reported more than double the rate of MDD, more than
triple the rate of recurrent depression, and more than double the rate of atypical BD relative to heterosexual men, whereas the rate of BD was about the same (Cochran & Mays, 2000). A large probability sample of men who have sex with men (MSM) yielded a depression prevalence (estimated from questionnaire scores) of 17% and an estimated odds ratio of 2.7 relative to men in general (Mills et al., 2004). The National Comorbidity Study similarly yielded evidence for increased risk of depression and suicidality in nonheterosexual adults (Gilman et al., 2001), and the estimates of the prevalence of depression among LGB individuals in California are considerably higher (e.g., 24%) than in heterosexual people (7%; Cochran & Mays, 2009), especially in bisexual women (36%) and in MSM who claim a heterosexual identity (31%). Such research replicates earlier smaller studies finding an elevated prevalence of ADs in homosexual patients (Hellman, Sudderth, & Avery, 2002). The most comprehensive study of AD prevalence by sexual orientation (Bostwick, Boyd, Hughes, & McCabe, 2010) estimated a lifetime prevalence of 59% in bisexual women, 44% in lesbians, 42% in gay men, and 37% in bisexual men, as compared with 31% and 20% in heterosexual women and men, respectively.

This study’s results differed from prior findings in that bisexual men had the lowest rates of MDD and dysthymia among LGB populations. (This may reflect the study’s careful assessment of sexual orientation; prior studies did not assess it dimensionally but asked participants to tick a box, which may have resulted in a disproportionate number of homosexual men rejecting a gay identity to choose the “bisexual” label.) The highly elevated rates of ADs in LGB persons may be due to the experiences of adolescents and young adults; some research suggests that depressive symptom rates in LGB people from their mid-20s onward may be comparable to those in heterosexuals (Bybee, Sullivan, Zielonka, & Moes, 2009).

Likewise, the base rates of depression appear to be higher in transgender relative to cisgender people (up to 60%; Clements-Nolle, Marx, & Katz, 2006). In one study, 44% of transgender persons (49% of women and 37% of men) reported clinical depressive symptoms levels; the difference between transwomen and transmen was not significant after controlling for demographic variables (Bockting, Miner, Romine, Hamilton, & Coleman, 2013).

Like most clinical research, research with sexual minorities has tended to rely on convenience samples, and it suffers from added difficulties with self-selection and ethnic underrepresentation.

**Risk Factors**

Evaluation of risk factors can aid the differential diagnosis as well as inform the prognosis, treatment planning, and other elements of an assessment. The most well-established risk factors for depression include genetics (heritability ≈ .40), neuroticism (negative affectivity), childhood adversity, negative life events, substance abuse, preexisting anxiety disorders, borderline personality...
disorder, and chronic or disabling physical illness (APtA, 2013). The major risk factor for BD is genetics (.60–.85; Smoller & Finn, 2003). Nevertheless, sex, gender, and sexual orientation have emerged as important variables in the study of risk factors for ADs.

**Childhood Adversity**

The most prominent childhood antecedents of ADs are neuroticism, incompetent parenting, and severe abuse, and they appear to independently predict morbidity (Bebbington, 2004). Childhood sexual abuse appears to be predictive of ADs (and other kinds of psychopathology) in both men and women but is much more common in girls, yielding small-to-medium effect sizes as a predictor of depression (Maniglio, 2010). Severe childhood abuse has been reported in as many as 50% of patients with BD (Garno, Goldberg, Ramirez, & Ritzler, 2005); although abuse types are highly intercorrelated, severe emotional abuse may be particularly predictive of substance abuse, whereas sexual abuse may be particularly predictive of suicidality. In BD, childhood sexual abuse history may predict greater severity (particularly with posttraumatic stress disorder [PTSD] comorbidity), earlier onset, suicide attempts, substance abuse and addiction, and psychotic symptoms (Maniglio, 2009).

**Gender-Related Psychological Factors**

These factors for depression emerge in adolescence and may persist into adulthood. In girls, they include self-focused negative rumination, reduced positive thinking, an interpersonally oriented self-concept that depends on approval and success, a negative focus on problems, and excessive concerns with appearance (Kuehner, 2003), whereas boys may develop impulsive/careless problem-solving styles and beliefs that rationalize violence (Calvete & Cardenoso, 2005; Nolen-Hoeksema, 2001). The development of these risk factors parallels the development of adolescents’ concerns with gender identity and gender roles.

**Socioeconomic Status (SES)**

This factor appears to have additive effects with sex in predicting self-reported depression symptom levels in nonclinical populations (Rabbitt, Donlan, Watson, McInnes, & Bent, 1995). Low SES, poverty, unemployment, permanent sickness or disability, and living alone predict clinical depression in both sexes, but women are more likely to experience subpar earnings and poverty (Nolen-Hoeksema, 2002). Poverty rates for female-headed families with underage children in the U.S. are very high and are several times higher than for the families of heterosexual married couples (McSweeney, 2004). Depressed women may worry about “being poor” more than equally depressed men do.
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(Lange, Thalbourne, Houran, & Lester, 2002), and this response appears to be independent of depression in differential item analysis. Thus, although some feminist authors have cautioned that clinicians should be careful not to pathologize the problems of the poor by attributing them to individual factors (Bullock, 2004), the evidence is clear that women are at a disproportionate risk of severe and chronic socioeconomic stress, which can precipitate depression. Even in vocationally successful women, the glass ceiling and workplace harassment may elevate job-related stress and contribute to depression (Chandra & Satyanarayana, 2010).

Family-Related Factors

The family factors that may affect women disproportionately include inequities in heterosexual relationships (Nolen-Hoeksema, 2002) and assuming the role of caregiver for disabled or elderly others. Gender inequities in marriage not only reduce women’s power in making important decisions within the family, but they may also place women at increased risk of domestic violence and marital rape (Chandra & Satyanarayana, 2010). The sex ratio in depression prevalence is higher among married than never-married populations, and unsupported young mothers with preschool-age children are at especially high risk, particularly in societies that undervalue the role of a homemaker (Bebbington, 2004). When gender inequities translate into a high preference for male children, women who gave birth to girls may be at an increased depression risk (Chandra & Satyanarayana, 2010). Such inequities may also be related to women’s tendency to have the caregiver role for disabled or elderly family members, a well-established risk factor for depression (Nolen-Hoeksema, 2001; Pinquart & Sörensen, 2003). More traditional gender roles in couples may be linked to an elevated risk of depression for women following significant interpersonal stressors (Nazroo, Edwards, & Brown, 1997).

Gender Roles and Gender Role Conflict

With regard to men and masculinity, two sets of findings stand out. One body of research concerns gender role conflict (GRC) in young men (Good & Mintz, 1990), which evidences a link with depression (a small-to-moderate effect size). It denotes the endorsement of beliefs that men should control their emotions, prioritize work over family, restrict affection toward other men, and pursue power, success, and competition more so than women should. GRC and the related construct of masculine gender role stress predict emotional distress, low well-being, high anger, and high alcohol use in young men (Blazina & Watkins, 1996). GRC also predicts psychological difficulties in gay men (G. Simonsen, Blazina, & Watkins, 2000) and, interestingly, also in women, particularly with regard to the GRC dimension of work-family conflict (Zamarripa, Wampold, & Gregory, 2003).
Thus, it appears important to distinguish GRC from the more basic dimensions of gender roles (masculinity and femininity). Masculinity has a replicable negative link to depressive symptoms (Sappington, Notte, & Broerman, 1998; Stoppard & Paisley, 1987), whereas the link between femininity and depression is unclear. It may be that moderate femininity levels may correlate slightly negatively with depression, whereas very high femininity levels may predict greater symptoms levels. It is important to distinguish sex-typical gender roles from cross-sex gender roles, which appear to be linked to depression (Sappington et al., 1998) and which have a correlation with suicidality, as will be discussed below.

We would like to see researchers take a less uncritical approach to the way the links between gender roles/GRC and depression are measured and interpreted. Research should address the possibility that item overlap between gender roles and depression questionnaires (rather than any real association at the construct level) may explain away the link between the two constructs; for example, the Bem Sex Roles Inventory (Bem, 1974) contains such items as “moody,” “happy,” “cheerful,” “makes decisions easily,” and other items that appear to be bona fide indices of symptoms rather than gender. It is also plausible that the link between gender role scores and depression is an artifact due to shared variance with the more basic dimensions of negative affectivity (neuroticism) and positive affectivity (extraversion). Along the same lines, given the phrasing of the questions used to measure GRC, researchers should address the possibility that relatively basic individual differences in self-criticism and dependency (Coyne & Whiffen, 1995) may explain away the connection between the GRC construct and depression.

**Sexual Minority Populations**

For sexual minority populations, the risk factors for general psychopathology and, in some studies, anxiety and depression have been receiving increasing attention. Internalized homonegativity, stigma consciousness, and anti-gay victimization are clearly important and merit attention during a culturally sensitive assessment (Herek, Gillis, Cogan, & Glunt, 1997; Lewis, Derlega, Griffin, & Krowinski, 2003; Newcomb & Mustanski, 2010). Avoidant coping and gay-related rejection sensitivity are emerging as vulnerabilities that may mediate the effects of anti-gay oppression on mental health in nonheterosexual individuals (Pachankis, Goldfried, & Ramrattan, 2008). MSM who disidentify with being gay or homosexual are at especially high risk of depression (Mills et al., 2004). In this population, not having attained a sexual minority identity status, childhood adversity (including abuse and anti-gay harassment), along with multiple instances of anti-gay violence, community alienation, and lacking a domestic partner may be especially predictive of depression. In addition to the severe discrimination and violence directed against them, transgender individuals may also be at higher risk of depressive disorder if they engage in avoidant coping or lack social support (Herek et al., 1997; Lewis et al., 2003; Newcomb &
Mustanski, 2010). Barriers to beginning hormonal transition may also be associated with depression in some transgender individuals (Budge et al., 2013; Gómez-Gil et al., 2012).

Co-occurrence and Comorbidity

ADs and other disorders are commonly co-occurring and comorbid, which has negative implications for severity, morbidity, and suicide risk (Bronisch & Wittchen, 1994). For example, in a study of outpatients with BD-I and II, 65% had at least one other lifetime mental disorder (often anxiety, substance use, and eating disorders); this was linked to earlier onset of BD, whereas co-occurrence was linked to increasing cycling and severity (McElroy et al., 2001). Depression’s highest comorbidity rates are with the anxiety, eating, substance use, and personality disorders (Joiner et al., 2005). Some ADs’ comorbidity patterns appear to evidence sex differences. For example, depressed outpatient women are more likely than men to have or to have had bulimia nervosa, simple phobia, and somatoform disorders, whereas men are more likely to have a lifetime history of alcohol or other substance use disorder (Fava et al., 1996; Marcus et al., 2005). We discuss the sex-based differential comorbidities of the ADs below.

Anxiety Disorders

Patients with suspected ADs should be assessed especially carefully for comorbid anxiety disorders, which are prospectively predictive of MDD, and their higher rate among women may account for the higher incidence of first-onset depression (Breslau, Schultz, & Peterson, 1995). Significantly more women than men with BD appear to have specific and social phobias and PTSD (Diflorio & Jones, 2010). The link between sex and depression or anxiety may be mediated by childhood adversity, feelings of mastery, behavioral inhibition, ruminative cognitive style, neuroticism, physical health, physical activity, and perceived interpersonal and employment problems (Leach, Christensen, Mackinnon, Windsor, & Butterworth, 2008). Comorbid anxiety disorders are uniquely linked to increased severity and suicidality in depression (Bronisch & Wittchen, 1994); in BD, lifetime anxiety disorder comorbidity has been linked to earlier onset, longer episodes, greater suicide attempts likelihood, decreased recovery likelihood, and poorer life quality and daily functioning (Simon et al., 2004).

Alcohol Addiction

Lifetime alcoholism is highly prevalent in BD patients (38% is a likely underestimate; Frye et al., 2003) and evidences sex-based patterning. Although women with BD are less likely to have alcoholism compared to their male counterparts, they are several times more likely to have alcoholism relative to women in general. Women with comorbid BD and alcoholism may be particularly likely to
have polysubstance use, family history of alcoholism, history of verbal abuse, multiple MDD episodes, and social phobia. Men with comorbid BD and alcoholism may be particularly likely to have family histories of alcohol and drug use disorders, family history of BD, history of physical abuse, and past suicide attempts.

The Externalizing Spectrum

This spectrum is another area of differential comorbidity concerning BD. Perhaps because of its earlier incidence in men, BD in adolescent boys and young men appears to have a link to conduct problems (Kennedy et al., 2005). Other BD comorbidities that are specific to men may include cannabis use and gambling disorders (Kawa et al., 2005). Attention-deficit/hyperactivity disorder (ADHD) is comorbid with BD in adults, and the lifetime rate is higher in men (15%) than women (6%; Nierenberg et al., 2005). Whether the sex ratio of ADHD in BD merely parallels the sex ratio of ADHD in the general population is unclear, but ADHD rates do appear to be considerably higher in patients with BD. We caution clinicians not to mistake the concentration impairment in BD with ADHD, as they most likely have different etiologies and ought to be possible to differentiate on the basis of history, at the very least.

Eating Pathology

This pathology’s most severe forms are associated with female heterosexuality and male homosexuality (Russell & Keel, 2002) and relate to gender roles and body image dissatisfaction. Unfortunately, studies on the sex differences in eating disorder (ED) co-occurrence with ADs have generally not taken gender or sexual orientation into account. Eating pathology is considerably higher in women with BD than it is in men, and the differences parallel the greater prevalence of EDs in women in the general population (Diflorio & Jones, 2010). In obese women, eating disruption is most likely to be linked to emotional dysregulation, and bingeing-purging predicts depression; in obese men, experiences of feeling socially or physically inadequate and efforts at fasting are most likely to predict depression levels (Musante, Costanzo, & Friedman, 1998). Patients with BD are more likely to suffer from obesity and metabolic syndrome than are people from the general population; women with BD are especially likely to be obese when compared to men with BD and to the general population (Baskaran, Cha, Powell, Jalil, & McIntyre, 2014). When they suspect an AD, clinicians should investigate eating patterns with an eye toward emotional or impulsive eating, particularly in women.

Borderline Personality Disorder (BPD)

This disorder is diagnosed predominantly in women (75%; APtA, 2013), and this appears to also be true in patients with BD (Benazzi, 2000). Although
rapid-cycling BD-II and BPD share some features and appear to be somewhat comorbid (or at least to co-occur), competent diagnosticians should be able to distinguish them using formal diagnostic criteria. Similarly, although examinees with BD-II may resemble individuals with BPD who have comorbid depression, the two presentations are separable and have somewhat different psychiatric history and comorbidity patterns (Zimmerman et al., 2013).

**Other Comorbidities**

Additional comorbidities that may involve sex differences include the sexual dysfunctions (which have a bidirectional association with depression; Atlantis & Sullivan, 2012; Tan, Tong, & Ho, 2012) and thyroid function abnormalities. The latter are more common in women with ADs than they are in men, and they are linked to poor AD treatment response; hence, they should be evaluated and treated (Bauer, Glenn, Pilhatsch, Pfennig, & Whybrow, 2014). Menstrual irregularities are more common in women with BD than in women from the general population (Diflorio & Jones, 2010). Although retrospective reports tend to reflect premenstrual worsening of BD symptoms, the link remains uncertain. The risk of a BD episode increases greatly postpartum; women with BD are at a high risk of a severe episode (25%). Therefore, clinicians should take pregnancy into account when assessing for and formulating a case of BD.

AD comorbidities have received little research attention for sexual minority populations. Apart from being more likely to meet criteria for any psychiatric condition, nonheterosexual individuals who have had at least one disorder in their lifetime are more likely to have had multiple disorders than heterosexual individuals with at least one disorder. Twelve-month prevalence rates of comorbid disorders are higher among gay and bisexual men compared to heterosexual men; evidence about past-year comorbidity is mixed for nonheterosexual women, although lifetime comorbidity is higher than that of heterosexual women (Cochran, Sullivan, & Mays, 2003; Sandfort, de Graaf, Bijl, & Schnabel, 2001). In a Swiss sample of gay men, about half of whom had at least one diagnosis and about 25% of whom had comorbid diagnoses, 10% had a pure AD, 4.5% had comorbid ADs and anxiety disorders, 2.6% had comorbid ADs and substance disorders, and 2.9% had ADs, anxiety, and substance disorders (Wang, Hausermann, Ajdacic–Gross, Aggleton, & Weiss, 2007). Information is lacking about the comorbidity of ADs in the lesbian, bisexual, and transgender populations.

**Suicide Risk**

Every assessment should evaluate for suicide risk and suicidality history, and clinicians should attend to all areas of risk (see Bryan & Rudd, 2006) when they suspect an AD. Chapter 14 on suicide (in this volume) discusses the most well-recognized general risk factors of suicide, including male sex, nonheterosexual orientation, transgender identity, and others (Bridge, Goldstein, &
Brent, 2006; Cochran & Mays, 2000; Herrell et al., 1999; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Pompili et al., 2014; Russell & Joyner, 2001; Safren & Heimberg, 1999). Whereas the suicide risk factors in depression are similar to the general ones, some of the risk factors in BD may be unique, including a mixed episode, rapid cycling (Saunders & Hawton, 2013), early stage in the course of illness, benzodiazepine use, psychiatric treatment engagement in patients who present at the emergency room, and recent (within one year) lithium discontinuation (Chesin & Stanley, 2013). While men are more likely to complete suicide than are women (most likely because of greater disinhibition, substance abuse, and lethality of means; Goodwin & Jamison, 1990), men with BD may be at even greater risk because of additionally elevated substance abuse levels (Diflorio & Jones, 2010).

Gender roles’ link to suicidality should receive more research attention as regards ADs. In studies of college students, a cross-gender role (reporting personality characteristics associated with the other sex) was linked to increased suicidality (Street & Kromrey, 1995), and its predictive power with regard to suicidal ideation was stronger than that of sexual orientation (Fitzpatrick, Euton, Jones, & Schmidt, 2005). Furthermore, cross−gender role may be uniquely predictive of suicidality in young gay and lesbian students (Fitzpatrick et al., 2005), and it was linked to lower adaptive problem solving and family and peer support. Such findings suggest that clinicians should investigate examinees’ gender role status and their degree of adjustment to or comfort with it. As noted above, whether the link between gender roles and psychopathology is genuine or artifactual remains unclear.

Assessment Methods

Below, we discuss evidence pertaining to the sound use of common assessment methods in the diagnosis of ADs and the association between ADs and neurocognitive test performance. Readers may also find it helpful to consult the preceding chapters on more general issues pertaining to sex, gender, gender identity, and sexual orientation in interviewing and testing.

Structured Clinical Diagnostic Interviews (SCDIs)

These interviews promote the detection of BD, which can remain undetected for years even in patients being treated for depression (Miller, Johnson, & Eisner, 2009; Zimmerman & Galione, 2011). As regards the ADs, SCDIs have the advantages of established reliability, full symptom coverage, disorder subtype coverage, questions about course and chronicity, and formal suicidality and comorbidity assessment (Joiner et al., 2005). The Structured Clinical Interview for the DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1995) offers a high level of detail, especially in suicidality assessment. Its reliability for lifetime and current BD range from .64−.92 in clinical samples—higher than interviewing
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as usual (Miller et al., 2009). The Schedule for Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978) is similarly reliable and has well-established temporal reliability for BD specifically (Miller et al., 2009). The MINI International Neuropsychiatric Interview (Sheehan et al., 1998) is noticeably briefer than the SCID, whereas the Longitudinal Interval Follow-up Evaluation (Keller et al., 1987) elicits a greater level of detail about the course of ADs.

Critics of psychiatry have written about sex bias in diagnosis (e.g., Caplan & Cosgrove, 2004). With regard to the ADs, research does not support the notion of psychometric bias in the SCIDs’ criteria or that trained professionals show bias. When not using a structured approach to diagnostic interviewing, clinicians tend to underdiagnose depression in men and to overdiagnose it in women; general medical practitioners may tend to give false negatives for depression in men, whereas mental health specialists may give false positives in women (Potts, Burnam, & Wells, 1991). These trends may reflect clinicians’ efforts to use knowledge about base rates. When sex has been examined in relation to SCIDs, the expected sex differences emerged (Rogers, 2001), and the SCID demonstrated a largely sex-invariant factor structure (Aggen et al., 2011). In experiments involving video-recorded interviews, primary care physicians and psychiatrists evidenced no sex bias in detecting depression in elderly patients, although internationally (vs. U.S.) trained physicians gave higher rates of false negatives regardless of sex (Kales, Neighbors, Blow, et al., 2005; Kales, Neighbors, Valenstein, et al., 2005). Continued education along with the use of SCIDs as part of a full assessment would likely correct such difficulties.

It seems possible that gender roles (and other cultural and personality factors) may influence the way patients respond during interviews. For example, Norman (2004) speculated that depressed men may be less likely than women to endorse feeling “guilty” but might endorse feeling “responsible.” (Note, however, that the clinician’s observations of the patient’s behavior, and not only the patient’s self-report, contribute to the scoring of such items.) As far as we are aware, gender invariance at the item level has not factored in the development of interview schedules. The extent to which clinicians who use unstructured approaches alter their language depending on the patient (and what effect that might have on validity of diagnosis) is unknown.

Little is known about the use of interviews for the assessment of ADs in LGBT persons. Although the SCID and MINI have been used with such populations (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Nuttbrock et al., 2010; Shoptaw et al., 2005), how their performance compares to that in heterosexual or cisgender populations is unknown.

Some authors have speculated that clinical interviewers may serve LGBT patients better by adopting an LGBT-affirmative perspective (Heck, Flentje, & Cochran, 2011). This includes: (a) making no heteronormative assumptions, (b) eschewing heterosexist language, (c) being mindful that LGBT persons’ affective problems may be unrelated to sexual minority stigma, and (d) actually making LGBT-affirmative statements to preempt problems with rapport that
may emerge based on LGBT patients’ perceived or actual past negative experiences with various service providers.

**Clinician Rating Scales and Brief Questionnaires**

The use of self-report ratings by patients with depression may contribute unique validity and utility to clinical interviews (Joiner & Rudd, 2002). They offer adequate current symptom coverage and may help gauge severity, but they do not provide detailed suicide risk assessment, inquiry into course or disorder subtype, or insight into comorbidity (Joiner et al., 2005). Furthermore, many commonly used tools do not ask about manic symptom history, whereas clinicians should always obtain a history of mania/hypomania in all patients (Zimmerman & Galione, 2011). Brief questionnaires and clinician rating scales may serve screening and treatment outcome monitoring purposes.

The self-report depression questionnaires that are most commonly in use and have the strongest empirical support are the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996; it asks about symptom severity), the Center for Epidemiological Studies—Depression Scale (CES-D; Radloff, 1977; it focuses on symptom frequency), and the Inventory to Diagnose Depression (Zimmerman & Coryell, 1987; it asks individuals to rate both the severity and the duration of symptoms). The most well-established clinician-report tools are the Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1967) and the Montgomery-Asberg Depression Rating Scale (MADRS; Montgomery & Asberg, 1979), which gauge symptom severity within a time frame.

The factor structures of the BDI-II, CES-D, and HAM-D have been well validated (Shafer, 2006). The CES-D, MADRS, and Geriatric Depression Scale perform similarly across age groups, sex, race/ethnicity, and years of education (Dmitrieva et al., 2014). Only “I had crying spells” on the CES-D has evidenced differential sex-based item functioning (Carleton et al., 2013), as women tend to endorse it for reasons other than depression. Nevertheless, women tend to obtain somewhat higher scores than men on self-report depression questionnaires, whereas clinician-report measures of depression tend to yield no sex differences (Kornstein et al., 2000). Sex differences on self-report measures may overestimate the actual difference because women may tend to endorse changes in food intake, hypersomnia, and low sex drive more so than equally depressed men (Lange et al., 2002). Such findings may represent genuine sex bias in questionnaires. Furthermore, cultural differences may complicate this sex difference; item response theory analyses revealed that, compared to Australian participants and to U.S. women, U.S. college men considerably underreported milder depressive symptoms (Lange et al., 2002).

With regard to BD, the Mood Disorder Questionnaire (MDQ; Hirschfeld et al., 2000) systematizes clinician ratings, including items about mania as well as depression. It appears helpful in identifying patients who are not at
risk of BD, but it should be given less weight in deciding that a patient has the disorder (Zimmerman & Galione, 2011; Zimmerman et al., 2009). It also functions better in inpatients rather than outpatients, because inpatients with severe pathology other than BD are unlikely to spuriously endorse features of hypomania (Miller et al., 2009). Other clinician rating scales for BD (Altman, Hedeker, Peterson, & Davis, 1997; Bech, Bolwig, Kramp, & Rafaelsen, 1979; Young, Biggs, Ziegler, & Meyer, 1978) can be useful in tracking symptom severity.

The General Behavior Inventory (Depue et al., 1981; Mallon, Klein, Bornstein, & Slater, 1986) is a self-report tool that stands out with its coverage of bipolar as well as depressive symptoms, using 52–73 items (depending on the version) that ask for symptom intensity, duration, and frequency. Although reliable, it lacks normative data and information about useful diagnostic cutoffs (Miller et al., 2009). Other self-report measures of mania include the Altman Self-Rating Mania (Altman et al., 1997), the Self-Rating Mania Inventory (Braunig, Shugar, & Kruger, 1996), and the Internal State Scale (Bauer et al., 1991). Although clinical lore cautions against relying on self-report to gauge symptoms during manic episodes, patients who undergo appropriate behavioral psychoeducation treatment may be able to use such scales to collect useful information, particularly for treatment and relapse-prevention purposes.

The structural invariance and differential item functioning of AD questionnaires and rating scales have not been studied in nonheterosexual populations. Researchers who have utilized them report high internal consistencies (e.g., Minniaga et al., 2012) and the expected associations with related mental-health constructs. It is conceivable that some items may perform differently in sexual minority persons than they do in heterosexual people, as guilt, shame, social anxiety, rejection sensitivity, and problems with work and relationships in these populations may stem from experienced or internalized stigma rather than ADs per se (Hatzenbuehler, 2009).

**Omnibus Self-Report Inventories**

These inventories (see also Chapter 7, this volume) tap a number of psychopathology dimensions that may enrich the assessment of ADs and their comorbidities. The restructured Minnesota Multiphasic Personality Inventory—2 (MMPI-2-RF; Ben-Porath & Tellegen, 2011), the Personality Assessment Inventory (PAI; Morey, 1991), and the emergent Personality Inventory for DSM-5 (Krueger, Derringer, Markon, Watson, & Skodol, 2012; Krueger et al., 2011) all include relevant scales. The systematic reviews of the literature on the MMPI or the PAI largely concern their use in forensic contexts to detect malingering. Surprisingly little is known about the performance of such inventories (or their component scales) with regard to screening or diagnosis of ADs, except for a meta-analytic finding (Gross, Keyes, & Greene, 2000) that the
MMPI-2 may be “moderately accurate” in predicting depression. In general, clinical depression may be linked to elevations on scales measuring depression, anxiety, obsessionality, dependency, and borderline personality characteristics, whereas BD may be linked to higher scores on scales capturing depression, hypomania, anxiety, psychosis, narcissism, exhibitionism, drive, compulsiveness, and antisociality (Wetzler, Khadivi, & Oppenheim, 1995). The MMPI-2-RF’s Hypomanic Activation scale may help distinguish depressed patients with BD from patients with MDD (Watson, Quilty, & Bagby, 2011), but it does not seem to be superior to the MDQ in this regard. We were unable to find literature on sex, gender, or sexual orientation as they may pertain to the use of the MMPI-2, MMPI-2-RF, PAI, or similar instruments in the assessment of ADs. (The introductory and other preceding chapters in this volume address the general shift from the use of sex-based to general norms in omnibus psychopathology inventories.)

Personality inventories based on the five-factor model (FFM), for example, the NEO-Personality Inventory–Revised (NEO-PI-R; McCrae & Costa, 1990), have not entered assessment practice as usual but capture constructs predictive of ADs. Sex differences on the FFM traits tend to be replicable and small in comparison to within-sex variation (Costa, Terracciano, & McCrae, 2001). Across cultures, women tend to obtain higher scores on neuroticism (N), agreeableness, the warmth facet of extraversion (E), and the feelings facet of openness; men tend to score higher on the assertiveness facet of E and the ideas facet of openness. As noted earlier, depression has a strong link to premorbid N, and it also has a replicable but weaker negative correlation with premorbid E levels (Kendler, Gatz, Gardner, & Pedersen, 2006). The estimated .55 genetic association between depression and N appears to be sex-invariant (Fanous, Gardner, Prescott, Cancro, & Kendler, 2002). BD is linked to higher levels of N as well as to higher levels of between-episode E (Klein, Durbin, Shankman, & Santiago, 2002).

**Neurocognitive Performance**

Current and lifetime MDD and BD are linked to neurocognitive task performance (see also Chapter 4, this volume) in several domains, as outlined below. We caution that much of the research comparing MDD and BD patients to healthier participants did not control for certain factors predictive of neurocognitive impairment. Thus, we wonder to what extent such factors as childhood adversity, substance abuse history, or repeated mild head trauma may confound the link between ADs and neurocognitive test performance.

In the areas of executive functioning (EF), patients with both MDD and BD are more likely than healthy controls to evidence impairments. MDD is linked to sustained attention, working memory, processing speed, and global EF deficits, regardless of current status and treatment, and especially more so with psychotic features (Cornblatt, Lenzenweger, & Erlenmeyer-Kimling, 1989;
Multiple EF impairments are more likely to be present, severe, and pervasive in BD-I than in BD-II (Quraishi et al., 2009; Simonsen et al., 2008). Sustained attention, inhibition, and working memory deficits have been reported most consistently, even during remission (Monks et al., 2004; Quraishi & Frangou, 2002; Robinson et al., 2006; Sole et al., 2011), and decision-making may be impaired even in medicated patients (Christodoulou, Lewis, Ploubidis, & Frangou, 2006). Because researchers have tended not to report sex differences (sometimes partially sex out without explaining the rationale), the extent to which the relative sex and gender invariance characteristic of adult EFs translates to the ADs is unknown, whereas gender and sexual orientation have not been studied in this regard.

Verbal learning/memory impairments (Sole et al., 2011; Thompson et al., 2005) are found consistently in BD, even in euthymic patients (Quraishi & Frangou, 2002; Robinson et al., 2006). Similar difficulties in MDD may dissipate with remission and treatment (Douglas & Porter, 2009). Although declarative memory difficulties attributable to weak encoding (Bearden et al., 2006) exist in depression as well as BD, it appears that episodic memory impairments characterize depression, whereas broader deficits characterize BD (perhaps due to a severity confound; Sweeney, Kmiec, & Kupfer, 2000). Nonverbal processing difficulties in the ADs appear to be subtle and task-dependent (Cornblatt et al., 1989; Quraishi et al., 2009). Visual processing impairments have been noted in unmedicated as well as remitted depression (Porter, Gallagher, Thompson, & Young, 2003; Weiland-Fiedler et al., 2004), whereas spatial span decrements have been suggested in BD (Thompson et al., 2005).

Although verbal and nonverbal ability do not evidence sex differences as higher-order constructs (Rovaininen, 2011), some of their underlying processes may do so, and such sex differences may interact with sexual orientation or transgender status (Gladue, Beatty, Larson, & Staton, 1990; Halpern & Collaer, 2005; Hassan & Rahman, 2007; Herlitz et al., 1999; Kimura & Hampson, 1994; Postma, Izendoorn, & De Haan, 1998; Quraishi et al., 2009; Quraishi & Frangou, 2002; Rahman et al., 2003; Rahman, Andersson, & Govier, 2005; Rahman & Koerting, 2008; Wegesin, 1998). Speculatively, such findings may have implications for the interpretation of certain neuropsychological test scores, as well as the kinds of complaints patients bring to an interview, particularly in sexual minority and transgender individuals. The relevance of such findings to neuropsychological assessment in the assessment of the ADs remains unknown.

Psychomotor speed can be impaired in MDD and in the depressive phase of BD, particularly in older age; in MDD, it may not improve with treatment response (Douglas & Porter, 2009; Malhi et al., 2007; Weiland-Fiedler et al., 2004). The potential link between performance on certain psychomotor tasks and sex and sexual orientation (Kimura & Hampson, 1994; Rovaininen, 2011; Sheppard & Vernon, 2008) has not been studied in the ADs.
Basic emotion processing may also be impaired in the ADs: Mania is linked to attentional and response biases to positive, whereas depression correlates with analogous biases to negative visual and lexical stimuli (Murphy & Sahakian, 2001). Facial affect and emotional prosody processing appears to be impaired in BD and may remain so after remission (Van Rheenen & Rossell, 2013), which may have implications for therapeutic communication. Whether sex or gender interact with the link between ADs and emotion processing is yet unknown.

**Conclusion**

In reviewing the research on sex, gender, and sexual orientation in the ADs, we found a tendency for researchers to conflate sex with gender, to neglect to measure and take into account sexual minority status, or to measure sexual orientation categorically as a label instead of using dimensions of attraction, arousal, behavior, and identity (Sell, 2007). We had great difficulty finding relevant literature in many areas of interest, especially with regard to sexual orientation and transgender status, although we acknowledge great improvements in this area over the past 20 years. We were pleased to find that researchers have given some attention to sex bias in the assessment of ADs (usually finding little evidence for it), but we did not find evidence for the differential predictive validity of various assessment tools across diverse groups.

When researchers study the intersection among sex, gender, and sexual orientation vis-à-vis neurocognitive processing, we suggest that they take into account the research that links sex, gender, and sexuality to the ADs; conversely, we suggest that researchers studying the links between ADs and neurocognitive variables begin to take into account the links between sex, gender, and sexuality to cognitive performance (see Chapter 4, this volume).

**Practical Points**

- **Base Rates and Symptom Presentation.** The higher the base rate of a disorder in the population a psychologist sees, the more likely it is that a diagnosis of this disorder is a true positive. Expect higher rates of depression in younger women and in younger sexual minority adults than in younger heterosexual men, and even more so in men with nonheterosexual behavior who do not identify as sexual minorities. Expect somewhat higher rates of bipolar disorder in younger men. Inquire in detail into the core symptom of dysphoria, given that men may underreport it. Evaluate for anger expression in men, but do not count it as a symptom toward the differential diagnosis unless irritable mood is present.

- **Risk Factors.** Careful attention to risk factors may aid in prospective prediction, and it can be helpful when differential diagnosis is difficult (e.g., when patients have external motivation to misrepresent their condition). Obtain a family psychiatric history, a history of childhood adversity,
lifelong neuroticism levels, preexisting anxiety disorders, and other risk factors. Despite the heavy genetic component in BD, evaluating for childhood abuse histories in patients with this diagnosis may be of unique importance.

- Treatment planning may benefit from evaluating for coping styles oriented toward negative emotions and self-focused rumination, particularly in girls. In sexual minority persons with depression, gauge rejection sensitivity, avoidant coping, and guilt/shame, as they may become important treatment targets.
- Be mindful not to attribute suffering due to gender inequity or sexual minority stigma to depression, but evaluate for such inequities and stress as possible triggers or maintaining factors. Ask about power dynamics and violence in patient’s close relationships, and remember that a caregiver role may be a strong predictor of depression.
- Always assess sexual orientation as well as sexual minority identity development levels in more than a cursory way, because low levels of gay identity development in nonheterosexual men may pose a particularly high risk of depression.
- Ask about current or planned pregnancy, as delivery may precipitate severe AD episodes.

- **Comorbidities.** Consult with a physician to screen for thyroid and other medical problems (note that such abnormalities do not always rule out ADs). Assess for anxiety disorders and PTSD. Suspect eating pathology in women and gay men with ADs, substance use disorders in women with BD and in men, and impulsivity disorders in men with BD. Differentiate ADHD from poor concentration in BD, as well as borderline personality from BD-II.

- **Suicide Risk.** Conduct a formal suicide risk assessment. Note that any nonheterosexual orientation, not just male homosexuality, should be treated as a risk factor. When suspecting BD, amend the usual list of risk factors for imminent suicide attempt to include early stage in the course of illness, mixed episode, rapid cycling, benzodiazepine use, and lithium discontinuation within the past year. In men, give additional weight to disinhibition, substance abuse, and lethality of means.

- **Diagnostic Interviewing.** Although trained to diagnose ADs, psychologists may misdiagnose BD as MDD, especially in women, and they may miss important comorbidities and risk factors. Use semistructured or structured approaches to interviewing to ensure that all AD symptoms, history of (hypo)mania, and major comorbidities have been addressed. The current evidence suggests that neither the diagnostic criteria nor the semistructured interviews for ADs suffer from sex bias, but they have not been tested in sexual minority populations. Use basic competencies to adapt the interview process to promote rapport, and note that this may require an explicit LGBT-affirmative stance with some sexual minority patients.
• **Questionnaires and Rating Scales.** Use self-report questionnaires and clinician rating scales as screening and outcome monitoring aides, not as diagnostic tools. Note that they may yield high false-positive rates. Scales that do not include retrospective questions about mania may contribute to the misdiagnosis of BD. It may be that women’s subjective ratings of symptom levels and symptom distress exceed the clinician’s ratings; when that occurs, it may be time to revisit the risk factors (e.g., external stressors), the comorbidities, or the working alliance. Concerns about sex bias in at least some of these tools have been laid to rest by research, whereas such research has not yet been conducted with regard to sexual minority status. Consider the possibility that women and sexual minority individuals may endorse certain items (e.g., worry, guilt, rejection sensitivity, social withdrawal) as a result of stigma or discrimination rather than psychopathology, and consider following up on such responses with verbal inquiry.

• **Omnibus Inventories.** Even though modern omnibus inventories are longer, well normed, and relatively gender-invariant, they may not perform better than brief questionnaires and rating scales designed specifically to assess for ADs (e.g., because of fewer items per AD, an inability to capture the course of disorders, and an emphasis on traits rather than states). Such tools as the MMPI-2-RF, the PAI, and the PID-5 may, however, help raise questions about important comorbidities.

• **Neuropsychological Functions.** Patients with ADs are much more likely than the general population to have detectable neurocognitive impairments, which are likely to be worse with greater AD severity, repeated episodes, and older age. It is unclear to what extent the impairments may be linked to neurodevelopmental insults that predate and may correlate with the development of ADs, but the authors of most studies finding such deficits seem to believe them to be expressions of the pathology underlying ADs. Clinicians may need to adjust their interview style or therapeutic communication to accommodate the attentional, executive, emotion-processing, and verbal processing difficulties in patients with ADs. Sustained attention, working memory, and verbal learning deficits occur in a sizeable proportion of patients even during remission and with treatment.

### Annotated Bibliography


*Comment:* This article presented a meta-analysis of the magnitude of neurocognitive deficits in BD and their link to everyday functioning. In addition to helping inform assessment, the data may be useful to clinicians who need to explain to third-party payers the clinical necessity of conducting an assessment.


*Comment:* These two articles offer helpful introductions to gender roles, gender role conflict, and their potential relevance to AD assessment; however, readers should be wary of certain methodological weaknesses we discussed earlier.


*Comment:* This author introduces concepts relevant to conceptualizing ADs in young sexual minority individuals (see also Safren & Heimberg, 1999).


*Comment:* These authors helpfully discuss the validity and clinical utility of a wide range of tools for the assessment of depression.


*Comment:* This author’s works are authoritative readings on sex differences in depression.


*Comment:* These authors introduce concepts relevant to conceptualizing ADs in young sexual minority individuals.


*Comment:* This article offers similar information to that of Depp et al. (2012) pertaining to depression.


*Comment:* These authors offer information and references on distinguishing BD-II from borderline personality with depression.

## References


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counseling for HIV-uninfected men who have sex with men abusing crystal methamphetamine. *AIDS Patient Care and STDs*, 26(11), 681–693. doi: 10.1089/apc.2012.0216


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Anxiety is a universally experienced emotion that organizes an individual's response to a perceived future threat. Functionalist definitions of anxiety posit three discrete adaptive goals served by anxiety: (1) organizing internal physiological and psychological resources to respond to a threat (e.g., cortisol reactivity, narrowing of attention); (2) signaling to others a potential danger via words, facial expressions, posture; and (3) signaling to others that help is needed (Campos, Mumme, Kermoian, & Campos, 1994). Anxiety is considered disordered when it exceeds norms in terms of frequency, severity, and interference in everyday life. In this sense, individuals with an anxiety disorder experience anxiety in a maladaptive way. In addition, anxiety disorders can be differentiated from adaptive levels of anxiety in that more severe anxiety is often described as uncontrollable and highly dysregulating.

The degree of maladaptation within anxiety disorders is determined by three interrelated factors: intensity, chronicity, and level of impairment. Intensity refers to the level of fear, worry, or anxious tension that arises in relation to threatening situations or events. Frequently, individuals with an anxiety disorder exhibit a fear response in situations that are widely considered threatening (e.g., public speaking) but do not typically result in extreme levels of physiological and psychological dysregulation (e.g., panic attack). Regarding chronicity, individuals with anxiety disorders often experience a pervasive and intrusive pattern of anxious symptoms more often than not in everyday life. This often results in an additional fear of experiencing anxious symptoms in future situations (i.e., the fear of fear). Finally, maladaptation resulting from anxiety disorders is related to
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the degree that symptoms lead to the avoidance of important or desired aspects of life, including pleasure, recreation, work, and medical care. As a class, anxiety disorders tend to worsen if left untreated and lead to future risks, including medical complications, substance abuse, social impairment, and the development of other mental illnesses (Kessler et al., 2005; McLean, Asnaani, Litz, & Hofmann, 2011; National Institute of Mental Health [NIMH], 2009).

The goal of this chapter is to summarize contemporary issues in the assessment of anxiety disorders with a specific focus on issues related to gender, sex, and sexual orientation. First, literature related to understanding the nature of anxiety disorders is discussed, including a consideration of prevalence, etiology, and prognosis as a function of age, gender, and sexual identity. Second, current best-practice guidelines for the assessment of anxiety in clinical settings are reviewed and analyzed to determine how well-established instruments handle sex, gender, and sexual orientation during standard administration procedures. Finally, clinical recommendations are provided with a specific focus on recommendations for selecting and utilizing assessment instruments that are sensitive to gender, sex, and sexual identity considerations.

Prevalence of Anxiety Disorders as a Function of Gender and Sexual Identity

Anxiety disorders have the highest lifetime prevalence rates among diagnostic classes of disorders (Antony & Stein, 2009). Estimates suggest that as many as one in five adults are affected by an anxiety disorder with a lifetime prevalence rate as high as 28.8% (Kessler et al., 2005; McLean et al., 2011). Rates for specific anxiety disorders vary considerably by age, gender, and sexual orientation (Kessler et al., 2005; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; McLean et al., 2011). Anxiety disorders, overall, have been shown to have an earlier age of onset than most other common mental health disorders. According to Kessler et al. (2005), the median age of onset for anxiety disorders is 11 years, but the range is quite broad among the various specific anxiety disorders. In particular, Phobias and Separation Anxiety Disorder (SAD) have the earliest median age of onset (7 years) while Panic Disorder and Generalized Anxiety Disorder (GAD) have the latest ages of onset (ages 23 and 30, respectively). The median age of onset for Social Anxiety Disorder is 13 years (Kessler et al., 2012). In addition, there is strong evidence that anxiety disorders disproportionately affect women and sexual minorities (Cochran, 2001; Kessler et al., 2005; Lewinsohn, Gotlib, Lewinsohn, Seeley, & Allen, 1998; McLean et al., 2011). These discrepancies appear at relatively early ages for the majority of forms of disordered anxiety.

Gender Differences

It is widely recognized that anxiety disorders are much more likely to affect women than men throughout the lifespan (Lewinsohn et al., 1998; McLean
et al., 2011). This disparity has been documented in research on anxiety disorders as an overall class, as well as research on specific anxiety disorders. According to the most recent, large-scale epidemiological study examining rates of anxiety disorders, the lifetime prevalence rate for anxiety disorders is 33.3% for women and 22% for men. For each specific disorder, lifetime prevalence rates for women compared to men were found to be: 7.7% versus 4.1% for GAD; 10.3% versus 8.7% for Social Anxiety Disorder; 16.1% versus 9.0% for Specific Phobias; 8.5% versus 3.4% for Posttraumatic Stress Disorder (PTSD), and 7.1% versus 4.0% for Panic Disorder (McLean et al., 2011). A related area of inquiry in the research on gender and anxiety examines the relationship between masculine and feminine traits—rather than biological sex—and anxiety symptoms. Research consistently indicates a strong negative correlation between masculinity and anxiety symptoms (Carter, Silverman, & Jaccard, 2011; Harmon, Langley, & Ginsburg, 2006).

McLean et al. (2011) also reported on other findings related to gender and anxiety disorders, such as age of onset, comorbidity, and functional impairment. For all of the anxiety disorders studied, there were no gender differences found in the mean age of onset; however, results suggested that women are more vulnerable than men to developing an anxiety disorder at any age. Regarding comorbidity, women with anxiety disorders were more likely than men to develop additional internalizing symptoms consistent with depression and eating disorders. In contrast, men with anxiety disorders were more likely to also be diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD), Intermittent Explosive Disorder (IED), and Substance Abuse Disorders. Functional impairment was also assessed by measuring missed workdays, and the study revealed that women with anxiety disorders tend to miss more workdays than men, suggesting that anxiety disorders are particularly disabling for women.

Results are mixed regarding gender differences in the course of anxiety disorders. For example, some studies have found that PTSD is more chronic for women than for men and that women have higher rates of relapse for Panic Disorders. However, other studies have found no gender effects on remission rates for Panic Disorder, Social Anxiety, or GAD (Gavranidou & Rosner, 2003; McLean et al., 2011).

**Prevalence and Sexual Minority Status**

There is increasing evidence that sexual minorities are disproportionately affected by anxiety disorders (Berg, Mimiaga, & Safren, 2008; Bostwick, Boyd, Hughes, West, & McCabe, 2010; Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; King et al., 2008). Several recent meta-analyses found compelling evidence that sexual minority groups have higher lifetime and 12-month prevalence rates of anxiety disorders than do heterosexual individuals (King et al., 2008; Meyer, 2003). Specifically, Meyer (2003) found that, compared to heterosexual men and women, gay men were 2.43 times more likely and lesbian women were 1.63 times more likely to have an anxiety disorder throughout
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their lifetime compared to their heterosexual counterparts. Regarding specific diagnoses, Panic Disorder is the most common anxiety disorder among gay men, and GAD, PTSD, and Specific Phobias are the most common anxiety disorders among lesbian women (Cochran et al., 2003; Gilman et al., 2001).

Despite a growth in recent studies of anxiety and sexual minority status, several methodological challenges have emerged regarding sampling and various dimensions of sexual identity (Berg et al., 2008; Bostwick et al., 2010; Gilman et al., 2001). In particular, a large number of studies defined sexual minority status based on recent sexual activity, even though it is widely believed that sexual identity exists on a continuum that extends beyond behavioral definitions to include other dimensions, such as identity and attraction (Bostwick et al., 2010). With respect to methodology, although a number of studies have detected an elevated level of risk among sexual minorities for anxiety and other mental health problems, small samples or sampling bias have limited the statistical power and generalizability of the results (Bostwick et al., 2010; Cochran, 2001; Mays & Cochran, 2001).

Recently, Bostwick and colleagues (2010) addressed some of these limitations by examining prevalence rates of anxiety and mood disorders across three dimensions of sexual orientation for men and women: sexual behavior, attraction, and identity. Results indicated that, for men, sexual minority status was correlated with a higher lifetime risk of developing anxiety disorders for all three dimensions assessed. For women, results were more nuanced. In particular, sexual minority identity was associated with higher prevalence rates of anxiety disorders, but same-sex attraction and sexual behavior were associated with lower rates of lifetime and past-year anxiety disorders.

Gender and Sexuality Differences and the Etiology of Anxiety Disorders: A Biopsychosocial Perspective

It is widely accepted that an interaction among biological, psychological, and contextual factors contributes to the development and maintenance of anxiety disorders. Biological factors include genetic, neurochemical, and neuroanatomical contributions to anxiety. Psychological factors include temperament, cognitive styles, and coping mechanisms. Contextual factors comprise the familial and cultural environment in which learning takes place (Antony & Stein, 2009; Degnan, Almas, & Fox, 2010; Kelly, Tyrka, Price, & Carpenter, 2008; Murphy et al., 2004). Each of these contributing factors is described below in greater detail followed by an examination of the specific components of each factor as they relate to the risk of anxiety disorders for certain groups such as women and sexual minorities.

Biological Factors, Gender, and Sexual Orientation

With respect to biological factors, the research on genetic predisposition for anxiety disorders is considerable. According to results from several studies,
including a recent large-scale meta-analysis on the genetic epidemiology of anxiety disorders, significant familial aggregation is evident for GAD, Panic Disorder, Social Anxiety Disorder, and Specific Phobias (Hettema, Neale, & Kendler, 2001; Topolski et al., 1997). Findings from twin studies indicate an estimated heritability across all anxiety disorders ranging from 30–40% (Hettema et al., 2001). Neuroanatomical and neurochemical processes are also implicated in the development of anxiety disorders. In particular, the neurotransmitter systems that employ serotonin and corticotropin-releasing factors have been shown to be relevant in understanding the brain chemistry of anxiety. Cortisol levels vary under stressful circumstances, and a sustained increase in cortisol impacts an organism’s ability to respond to and tolerate stress and adversity. Serotonin deficiencies in certain areas of the brain are associated with alterations in mood, and research (Antony & Stein, 2009) has shown that disruption in the functioning of certain serotonin receptors is associated with the development of anxiety disorders. The research on anxiety and neuroanatomy has shown that individuals with anxiety disorders tend to have increased activity levels in certain brain regions, such as the amygdala and insula cortex, when presented with anxiety-producing stimuli (Antony & Stein, 2009).

An accumulation of empirical findings suggests that women may be more biologically predisposed to anxiety than are men. Results from Topolski et al.’s (1997) twin study on genetic correlates of anxiety symptoms provided evidence that the genetic influences on anxiety in children manifest more strongly in girls than in boys. Another genetic study on Panic Disorder provided evidence of gender-specific impact of a risk allele (GAD1), which increases the susceptibility for Panic Disorder in females but not males (Weber et al., 2011). Other studies have explored possible gender differences in the function of serotonin in the brain and yielded mixed results. For example, females have a more sensitive hypothalamic-pituitary-adrenal axis, which plays a key role in the release of cortisol in response to stress (Valdez & Lilly, 2014). Finally, hormonal changes associated with menstruation, pregnancy, and childbirth are specific to women and have been shown to impact mood and anxiety symptoms (Zerbe, 1995).

Decades of research indicate that biological factors play a role in determining sexuality. However, the research is fraught with controversy and lack of consensus, and it is heavily weighted toward research on males (Ellis, Ficek, Burke, & Das, 2008; Jenkins, 2010; McKnight, 2000; Money, 1987; Schwartz et al., 2010). In the early 1990s, evidence emerged suggesting a relationship between an X-chromosome marker (Xq28) and gay male sexuality, but this research has not since been replicated (O’Riordan, 2012). However, a number of twin studies have offered compelling evidence for heritability of male sexual orientation. To help explain the mechanism of heritability, there has been considerable research on various biological factors, including hormones, patterns of gene expression, and neuroanatomy (Jenkins, 2010; McKnight, 2000; Money, 1987; Schwartz et al., 2010).
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Despite the compelling evidence for biological influences on the development of sexual orientation, the current research does not provide any evidence for the relationship between these factors and mental illness. While it was considered a mental disorder at one point in time, homosexuality was officially reclassified and depathologized in the 1970s. Recent research has confirmed that homosexual behavior is not accompanied by mental illness in the vast majority of LGBT individuals (Cochran & Mays, 2000; Meyers, 2003). Thus, according to current literature, it can be asserted that biological factors influence sexual orientation, but the elevated risk of mental health issues, such as anxiety, among sexual minorities is primarily due to environmental risk factors.

Psychological Factors, Gender, and Sexual Orientation

A number of theories help explain the role that temperament plays in the development of anxiety, with particular attention paid to the temperamental constructs of behavioral inhibition, negative affectivity, and hyperarousal (Antony & Stein, 2009; Jacques & Mash, 2004; Joiner & Blalock, 1995). These theories can be linked to gender differences in anxiety responses. Behavioral inhibition is measured by an individual’s response to novel situations. Individuals who tend to move away from or avoid new and/or ambiguous stimuli are considered to be more behaviorally inhibited than those who tend to engage in approach behaviors. Negative affectivity refers to a propensity for heightened and enduring feelings of emotional threat, pain, despair, and the like in the face of stressors. Both behavioral inhibition and negative affectivity have been shown to be positively correlated with symptoms of anxiety. Physiological hyperarousal is a dimension of temperament that refers to a state of muscular and emotional tension characterized by reduced pain tolerance, disturbances in sleep, and an exaggeration of the startle response. Research has shown a correlation between sensitivity to and fear of the symptoms of hyperarousal (e.g., high anxiety sensitivity) and the experience of panic attacks (Antony & Stein, 2009; Jacques & Mash, 2004; Joiner & Blalock, 1995).

Cognitive processes are also closely tied to the experience of dysfunctional anxiety. For example, Panic Disorder symptoms seem to be maintained in part by the interaction between high anxiety sensitivity and cognitive tendencies to misinterpret the sensations associated with physiological arousal (i.e., assuming that the physical symptoms are a sign of impending danger) (Antony & Stein, 2009; Joiner et al., 1999). More broadly, cognitive processes such as self-efficacy and locus of control play a role in the developmental and maintenance of anxiety disorders. Specifically, self-efficacy refers to belief in one’s ability to successfully perform a behavior or action, and locus of control relates to the perception of ability to exert some measure of control in an adverse circumstance. Cognitive tendencies to approach stressful situations with the perception of lack of control and with a low sense of self-efficacy have been consistently linked to symptoms of anxiety (Antony & Stein, 2009; Endler et al., 2001; Zalta & Chambless, 2012).
Differences in coping styles are also thought to influence the development of anxiety disorders. Coping refers to the way in which individuals use behavioral and emotional strategies to manage stress, and two distinct styles have received attention in the literature on coping and anxiety. Problem-focused coping is characterized by planning and taking action in response to a problem or stressor. In contrast, emotion-focused coping is described as a relatively passive and avoidant way of coping that includes such processes as venting, ruminating, blaming, or wishing the problem would go away. In general, emotion-focused coping is associated with higher levels of anxiety (Joiner & Blalock, 1995; Kelly et al., 2008).

Regarding gender differences in the relationship between psychological factors and anxiety, certain psychological processes that are correlated with anxiety are more common in women than in men. First, women are more likely to assume an emotion-focused coping style characterized by rumination and avoidance (Joiner & Blalock, 1995; Kelly et al., 2008; Lewinsohn et al., 1998). Interestingly, in studies that have compared men and women with a penchant for emotion-focused coping, the women were still more at risk than the men for anxiety disorders. For example, women who used self-blame as a strategy for coping were more at risk for anxiety than were men who employed the same strategy (Kelly et al., 2008). Second, on measures of temperament dimensions, women have been shown to be more likely to display higher levels of negative affectivity, behavioral inhibition, and psychological hyperarousal than their male counterparts (Jacques & Mash, 2004; Joiner & Blalock, 1995; Murphy et al., 2004). Third, there is evidence in the literature to suggest that, compared to men, women are socialized in such a way that leads them to perceive a lack of autonomy and control, which limits opportunities to develop a sense of mastery (Antony & Stein, 2009; Carter et al., 2011; Zalta & Chambless, 2012). Not surprisingly, research shows that women generally report lower levels of self-efficacy than male counterparts (Zalta & Chambless, 2012). Further, it has been documented that women are more likely than men to experience a sense of danger, threat, and inability to control outcomes, in general, and particularly in the face of traumatic stimuli (Antony & Stein, 2009).

Regarding sexual orientation and psychological factors related to the experience of anxiety, recent research has demonstrated that the higher risk for mental health disorders, including anxiety, among sexual minorities is due to the impact of social stress (Berg et al., 2008; Bostwick et al., 2010; Gilman et al., 2001; Meyer, 2003). Disadvantaging institutional practices such as prejudice and discrimination (including homophobia) disproportionately impact sexual minorities, and affective disorders, including anxiety, are known to be particularly sensitive to the impact of social stressors (Berg et al., 2008; Bostwick et al., 2014; Gilman et al., 2001; Meyer, 2003). According to the Minority Stress Model articulated by Meyer (2003), “distal social attitudes gain psychological importance through cognitive appraisal and become proximal concepts with psychological importance to the individual” (p. 5). Self-esteem and sense of mastery
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are impacted, in part, by experiences of negative regard from others (Mays & Cochran, 2001; Meyer, 2003). Specifically, for sexual minorities, the process of internalizing homophobic attitudes can have a serious impact on one’s self-perception. Self-acceptance among sexual minorities has been shown to have a positive relationship with mental health outcomes (Meyer, 2003). On the other hand, internalized homophobia is associated with poor coping and self-blame in the face of certain stressors and a higher incidence of mental health issues, including anxiety disorders (Meyer, 2003). Further, for sexual minorities, mental health outcomes are improved when individuals achieve a sense of “identity synthesis,” in which the minority identity is integrated with other aspects of individual identity. This process may be increasingly complicated for certain groups. For example, Meyer (2003) suggested that lesbian women may experience an increase of identity stress in navigating both gender and sexual identity roles (see Chapter 2, this volume, for the further exploration of intersectional phenomena created by the conjunction of two minority statuses).

Hiding one’s sexual orientation is another way in which sexual minorities experience an increase in psychological factors that likely promote and/or maintain dysregulated anxiety (Gilman et al., 2001; Meyer, 2003). In the literature, the stress of “concealment” has been discussed with respect to coping. For example, concealing sexual identity is a common way to cope with stigma and avoid rejection, but it takes a high toll on individuals who employ this coping strategy. Specifically, concealment leads to suppression of affect and nondisclosure around negative life events, which can increase the experience of anxiety, according to the literature on the processing of trauma (Meyer, 2003). Another negative impact of concealment among sexual minorities is that it limits opportunities for accessing support and affiliation, which exacerbates mental illness risk factors such as isolation and loneliness (Gilman et al., 2001; Meyer, 2003).

Another psychological process that is linked to sexual minority status and mental health is an increased level of vigilance and expectations of rejection in interactions with others. This stance has been described as a “defensive coping” posture of expecting to be negatively received by others that emerges from the chronic experience of feeling stigmatized. Research has shown that anticipation of social rejection is predictive of psychological distress (Meyer, 2003). Within the minority community, the negative impact of internalization of rejection seems to be particularly salient for bisexual and transgender individuals. Recent research has shown that compared to their lesbian and gay counterparts, bisexuals report worse mental health outcomes, and it has been suggested that this may be due to a sense of not being accepted within the sexual minority community as well as among the sexual majority (Bostwick et al., 2010). A recent study on anxiety and depression in individuals identifying as transgender reports increased mental health risks for this population in particular. In this study, 47% of transgender men and 40% of transgender women reported symptoms of anxiety, and coping style was identified as a mediator, with higher levels of avoidant coping associated with higher levels of psychological distress (Budge,
Adelson, & Howard, 2013). Nonetheless, it is important to keep in mind that LGBT identity may be a source of strength when it provides opportunities for affinity group membership, connections to resources, and coping that can offset the impact of stress (Meyer, 2003).

**Contextual Factors, Gender, and Sexual Orientation**

Contextual factors that relate to anxiety disorders include parenting practices, trauma or adverse events, peer influences, and cultural variables (Antony & Stein, 2009; Degnan et al., 2010; Gavranidou & Rosner, 2003; Valdez & Lilly, 2014). For example, there is significant evidence that certain parenting practices influence the development and maintenance of anxiety disorders. Specifically, anxiety disorders are more common among children of parents who are over-controlling, overprotective, and who model and encourage avoidant responses to challenges. Further, certain attachment variables, such as warmth, support, and cohesion within a family, are negatively correlated with the development of anxiety disorders during childhood (Harmon, Langley, & Ginsburg, 2006; Valdez & Lilly, 2014). The relationship between child temperament and parenting practices is thought to be bidirectional. For example, behaviorally inhibited children may elicit overprotective reactions from their parents, which may in turn limit the child’s ability to develop a strong sense of self-efficacy (Degnan et al., 2010; Nugent, Tyrka, Carpenter, & Price, 2011; Valdez & Lilly, 2014).

Early life stressors or exposure to trauma have also been shown to increase the risk of developing an anxiety disorder (Antony & Stein, 2009; Degnan et al., 2010; Nugent et al., 2011). In particular, children who experience the death of a parent, sexual abuse, and/or financial or marital strain in the household are at higher risk for anxiety disorders (Nugent et al., 2011). Further, although exposure to trauma is a risk factor for all children, the likelihood of developing PTSD following exposure is increased for children who have certain personality traits, such as difficulty with emotional regulation (Degnan et al., 2010). Adverse peer experiences (e.g., bullying, social rejection) have also been shown to leave children more vulnerable to anxiety disorders (Antony & Stein, 2009).

A great deal of research has elucidated the impact of gender socialization factors on the development of anxiety, and it has been well documented that girls are socialized differently than boys. For example, girls are frequently encouraged to adopt a feminine gender role, which supports fearful, negative, and avoidant responses to adversity that contribute to an increased risk for anxiety (Carter et al., 2011; Valdez & Lilly, 2014; Zalta & Chambless, 2012). In addition, the need for affiliation is emphasized more in the upbringing of girls, leaving them more vulnerable to anxiety in the face of rejection or bullying (Murphy et al., 2004). Furthermore, with regard to parenting practices, researchers have found that negative parenting practices impact girls more strongly than boys, and parents are more likely to engage in overcontrolling behaviors with daughters compared to sons (Murphy et al., 2004; Zalta & Chambless, 2012). Also, evidence exists
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that men and women differ in the frequency of certain traumas. For example, women experience more interpersonal trauma (such as rape and sexual abuse) than men. It has been suggested that such traumas impact core components of personality structure and sense of self, which may help to explain the higher incidence of PTSD among women compared to men (Gavranidou & Rosner, 2003).

Regarding cultural variables, several theories have been proposed that suggest a relationship between anxiety and the societal role of women, and a number of studies have provided evidence that sexism plays a key role in the mental health disparities between men and women (Bostwick et al., 2014; McLean et al., 2011). Women also experience more daily life stressors than men due to their competing social roles and their limited social power, relative to men (Zalta & Chambless, 2012). These contextual factors may bring about tensions, such as those pertaining to having a career and being at home with a family, that may leave room for increased levels of anxiety in women (Zerbe, 1995).

With respect to contextual factors and sexual orientation, according to the minority stress model, social stressors can impact sexual minorities in proximal and distal ways (Meyers, 2003). Specifically, in addition to the more proximal impacts on self-perception and cognition described above, social events and conditions can have an objective impact on sexual minorities independent of subjective appraisal. Within the literature, specific social conditions and events have been studied in connection with anxiety disorders among sexual minorities, including anti-gay violence, stigma, and discrimination (Bostwick et al., 2014; Mays & Cochran, 2001; Meyers, 2003). Research has shown that compared to heterosexual peers, sexual minorities are significantly more likely to experience discrimination and violence, including reduced wages, job terminations, sexual and physical assault, and robberies. Studies have shown that 75% of LGBT individuals have experienced discrimination, and sexual minority youth are even more at risk than adults for such victimization (Meyers, 2003; Mays & Cochran, 2001). These traumatic experiences are associated with such mental health symptoms as increased agitation and restlessness, somatic complaints and sleep disturbances, and specifically, with higher rates of PTSD (Berg et al., 2008; Meyers, 2003).

Contextual factors also impact the mental health of sexual minorities because LGBT individuals may lead lives that differ in some key ways from their heterosexual counterparts in such realms as participation in the job force, childrearing, and marriage (Cochran, 2001). In many cases, these differences are due to the influence of the political or social structure, which leads to increased stressors around such experiences as marriage and parenting. In addition, HIV-positive status among gay men has been associated with disproportionately high rates of anxiety disorders, presumably due to the stress of coping with the illness itself and social stigma (Cochran & Mays, 2001).

Taken together, a biopsychosocial perspective offers a comprehensive framework for understanding high rates of anxiety among women and sexual
minorities. Likewise, an examination of biological, psychological, and contextual factors in the assessment of anxiety-related problems is imperative to acquire a full understanding of the interrelated web of influences that maintain dysfunctional patterns of anxiety. In this sense, the same understanding of how anxiety disorders develop and are maintained permits the ability to identify opportunities for effective clinical treatment. The following section describes current best practices in the assessment of anxiety in clinical settings and the relative strengths and challenges in using instruments and procedures with males and females with diverse sexual identities.

Best-Practice Guidelines for the Assessment of Anxiety Disorders

There are several methods by which one can assess anxiety disorders, spanning from clinical interview and judgment to formal standardized measures. No set protocols for assessing anxiety disorders are appropriate for every individual, especially when considerations of gender, sexual identity status, ethnicity, and culture come into play. In fact, Silverman and Ollendick (2005) argue that it is not advisable for clinicians and researchers to rely solely on their preferred assessment methods without considering how individual differences might impact the test findings. However, best practices that surround the assessment of anxiety should still be followed to ensure a standard level of care for all clients.

Connolly and Bernstein (2007) recommend that any person being assessed for mental health concerns be screened for anxiety due to its high prevalence. If significant anxiety is detected through the screening process, then a more thorough assessment should occur in order to determine the level of impairment as well as a more specific diagnosis. Throughout the course of an assessment, a thorough history should be taken to assess the severity of symptoms, level of impairment, and any history of trauma and psychosocial stressors that might be impacting the existence of anxiety for an individual. In childhood anxiety disorders, somatic symptoms such as headache or upset stomach are common complaints and should not be overlooked. All symptoms should be noted and assessed in order to increase the client’s understanding of his or her symptoms and to differentiate these symptoms from medication side effects or other ailments as treatment progresses. In all cases, consultation with appropriate professionals, such as medical practitioners and teachers, should be accessed as needed.

In addition to assessing for anxiety disorders, assessors must consider other mental health disorders that have similar symptoms, such as ADHD, psychotic disorders, autism spectrum disorders, learning disabilities, bipolar disorder, and depression. Furthermore, a number of physical health issues may present with similar symptoms to anxiety, such as hyperthyroidism, asthma, seizure disorders, hypoglycemia, cardiac arrhythmias, and even side effects from other medications.
Finally, in addition to completing a differential diagnosis, evaluations must also consider commonly comorbid disorders such as depression, ADHD, oppositional defiant disorder, learning disorders, and language disorders.

The following sections provide a brief review of assessment techniques and instruments commonly used for anxiety, highlighting potential challenges in using the instruments in a manner that is sensitive to age, gender, and sexual identity diversity. Unless otherwise described, it should be noted that very little research exists that examines the psychometric properties of these instruments for use with clients who do not present as heterosexual men or women. Further, the review is not intended to be exhaustive but focuses on commonly used instruments to highlight thematic challenges in the assessment of anxiety for certain demographic subgroups.

**Special Considerations When Assessing Children and Adolescents**

Available research on gender differences in adolescent presentations of anxiety reveals that there are parallel prevalence rates for adolescents as for adults; adolescent females experience anxiety at higher rates than do males (Lewinsohn et al., 1998). While psychosocial factors certainly have an impact on the discrepancies between male and female adolescents, they do not explain the totality of gender differences. There are still unique challenges that must be considered in the assessment of anxiety in children and adolescents. One challenge is that relatively few psychometrically sound assessment instruments exist for use with youth presenting with anxiety-related concerns. Although several instruments are well-validated, many were initially created as downward extensions of instruments originally developed for use with adults (Silverman & Ollendick, 2005). Another complicating factor in assessing anxiety in children and adolescents is that chronological age is an imperfect metric to gauge developmental status. Specifically, norms from an instrument organized by chronological age may not be appropriate for an individual with a delay in important developmental domains (e.g., language, intellectual functioning). Furthermore, age impacts the utility and effectiveness of certain assessment measures. For example, young children with anxiety struggle with lengthy diagnostic interviews and accurately completing self-report measures (Silverman & Ollendick, 2005).

Another challenge in assessing anxiety in youth is that what is considered “normal” with regard to the experience, expression, and regulation of anxiety varies greatly across childhood and adolescence (Connolly & Bernstein, 2007; Silverman & Ollendick, 2005). For example, one can question: How much separation anxiety is considered “clinically significant” at age 3 or age 12? Further, when assessing anxiety in children, the assessor should consider not only what children are anxious or fearful about, but also whether the fear is typical for their age group, as different fears are considered typical at different ages. For example,
infants fear loud noises, toddlers are afraid of the dark, school-aged children are afraid of injury and storms, and adolescents worry about social abilities and school (Connolly & Bernstein, 2007). It is also important to be sensitive to the fact that fears are normal to some extent in childhood, but they raise concern if children do not outgrow them within an appropriate time frame or if the fears begin to impede everyday functioning.

To add to the difficulty in assessing anxiety in children and adolescents, limited research is available about assessment of sexuality-related issues in these age groups. Developmental and gender norms needed for comparison are consequently left up to the clinician’s judgment, making assessment of transgender and gender-variant clients less objective and empirically guided (Paikoff, McCormick, & Sagrestano, 2000). It follows logically from the etiological research presented earlier in this chapter that contextual considerations are particularly important in assessment and treatment of anxiety disorders in children and adolescents. In youth who are sexual minorities or gender variant, the level of support within the family, school, and other environments needs to be carefully assessed, since it is well documented that contextual factors are particularly important in the etiology of anxiety disorders for sexual minorities. Clinicians assessing for anxiety should consider the interactions between psychological and contextual factors with youth who are exploring their sexual identity in ways that differ from the majority. For example, certain reactions from family members when a child reveals a minority sexual identity or a gender identity that is discordant with the biological sex may increase the child’s vulnerability to anxiety (Lev, 2004). It may be particularly important for assessors to inquire about whether a child or adolescent feels familial pressure to conceal his or her identity since it is documented that secrecy (or concealment) exacerbates anxiety.

Research about the families of transgender individuals is very limited at this point; no research was found specifically targeting familial factors and the assessment of anxiety in these populations (Lev, 2004). However, it follows logically that family factors should be considered in the assessment process, because transgender identities, in particular, may manifest at young ages (Fausto-Sterling, 2012). Failing to account for the impact of family factors in the assessment of anxiety with transgender youth will lead to incomplete data in the assessment and may lead to comparisons to inappropriate gender norms on standard assessment measures of anxiety. Overall, an understanding of the family system in a transgender youth can help explain some of the mechanisms of anxiety in a child or adolescent.

**Review of Assessment Instruments**

This section presents a review of tools commonly used to assess anxiety disorders in order to fully examine the clinical implications of gender and sexuality on the assessment process.
Structured/Semi-structured Interview

Interviews used in the assessment of anxiety range from completely structured computer-administered to unstructured. The most widely used and psychometrically sound interviews tend to use a semi-structured format that outlines critical questions covering a comprehensive set of symptoms while permitting the clinician to use judgment and personal style while navigating the conversation. A strength of these instruments is the provision of sample questions that help clinicians find effective ways to craft queries about difficult and/or sensitive topics.

An example of a structured interview for children and adolescents is the Schedule for Affective Disorders and Schizophrenia for School Aged Children (6–18 Years), referred to as the K-SADS-PL (Kaufman et al., 1997). The K-SADS-PL includes an initial unstructured interview, a structured screening interview that covers critical diagnostic items for most forms of psychopathology, and supplemental modules that cover all symptoms of a specific diagnostic category. Several other semi-structured instruments are available to help diagnose anxiety disorders in children and adolescents, including the revised version of the Diagnostic Interview for Children and Adolescents (DICA-R; Reich & Weiner, 1998) and the Anxiety Disorders Interview Schedule—Child and Parent Versions (ADIS-C/P; Silverman & Albano, 1996). The K-SADS-PL, DICA-R, and ADIS-C/P all include parallel versions for child and parent report. For assessment of adults, the most commonly used semi-structured interview is the adult version of the Anxiety Disorders Interview Scale (ADIS-IV; Brown, Di Nardo, & Barlow, 1994).

A review of the language in commonly used semi-structured interviews did not reveal overt problematic gender-specific language. That said, all interviews limited options for selection of gender to “male” and “female.” Another limitation is the lack of sample questions that may be useful in assessing specific links between anxiety symptoms and gender/sexual-identity issues. A review of available research did not provide insight into gender or sexuality differences or considerations specific to these forms of interviews. Rather, we speculate that sound clinical judgment is paramount with the use of such assessment tools so as to provide an open-minded assessment process that embraces difference and protects against biased administration. Specific recommendations for how to capitalize on the flexibility permitted by semi-structured interviews will be discussed in the clinical recommendations section of this chapter.

Broadband Self- and Other-Report Instruments

There are many examples of assessment instruments for adults and for children that are characterized by their ability to survey broad symptomology and help the clinician quickly identify areas in need of more detailed evaluation. For adults, the most common instruments used in the assessment of anxiety
disorders include the Personality Assessment Inventory (PAI; Morey, 1991) and the Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). The PAI is a self-report measure that instructs clients to answer 344 items based on a four-point Likert scale of how well the item matches their current experiences (Morey, 1991). Responses yield 22 scales including four validity scales, 11 clinical scales, five treatment scales, and two interpersonal scales. Among the clinical scales, the Anxiety (ANX) scale assesses cognitive, affective, and physiological aspects of anxiety using three subscales. Additionally, the Anxiety-Related Disorders (ARD) scale includes three subscales to differentiate among symptoms associated with Obsessive Compulsive, Phobias, and Traumatic Stress. Inspection of items on the PAI revealed a commendable use of gender-neutral terminology, using the terms “people” and “person” and no references to sexual orientation. Initial demographic questions do require the individual to select “male” or “female” for gender, but the PAI does not use gender-based norms to produce standardized scores. Research analyzing the impact of gender on the PAI revealed that gender did not impact scales related to anxiety (Morey, 2007). No research regarding sexual orientation or other aspects of sexuality in relation to the PAI was available.

The MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) is a self-report instrument that requires individuals to rate 567 true/false statements yielding nine validity scales, 10 clinical scales, and 17 supplemental scales (Greene, 2011). In contrast to the PAI, the MMPI-2 uses different norms for males and females. Regarding gender, the most notable difference found in the research is that women are more willing to report their subjective experience of distress and negative affect compared to men (Greene, 2011). Meyer et al. (2014) demonstrate that men and women differ significantly on MMPI-2 scores. While the exact cause is unclear, Meyer et al. speculate that men and women may view themselves differently, which is revealed on self-report measures but not on performance tasks as described below. Another explanation may be that self-report measures are simply better able to capture the differences between genders in their results. Regardless of the cause, it is clear that self-report measures are crucial in the assessment of anxiety, despite their limitations.

To date, no guidance for how to use the MMPI-2 with transgender and gender-variant clients exists. Scale 5 (Masculinity-Femininity) has been the subject of debate regarding interpretation and contemporary relevance. Initially validated based on a group of “male homosexual inverts” (Greene, 2011, p. 125), an elevated score on this scale is intended to indicate deviation from gender-specific norms. Because gender is a social construction that is not based in scientifically derived or even consistently observable traits and has variable meaning as a function of culture, the interpretation of elevations (or lack thereof) on this scale are particularly challenging, especially when used with sexual minorities or gender-variant individuals (Fausto-Sterling, 2012; West & Zimmerman, 2010).
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Despite the lack of clarity about transgender individuals’ results on this scale, it is possible that Scale 5 can still provide some useful information regarding the assessment of anxiety. As higher rates of masculinity, regardless of gender, are negatively correlated with anxiety, scores on this scale may provide collateral information about the likelihood or presentation of anxiety in a client. On the MMPI-2, research suggests that gender primarily impacts the intentionally gendered scales of masculinity-femininity but does not significantly affect anxiety-related scales; the only exception is a small association between gender in the elevation of women on the phobia subscale (Greene, 2011; Schinka, LaLone, & Greene, 1998). Schinka et al. (1998) do not place much weight on the phobia scale as they point out that women have higher rates of phobias, which explains the higher rates of response on these scales.

For children and adolescents, the Child Behavior Checklist (CBCL; Achenbach, 1991, 1992), the Conners Comprehensive Behavior Rating Scales (Conners CBRS; Conners, 2008), and the Behavior Assessment System for Children, 2nd Edition (BASC-2; Reynolds & Kamphaus, 2004) are the most widely used instruments. Each instrument includes parallel forms for children, parents, and teachers and uses Likert-scale ratings to indicate the degree to which a symptom is present. These scales all use gender-based norms to derive standard scores and in this way suffer the same limitations as the PAI and MMPI-2. No other concerns were identified in the literature surveyed regarding content or clinical implementation. Additionally, no research was found addressing gender or sexuality considerations or differences when assessing anxiety using these measures in children and adolescents.

Anxiety-Specific Scales

Comparable to the self-report measures discussed above, anxiety-specific scales are often shorter self-report measures that are limited to assessing the experience of anxiety. As was previously discussed with other self-report measures, these scales also have limited gender-based norms. Given the similarities among the various anxiety-specific self-report scales, as well as the lack of research available about these tools in reference to sexuality and gender, only one measure is specifically noted in this section. However, we believe that information presented here may be extrapolated to other scales that specifically measure anxiety. A commonly used anxiety-specific instrument is the Beck Anxiety Inventory (BAI; Beck, 1990; Beck & Steer, 1993). This measure assesses the level of cognitive and physical symptoms of anxiety for adults. Clients rate the degree to which anxiety-related concerns have been present over the past week on a Likert scale, producing a global score. For the purposes of appropriate gender and sexuality-informed assessment, inspection of the instrument revealed no significant concerns regarding content of items. Research regarding the differences between male and female responses on the BAI indicated that differences are minimal to absent other than the expected higher response rates by women.
because of their higher levels of experiencing anxiety overall (Steer, Beck, & Beck, 1995). Additional research on sexuality factors with anxiety-specific assessment scales would greatly benefit the field.

**Performance Tests**

The benefit of using performance measures when assessing anxiety lies in their ability to obtain information about a client without the client’s defenses or lack of insight regarding symptoms getting in the way (Wright, 2011). In the assessment of anxiety, hypervigilance about one’s presentation or concerns about social rejection may lead a person to downplay symptoms on overt self-report measures, thus not providing thorough information to accurately assess for anxiety. The act of hiding part of one’s identity may be particularly relevant for sexual minorities, due to the pressures and impact of discrimination and bias. As such, it follows that performance-based measures could be very useful in helping a clinician see beyond patterns of “concealment” with certain individuals.

While performance tasks are able to provide information only about an individual’s functioning at the time of the test and are highly sensitive to dynamic factors that influence performance (e.g., stress level, level of fatigue, practice effects), they may offer some insight into a client’s level of anxiety in new and unstructured settings, more generally. This information can alert the clinician to a unique aspect of the individual’s functioning in anxiety-producing contexts. Also, performance measures yield nuanced behavioral observations that may help link a diagnosis with other personality characteristics or contextual factors. Given what we know about the impact of not only biological causes but also social and contextual influences on anxiety, a more thorough understanding of these factors may add a richness to the conceptualization of a client with anxiety. This additional layer of insight may be particularly important with sexual minorities, who experience higher levels of social and environmental stressors in their lives, leaving them more vulnerable to developing anxiety disorders.

Commonly used performance tests in assessing anxiety disorders include the Rorschach Inkblot Method (Rorschach Performance Assessment System [R-PAS]; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011), the Thematic Apperception Test (TAT; Murray, 1943), the Children’s Apperception Test (CAT; Bellak & Bellak, 1949), and the House-Tree-Person tasks (Buck, 2002). None of these tests provide direct diagnoses, but they do provide rich information that is useful in understanding clients with anxiety. This section exemplifies how the Rorschach may be used in assessing anxiety, with a focus on considerations of gender and sexual minority status. Typically, the Rorschach is used to evaluate a person’s functioning in areas of cognitive processing, perception and thinking problems, stress and distress, and self-representation, as well as the accuracy with which they are viewing the world (Meyer et al., 2011). Given the relative newness of the R-PAS scoring system (Meyer et al., 2011), little published research is available about this scoring system, and no research was found describing
sexuality differences in the R-PAS. However, Meyer et al. (2014) found no significant gender differences in performance on the Rorschach. Notably, this research did not subgroup individuals according to gender identity and most likely contained primarily cisgendered individuals based on their prevalence in the population in general.

In the examination of variables that follows, they will be clustered by functional interpretations as they relate to the assessment of anxiety, rather than according to domains as they are typically organized. A number of variables, described by Meyer et al. (2011), may indicate signs of current life stressors, capacity to deal with stressors, anxiety, and trauma/post-traumatic experiences. According to best practices, each variable should be looked at within the context of the entire Rorschach protocol as well as within the context of the overall assessment battery. (For the purpose of this explanation, the variables are presented very simplistically; Meyer et al. should be referenced for a more nuanced explanation of variables and interpretation.)

Variables across domains indicate the presence of current life stressors impacting the individual, providing information about contextual factors that may increase vulnerability to anxiety. In particular, according to Mihura, Meyer, Dumitrascu, and Bombel (2013), the Experienced Stimulation variable correlates significantly to internal distress, distraction, and feelings of irritation. Within this variable, scores on Inanimate Movement (m) and Diffuse Shading (Y) may be especially important to pay attention to when assessing for anxiety, as they have been shown to be related to moderate to severe stressors including acute stress reactions, sexual assault, and PTSD (Mihura et al., 2013). Furthermore, Color Blended with Shading and Achromatic Color (CBlend) indicates how sensitive to emotion and the environment a person is, which reveals how much contextual factors may play a role in one’s experience of anxiety. With sexual minorities, it is likely that these variables may be elevated given that experiences of discrimination and prejudice are so common, as discussed early in this chapter.

In addition to indicating the presence of stressors, the Rorschach also provides information about the capacity of the person to deal with the stressors they encounter. Those with low MC-PPD scores tend to have a low capacity to cope with daily stressors, which may be a common trait in individuals with anxiety. In contrast, a high score in this variable indicates that a person has sufficient psychological resources and resilience to cope with daily stressors, which might be a protective factor against anxiety. What is most important to consider with this variable is the interaction between the severity of stressors and the effectiveness of coping resources. For example, if stressors are extremely elevated, even a person with exceptional coping skills could be overwhelmed and be vulnerable to experiencing anxiety-related symptoms. Since the interaction between contextual and psychological factors is important in understanding the etiology of anxiety with sexual minorities, these Rorschach variables deserve particular attention in the assessment process because they provide information about the psychological resources that clients have at their disposal.
Indicators of anxiety and trauma are present in a number of variables on the Rorschach, revealing not just the presence of these factors, but the way that they manifest in the client’s thinking and behavior. An analysis of relevant variables reveals how responses may provide information that is important in the assessment of anxiety disorders. For example, a low level of Card Turns (CT) may be associated with anxiety-related behavioral inhibition and suggest resistance in engaging with the task. High levels of Complexity can be associated with losing control of one’s thoughts, which can happen during the flooding of trauma. Low levels of Complexity may be due to the existence of high anxiety or a traumatic history and the related symptoms of emotional numbing or constriction of affect. Several other Rorschach variables suggest coping styles that are common with trauma and PTSD: elevated Form % (F%) may indicate an approach to the world that is simplistic and removed; high Vigilance Composite score (V-Comp) may suggest hypervigilance; and people who have a history of trauma are more likely to have elevations in Critical Contents (CritCont%), which is associated with traumatic imagery (e.g., blood, aggression, damage). With sexual minorities, these domains may provide valuable information, especially given their higher prevalence rates of damaging social experiences, which may be traumatic.

In sum, although sexual minorities have not been studied empirically on the Rorschach, it is likely based on the general Rorschach literature that this population will show higher levels of relational and environmental stress. If so, the Rorschach will provide valuable information for conceptualizing their experiences of anxiety. Furthermore, given the aforementioned vulnerability of women to experience anxiety and to have negative coping styles, the Rorschach provides information that helps assessors to better understand contributing factors that may lead to anxiety disorders.

Practical Points: Assessing Males and Females

When assessing anxiety, assessors should seek to understand not just the degree of anxiety, but the underlying mechanisms of anxiety as well, which are likely to be different in males and females. As described below, gender differences should be considered when determining a diagnosis of an anxiety disorder in order to have a more complete and complex understanding of the functioning of the individual.

- Women are more vulnerable to developing anxiety disorders, due to a number of factors in their biology, emotional and cognitive functioning, and socialization.
- On assessment measures, women are more likely to manifest anxiety in internalizing ways, consistent with depression and eating disorders.
- Men tend to experience anxiety in more externalized ways; they often have comorbid ADHD, intermittent explosive disorder, and substance abuse issues.
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- Women are more likely than men to experience interpersonal traumas, and they are more likely than men to develop PTSD following a traumatic experience.
- Women are more functionally impaired by their anxiety, reporting increased disability and missing more work when dealing with an anxiety disorder.
- Unrelated to gender itself, those with higher levels of masculinity have lower rates of anxiety.

Practical Points: Assessing Anxiety in Gender and Sexual Minorities

The interaction among adverse contextual experiences and psychological factors related to feelings about self, others, and safety increases vulnerability to anxiety for sexual minorities. Thus, it is important for assessors to seek an understanding of familial, cultural, and sociopolitical factors that impact highly influential values, norms, and expectations surrounding a client. Specific information and suggestions are provided below to help clinicians effectively consider the protective or destructive factors within which anxiety may arise for sexual minorities (Long, Burnett, & Thomas, 2006; McGoldrick, Loonan, & Wohlsifer, 2007; Ribner, 2012).

- Gay men are more likely to develop panic disorder. Lesbian women have higher rates of generalized anxiety disorder, PTSD, and phobias.
- It is important to consider identity, attraction, and behaviors when looking at interactions with anxiety. In women, sexual minority identity is correlated with higher anxiety rates, but same-sex attraction and behaviors are not.
- A protective factor from anxiety is having social supports or being a member of a group. In contrast, being socially isolated or concealing one’s identity leads to higher anxiety.
- The majority of people who identify as a member of a sexual minority subgroup will experience subtle or overt violence, stigma, discrimination, or prejudice, which leads to higher rates of anxiety and PTSD. Transgender and bisexual individuals experience even higher levels of rejection than do gay men and women, further increasing their vulnerability to anxiety disorders.
- In sexual minority groups, a cultural history of stigmatization increases the chance that an individual will be particularly sensitive to rejection, validation, and acceptance by the clinician, potentially creating a barrier in the assessment of anxiety if the client downplays or distorts his or her experiences for fear of rejection.
- When assessing a transgender client for hormonal treatments and/or sex-reassignment surgery (SRS), the clinician stands between the client and the medical care they are seeking (Lev, 2004; McGoldrick et al., 2007; Raj,
This could impact the clinician’s ability to effectively assess anxiety; it may also justifiably increase situational stress for the client and skew the effectiveness of some assessment measures.

• Instruments used to assess anxiety in transgender clients must be chosen carefully and with consideration of the lack of empirically validated gender norms as well as known distortions on measures such as the Rorschach. As such, for these clients, clinical judgment and interview may prove more valuable than standardized measures of anxiety.

Annotated Bibliography


*Comment:* This study explored the association between the perception of discrimination based on numerous, interacting aspects of identity—race, ethnicity, sexual orientation, gender—and mental health outcomes in a sample of LGBT individuals. Results showed that nearly two-thirds of the participants experienced discrimination within the past year based on at least one aspect of their identity. Results were mixed about which combinations of discrimination experiences had the most impact on mental health outcomes. The authors suggest that several findings warrant further research regarding the role of certain social or psychological factors or the unique set of stressors that bisexual individuals face. Overall, the findings from this article suggest the need for new theories and frameworks incorporating multiple, overlapping identities and their interplay with multiple, overlapping levels of influence that explain the relationship between discrimination and health outcomes within the LGBT population.


*Comment:* This study explored gender differences in anxiety in a sample of adolescents. The authors hypothesized that certain psychosocial variables mediated the association between anxiety and gender (in which females have been shown to be more likely than males to experience anxiety). The findings did not support the hypothesis, as it was not shown that gender differences in anxiety can be explained by differing social roles and experiences for boys versus girls. Rather, the authors suggested that the results were in line with the contention that gender differences in anxiety are influenced by genetics.


*Comment:* This article summarizes the “state of the field” with respect to evidence-based assessment measures of anxiety for children and adolescents. It also uncovers certain gaps that provide a direction for future research and increased knowledge on the topic. The authors conclude that there are a number of sound instruments and methods, including structured and semistructured diagnostic interviews, self-rating scales, direct behavioral observation systems, and self-monitoring forms. The article offers twelve “tentative evidence-based recommendations” based on the authors’ review of the literature.
Anxiety Disorders

References


Anxiety Disorders


Nutrient consumption fulfills biological requirements of body growth, reproduction, and maintenance for all species (Spitzer & Rodin, 1981). For humans, eating can be a source of pleasure involving the symbolic use of food (Ulijaszek, 2002). Unique cuisine and rituals involving the amount, type, and way in which food is consumed define central components of social life and identity. Thus, eating disorders (EDs), gender, and sexuality are intertwined with biology, ontological development, and culture.¹

In this chapter we discuss the assessment of Feeding and Eating Disorders through the lens of gender and sexuality. The six DSM-5 disorders are briefly described: pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED). Relevant gender, sexuality, culture, and developmental differences are illuminated. Then, we review dimensions of personality and environment, including psychological issues that may underlie eating disorder symptom patterns, such as comorbidity, perfectionism, shame, body image concerns, and environmental factors. We discuss sociocultural pressures that may contribute to the development of the disorder, with specific attention to gender-related differences. Next, we evaluate the most common assessment tools for the diagnosis of AN, BN, and BED. A critique will be provided with regard to gender, age (development), culture, and the interactions among these identity areas. Finally, we provide a case example, practical tips for the assessor, and annotations for further reading.

The study of possible interactions between sex, gender, gender identity, and sexual orientation with EDs has unfolded slowly. Many extant studies did not include demographic information, much less differential analysis related to sex and gender. Heterosexual, female participants dominated the samples, simply by virtue of their prevalence. Lesbian and bisexual individuals and trans women may have participated in the studies, but they typically were not recognized as a
A growing number of investigations are focused on males with some attention to sexual orientation. However, few studies have focused on bisexual orientations or transgender identity.

Types of Feeding and Eating Disorders

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013) has three feeding disorders—pica, rumination, and avoidant/restrictive food intake disorder—and three eating disorders—AN, BN, and BED. In contrast to EDs, few studies have examined feeding disorders (Kreipe & Palomaki, 2012). A brief discussion will be provided on the feeding disorders, followed by information on the eating disorders with particular attention to gender and culture factors, both sets of which are relevant to most of these disorders.

Pica

Pica is the developmentally inappropriate ingestion of non-nutritive substances on a regular basis for at least one month. The assessor may see this behavior often occurs in conjunction with another disorder such as schizophrenia, obsessive-compulsive disorder (OCD), intellectual disability, autism, or other eating disorders. However, it must be of sufficient severity to warrant a separate diagnosis (APA, 2013). The diagnosis is not usually given to children under 2 years old or if ingestion is to intentionally control weight or harm the self.

Pica is identified by a common set of behaviors, but prevalence, gender differentials, and cause vary. In institutionalized individuals with intellectual disabilities, prevalence ranges from 9–25%, with possible causes of reinforced oral stimulation and neurological/neurochemical issues (Ali, 2001; Gravestock, 2000). In those with normal intelligence, primarily two groups engage in pica: (a) communities that endorse a norm such as geophagy (eating clay) in women from African and African American communities and pregnant women in rural communities who consume mud, ash, and charcoal (Ali, 2001; Stiegler, 2005); and (b) those with severe OCD, schizophrenia, and intense generalized anxiety (Rose et al., 2000).

Rumination (RD)

Rumination disorder is a functional condition where there is unintentional regurgitation of undigested food within a few minutes of eating (APA, 2013). The food is spit out or rechewed. Until recently, it was considered a disorder of infants and children or those with profound intellectual disabilities. However, it has been an obscure disorder due to a lack of epidemiological studies, the disparate cluster of symptoms varying by age, and secretiveness in otherwise healthy adolescents and adults (Delaney et al., 2014). The causes and demographics of RD vary distinctly by age. Approximately 5% of infants between 3 and 6 months old, evenly distributed by gender, experience it (Parry-Jones, 1994). It is believed to
be primarily rooted in the lack of environmental stimulation or the unavailability of the primary caretaker, often remitting spontaneously (Green, Alioto, Mousa, & Di Lorenzo, 2011). In 5–10% of predominantly male individuals with intellectual disabilities, the experience appears to be a pleasurable reinforcing source of stimulation (Mayes et al., 1988).

Rumination in adolescents and adults of normal intelligence is increasingly recognized as a component of EDs (Malcolm, Thumshirn, Camilleri, & Williams, 1997), endorsed by 7% of the patients in a residential ED program and 2% of patients in an outpatient weight loss clinic (Delaney et al., 2014). It is more common in females, who are often conscientious individuals who experienced significant stress and are more likely to have experienced another ED such as AN or BN (Chial, Camilleri, Williams, Litzinger, & Perrault, 2003). Rumination can mimic the purging aspect of other eating disorders but is not self-inflicted.

**Avoidant/Restrictive Food Intake Disorder (ARFID)**

Diagnostic criteria for ARFID (APA, 2013) include an eating or feeding disturbance with failure to meet appropriate nutritional needs with one or more of the following: (a) significant weight loss (or failure of expected weight gain in children), (b) significant nutritional deficiency, (c) dependence on enteral feeding or nutritional supplements, and/or (d) marked interference with psychosocial functioning. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice or within the course of AN or BN. No evidence exists of a disturbance in the way in which one’s body weight or shape is experienced, and it is not attributable to a medical condition or another mental disorder.

During infancy and early childhood, ARFID is equally common in males and females. However, ARFID, when comorbid with autism, is more prevalent in males. For pregnant females and other physiological conditions in male and female adults, some food avoidance or restriction related to altered sensory sensitivities has been observed, but this behavior often does not meet the full criteria. Possibly due to the recent inclusion of ARFID in the DSM-5, research related to sexual orientation or gender identity and ARFID is not available.

Assessment involves a clinical interview, parental observations (with younger patients), measurement of weight and height, and evaluation of current food intake. Further medical tests may also be advised. Clinical judgment is utilized to assess sufficiency of weight loss and nutritional deficiency. Validated narrow-band assessment measures for ARFID (Bryant-Waugh & Kreipe, 2012) have yet to be developed.

**Anorexia Nervosa (AN)**

Anorexia nervosa is an intense fear of being fat and distorted body image, which results in the pursuit of becoming thinner, food restriction, dieting, and food
Assessment of Feeding and Eating Disorders

obsessions and rituals. These cognitions and behaviors result in a body mass index (BMI) that is significantly below normal for age, sex, and physical health. Amenorrhea was eliminated from DSM-5; this previous requirement precluded AN for males and pre- and post-menopausal women. Low BMI is achieved by food restriction and/or a combination of binge eating and purging. Most anorexics begin with restriction, but approximately 50% of individuals add bingeing and purging to control weight, although this distinction is not stable over the course of the illness (Peat, Mitchell, Hock, & Wonderlich, 2009; Focker et al., 2013). AN usually begins during adolescence (Currin, Schmidt, Treasure, & Jick, 2005); incidence drastically lessens after age 40. Overall prevalence is around 1% but varies by gender, culture, ethnicity, and social class (Garner & Garfinkel, 1982).

The ratio of female to male ranges from 3:1 to 10:1 (Hudson, Hiripi, Pope, Bohr, & Garfinkel, 2007; Smink, van Hoeken, Oldehinkel, & Hoek, 2014). Males present for treatment at older ages and are more likely to have a history of being overweight (Gueguen, Godart, Chambray, Brun-Eberentz, Foulon et al., 2012). They may not have an unwavering drive for thinness but rather desire a lean, muscular build. An equal number of males desire to gain as lose weight and are more likely to use excessive exercise than vomiting or laxative abuse (Strother et al., 2012). The preponderance of females over males is stable across cultures. However, issues of sexual orientation are rarely considered. In the United States, bisexual and gay men have significantly higher incidence of EDs than do heterosexual men (Jones & Morgan, 2010). In contrast, sexual orientation is not a differential factor in women (Moore & Keel, 2003). Embracing feminist perspectives may be a protective factor (Maine & Bunnell, 2010; Mur-nen & Smolak, 2007).

The prevalence of anorexia nervosa is higher in societies in which thinness is valued, such as the United States, Europe, Australia, and Japan, and it is lower in India, China, and Africa (Fallon, 1990; Liao et al., 2013). Until recently, it was rare in Arab and Muslim countries (Abou-Saleh, Younis, & Karim, 1998). Mass media is seen as influencing body ideals (Groesz, Levine, & Murnen, 2002), and exposure to Western culture increases AN (Hoek, 2006; Lee, Ng, Kwok, & Fung, 2010). Becker and colleagues (Becker, Burwell, Gilman, Herzog, & Hamburg, 2002) provided an example of the change in eating behaviors, attitudes, and body ideals after Fijian girls were exposed to television.

In post-industrialized countries, the incidence is greater in higher socioeconomic status (SES) classes and among some groups such as athletes, ballet dancers (Hincapié & Cassidy, 2010; Tseng, Fang, & Lee, 2014), and models where physique is important to success (Toro et al., 1994). Variations in body ideal and pressure to achieve the ideal may play a role in the development of the disorder. For instance, African American women compared to Caucasian women idealize a full female form, and the higher the level of ethnic identity, the more it may protect the former from AN (Shuttlesworth & Zotter, 2011).
Bulimia Nervosa (BN)

Bulimia nervosa entails recurrent episodes of bingeing and inappropriate compensatory behaviors to prevent weight gain (e.g., self-induced vomiting, misuse of laxatives and diuretics, fasting, excessive exercise) at least once a week for three months. Self-evaluation is unduly influenced by body shape and weight, and the disturbance does not occur exclusively during AN. BN typically begins in adolescence or early adulthood, with infrequent onset before puberty or after age 40 (Le Grange, 2011). Bulimia is more common in females; men have been underrepresented in research and treatment-seeking samples (Hepp, Spindler, & Milos, 2005). In the United States, lifetime prevalence of BN is 0.5% for females and 0.1% for males (Hudson et al., 2007). However, bulimic symptoms and body dissatisfaction in gay men may be as high as 14% (Russell & Keel, 2002). A connection exists between pubertal status and timing and ED, with an increased risk for pubertal females (Klump, Perkins, Burt, McGue, & Iacono, 2007) and achievement of early menarche (prior to age 11 or 12) (Graber et al., 1994; Harden, Mendle, & Kretsch, 2012).

Race and ethnicity may be factors in ED development in African American women (Striegel-Moore & Smolak, 1996). The restraint model proposes a sequence that begins with the internalization of an unrealistically thin beauty ideal and progresses to body image dissatisfaction, cognitive and behavioral restraint, and binge eating. Overall, African American women are heavier than Caucasian women, but they have reported less social pressure to conform to the thin ideal. However, when African American females do experience weight-related social pressure, they tend to want to be thinner.

African American females may be more vulnerable to certain eating problems (e.g., obesity, binge eating) while protected against others (e.g., body dissatisfaction, AN) (Striegel-Moore & Smolak, 1996). Three factors may be applicable: adiposity, gender roles, and identity. Children of African American women are more likely to be obese and to enter puberty earlier. Therefore, it may be more difficult for African American females to achieve the thin body ideal. African American females tend to adhere more closely to racial identity than do Caucasians (Striegel-Moore & Smolak, 1996). Group identification can increase self-esteem by allowing the individual to receive support. Acceptance of African American standards for attractiveness may include greater tolerance for diverse body shapes.

Binge Eating Disorder (BED)

The DSM-5 (APA, 2013) added BED, partially to emphasize the difference between general overeating and pathological bingeing. Diagnostic criteria include recurrent episodes of binge eating with three (or more) of the following: eating more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating
alone due to embarrassment, and/or feeling disgusted, depressed, or very guilty after overeating. The individual feels distress regarding bingeing, and there is an absence of compensatory behaviors (such as purging).

BED is the most common eating disorder in the United States. Onset is typically in adolescence or young adulthood. BED occurs in children and is associated with increased body fat, weight gain, and psychological symptoms. Other industrialized countries reported similar frequencies of BED to the United States (Nakai, Fukushima, Taniguchi, Nin, & Teramukai, 2013). Within the United States, BED has comparable prevalence rates among whites, Latinos, Asian Americans, and African Americans (Hudson, Hiripi, Pope, & Kessler, 2007; Ogden et al., 2006; Talleyrand, 2006).

Males have been included in research less often than females. BED may affect 3.5% of adult females and 2% of adult males (Swanson et al., 2011), although other studies have found nearly equal prevalence (Streigel, Bedrosian, Wang, & Schwartz, 2012). Some studies suggested that in females BED is most common in early adulthood, but in males it is more common in midlife. However, in another study males and females did not differ significantly on ages at first overweight, first diet, onset of regular binge eating, or number of weight cycles (Barry, Grilo, & Masheb, 2002). Similar mood and anxiety disorder comorbidity have been found, but males with BED have higher rates of concurrent substance use disorders (Grilo, White, & Masheb, 2009).

Literature searches for BED and transgender and transsexual participants produced no results. Few studies examined gay men, lesbian women, and bisexual individuals and the role of sexual orientation and gender identity and BED. A few studies that discussed eating disorder symptoms more generally related to gender are reviewed later in the chapter (e.g., Feldman & Meyer, 2010; Austin et al., 2004).

Factors Impacting the Assessment of Eating Disorders

While specific diagnosis can be helpful, the assessor should recognize that diagnoses do not yield discrete and uniform groups. Considerable overlap is present in the symptoms of AN, BN, and BED with body image dissatisfaction, restricting food intake, bingeing, purging, and resultant weight loss and gain as the most common. These behaviors can be mild and transient; about 33% of adolescent girls and 15% of adolescent boys have symptoms that never reach the level of severity for an ED diagnosis (Herpertz-Dahlmann et al., 2015). The highest incidence of symptoms occurs during adolescence, and individuals can move between diagnostic categories. Of those with symptoms during adolescence, 80% of the girls and almost all of the boys remain symptomatic 3–10 years later (Ackard et al., 2011; Liechty & Lee, 2013). In contrast to AN and BN, BED has less severe symptoms (Brewerton et al., 2014). The earlier the symptom development occurs, the more severe and long lasting the disorder will be (Herpertz-Dahlmann et al., 2015).
Environmental factors and individual attributes not specifically captured by diagnostic categories can shape the presentation of symptoms, predate and influence the underlying pathology, and impact the course of the treatment and chronicity. Some empirically supported factors in the assessment of eating disorders include psychiatric comorbidity, perfectionism and shame, body image concerns, and environmental factors such as history of sexual abuse and the role of gender. In reviewing factors, we collapsed diagnoses and correlated symptoms (e.g., distorted body image, bingeing) with outcome or personality characteristics (e.g., impulsivity) for three major reasons: (1) there is overlap of symptoms in diagnoses; (2) symptoms not yet meeting full diagnostic criteria can develop into full-blown disorders; and (3) personality characteristics and symptoms may be more illuminating in terms of assessment, treatment, and prognosis (Westin & Harnden-Fischer, 2001; Wonderlich et al., 2005).

**Psychiatric Comorbidity**

Psychiatric comorbidity is common, particularly in terms of prevalence, reported both by individuals with EDs with another psychiatric condition and those with psychiatric disorders who have an ED. In a large community sample (n = 9000+), more than 50% of those with AN, 95% of those with BN, and 77% of those with BED also met criteria for at least one Axis I disorder (Hudson et al., 2007). EDs most frequently occur with anxiety and depression (Swanson, Crow, Le Grange, Swenson, & Merikangas, 2011; Swift, Andrews, & Barklage, 1986) but also with substance use (Spindler & Milos, 2007). Comorbidity is associated with greater severity of ED symptoms (Spindler & Milos, 2007) and can aggravate EDs (Bulik, Sullivan, Joyce, Carter, & McIntosh, 1998). The co-occurrence with substance abuse in females results in greater mortality than with either disorder alone (Perlstein, 2002). Less comorbidity lowers relapse risk (Zeeck, Weber, Sandholz, Joos, & Hartmann, 2011).

**Mood and Affective Disorders**

In those with AN or BN, lifetime prevalence of an affective disorder is 50–75% (Rodgers et al., 2014). The absolute numbers of comorbidity is higher in women, but some studies have suggested that the rates may actually be higher in males (Bramon-Boesch et al., 2000; Grilo, White, & Masheb, 2009). If, however, a diagnosis of PTSD is involved, then comorbidity is higher in women (Litwack et al., 2014), and about one-third of female patients with bipolar disorder have an ED (Fornaro et al., 2010). Men are more likely to have comorbid substance abuse (McElroy et al., 2005). It is difficult to ascertain whether failed diet attempts, loss of control of eating, purging, or body distortion and dissatisfaction with body image influence mood states or whether initial mood symptoms fosters and exacerbates ED behaviors. The presence of an ED denotes body dissatisfaction and eating behaviors that unduly influence self-esteem and mood.
**Anxiety Disorders**

Studies regarding the lifetime prevalence of anxiety disorders for both AN and BN range from 25% to 75% (Swinbourne & Touyz, 2007). In over 75% of the female cases, the onset of anxiety precedes the development of the ED, suggesting that the presence of significant anxiety may leave individuals vulnerable to the development of an ED (Godart, Flament, Lecrubier, & Jeammet, 2002). For example, 12% of the women who presented to an anxiety clinic met criteria for an ED (Black Becker, Deviva, & Zayfert, 2004). The most common comorbid anxiety disorders are OCD, obsessive-compulsive personality disorder (OCPD), and social phobia. An interaction exists between anxiety and severity of ED symptoms (Spindler & Milos, 2007). However, even though ED symptom severity does lead to greater risk for poor prognosis, there is not a direct relationship between outcome and comorbidity (Swinbourne & Touyz, 2007). People with BED have lower rates of anxiety than do those with BN (Brewerton et al., 2014).

**Substance Abuse**

Substance abuse and ED share common features, such as cravings, preoccupation with food, self-destructive behavior, denial, and medical sequelae (Mann et al., 2014). Substance use in those with ED is used to relax and “get away,” reduce anger, and avoid eating (Stock, Goldberg, Corbett, & Katzman, 2002). Although many studies have examined the co-occurrence, identification of specific substances used and range of ED symptoms along with participant population (e.g., inpatient, outpatient, community) varied between studies, which makes comparison difficult. In a large review, Holderness, Brooks-Gunn, and Warren (1994) concluded that for BN, drug and alcohol abuse ranges from 3–55%. The rates of drug and alcohol abuse for AN were lower than for BN. For those anorexics who binged, the rates were twice as high as for those who primarily restricted their intake.

While most of the above information was from studies that included only women, in a study that examined male ED patients, more than one-third met criteria for substance abuse (Carlat, Camargo, & Hertzog, 1997). A study with adolescent ED inpatients found that boys used substances at a greater rate than did girls (Mann et al., 2014). A large Canadian community sample found that for both men and women the risk for ED was associated with alcohol amphetamine use. In addition, for women, but not men, the number of different illicit substance classes was related to the severity of ED (Gadella & Piran, 2007).

Impulsivity is a key common characteristic with substance abuse and BN (Spindler & Milos, 2007; Wiederman & Pryor, 1996). Thus, when designing ED treatment, evaluation and treatment of substance use and impulsivity should be considered in conjunction with ED symptoms.
Mortality

EDs lead to a high risk of premature mortality, particularly by suicide (Preti, Rocchi, Sisti, Camboni, & Miotto, 2011), and gender appears to be an important factor. A meta-analysis revealed that the risk of death for AN patients was five times the rate of the general population (Arcelus, Mitchell, Wales, & Nielson, 2011). In a review of hospital records in England over nine years, Hoang, Goldacre, and James (2014) found that those with AN had the highest risk, 11–14 times higher than the general population, followed by BN and Eating Disorder Not Otherwise Specified (EDNOS). A cross-cultural meta-analysis (Preti et al., 2011) found no suicides in the BED group, although the number of patients was low due to recent appearance as a diagnostic category. In the only study with eating-disordered males and females, half the males and one-quarter of the females had made at least one suicide attempt (Bramon-Boesch et al., 2000), an outcome in contrast to the general population finding that females more frequently attempt suicide.

Mortality for those over age 25 was greatest, with women being at higher risk than men (Hoang et al., 2014). This initial cross-sectional comparison suggested that if recovery did not occur early, the negative impact of the ED deepened. Follow-up analysis (Preti et al., 2011) found that suicide rates significantly decreased among those with AN, attributed to better identification. In contrast, the rate of suicide increased for the BN group, explained by the fact that most ED persons do not present for treatment, and if they do, it is to primary care rather than a mental health professional. Those with AN are often more overtly identifiable than those with BN or BED, in whom symptoms can be more easily hidden.

Perfectionism and Shame

Perfectionism consistently emerges as a vulnerability to the development of ED in both nonclinical and clinical groups (Bardone-Cone et al., 2007). It includes the pursuit of high personal standards, critical evaluations of one’s self and behavior, and concern that others will disapprove. Individuals who are high on perfectionism tend to invest their self-worth obsessively and rigidly on narrow aspects of the self. If this form of perfectionism focuses on a drive for thinness, the resulting body dissatisfaction can increase disordered eating symptoms (Boone, Soenens, & Luyten, 2014).

Self-criticism and shame have significant roles in the development and maintenance of ED symptoms (Gee & Troop, 2003). Shame is an internal evaluation that certain personal aspects (e.g., body shape or overeating) are not acceptable and might result in rejection (Pinto-Gouveia, Ferreira, & Duarte, 2014). In extreme forms, shame and self-criticism can drive a harsh attack on the self, characterized by self-hatred, disgust, and self-contempt. Self-blame and lack of self-affirmation are positively related to ED symptoms, which was similar for
both adolescent girls and boys; however, the correlation is three times stronger for girls (Forsén Mantilla, Bergsten, & Birgegård, 2014).\(^7\)

Shame associated with body dissatisfaction increases a sense of inferiority in social standing. It is presumably this shame with regard to dissatisfaction with the body that increases the drive for thinness (Pinto-Gouveia et al., 2014) and contributes to a resolution to diet and refrain from eating. Restrained eating can fuel binge eating rather than having its intended desire of weight loss (Polivy & Herman, 2002). Thus, shame fuels binge eating (Duarte, Pinto-Gouveia, & Ferreira, 2014).

**Body Image, Environmental Pressures, and Body Dissatisfaction**

Self-image, and more specifically body image, encompasses individuals’ perceptions of themselves and the way they think others view them (Fallon, 1990). Negative self-image and body dissatisfaction are some of the most consistently found risks in the development and maintenance of ED (Stice, 2002). In non-clinical populations, this relationship is stronger for women (Forsén Mantilla et al., 2014). Certain environments heighten the risk for ED (Streigel-Moore, Silberstein, & Rodin, 1986). In college settings, subthreshold ED symptoms are as high as 67% for women, suggesting that weight and shape preoccupation is normative for this group (Rozin & Fallon, 1988). In this population, disordered eating should be viewed as a continuum from lack of concern about weight to “normative discontent” to symptoms that reach full diagnostic criteria of an ED (Striegel-Moore, Silberstein, Frensch, & Rodin, 1989). While body dissatisfaction is present in those without ED, it is rarely absent in those with ED (Coker & Abraham, 2014). Even in large nonclinical samples, almost one-third of men and women expressed some dissatisfaction (Fallon, Harris, & Johnson, 2014).

The physical changes of adolescence heighten self-consciousness and sensitivity to the body, and youth look for grounding both internally and externally. Cultural, familial, and peer group ideals of body physique help create an internalized ideal. When an ultra-thin physique is an emphasized facet of beauty and offers the promise of success, some adolescents look for ways to conform. Repeated external messages from media, family, and peers about a thin shape can contribute to an internalized expectation with negative effects (Thompson, van den Berg, Roehrig, Guarda, & Heinberg, 2004).

Two related processes for how these effects occur have been articulated (Fitzsimmons-Craft, 2011). In line with Social Comparison Theory (Festinger, 1954), individuals compare themselves to others, either upward or downward. By repeated upward social comparisons (e.g., thin models in the media), individuals believe they have not achieved their ideal image. A second process utilizing Objectification Theory (Fredrickson & Roberts, 1997) involves viewing oneself from an observer’s perspective. Body surveillance involves thinking
about how one’s body looks to others rather than how the body feels to the self. Both social comparison and objectification influence the internalization of a thin ideal (Fitzsimmons-Craft et al., 2011). More frequent use of social comparison leads to an increase in body dissatisfaction and ED (Fitzsimmons-Craft, Bardone-Cone, Bulik, Wonderlich, Crosby, & Engel, 2014).

Although self-objectification has previously been used regarding female body image discontent, evidence is increasing that boys are also exposed to unrealistic body shape ideals. The differential rates of body dissatisfaction and ED between boys and girls may be in part an artifact of the specific instruments used for identification. The body ideal for males may focus on muscularity and leanness rather than thinness (Olivardia, Pope, Borowiecki, & Cochane, 2004). The phrase *Adonis complex* has been coined to capture men’s desire for a sculpted muscular body. Consistent with this understanding, a large sample of adolescent girls and boys (age 14–15 years) were interviewed yearly for three years (Dakanalis et al., 2014). They found no differences between groups in internalization of media ideal and the effects on self-objectification. Scrutiny predicted negative feelings about the body, which predicted dietary restraint and binge eating. For both boys and girls, self-objectification highlighted the discrepancy between their current and ideal stature, which resulted in later body shame and anxiety about appearance.

**Body Dissatisfaction, Disordered Eating, and Gender**

A binary categorization of biological sex in conjunction with the preponderance of females with ED seeking treatment may have lead the early psychoanalytic theorists to emphasize fear of becoming a woman and impregnation as a cause for ED. Sociocultural theories, centering upon how society fosters an unrealistic expectation for women’s bodies, also contributed to the predominance of research with females. Yet, identification with any group in which an ideal is far from real is likely to result in similar pressures of conformity. Examination of ED in the context of gender identification, sexual orientation, and gender conformity makes this fact salient.

**Gender Identity, Body Dissatisfaction, and Disordered Eating**

When gender identity is incongruent with biological sex at birth, females experience more body dissatisfaction and are more at risk for ED than are males. This divide burgeons in early adolescence for reasons discussed previously. Conflicted gender identity increases the risk for body dissatisfaction and ED (e.g., Algars, Santtila, & Sandnabba, 2010; Austin, Nelson, Birkett, Calzo, & Everett, 2013). Finnish adults with self-reported conflicted gender identity were matched with controls with congruent gender identity on age and biological sex. Results indicated that participants whose natal sex did not match their felt gender had more body dissatisfaction, and women with gender identity that was at odds with their
natal sex reported more eating problems. More body dissatisfaction and ED was found in men with conflicted gender identity who engaged in male-to-male sexual experiences. However, in females with conflicted gender identity, less body dissatisfaction was reported with those who engaged in female-to-female sexual experiences. In a qualitative study of Finnish adults who self-identified as transgender, the majority of participants reported past or current ED (Algars, Alanko, Santtila, & Sandnabba, 2012). Striving for thinness was described as a way to suppress biological gender or enhance the features of desired gender. Disordered eating improved following gender reassignment procedures.

Eating and body image disturbances were higher in transsexual individuals when compared with male controls and elevated scores when compared with female controls (Vocks, Stahn, Loenser, & Legenbauer, 2009). Male-to-female transgender participants indicated higher scores on bulimia, restrained eating, weight and shape concerns, body dissatisfaction, body checking, and drive for thinness. Female-to-male participants reported more restrained eating, weight and shape concerns, body dissatisfaction, and checking. Depression scores were higher for both groups versus controls. Witcomb and colleagues (2015) found that trans men and women were more dissatisfied not only with gender-identifying body parts but also with their weight and body shape relative to cisgendered individuals.

**Sexual Orientation**

Incorporated into the cultural ideal, body dissatisfaction is dependent upon not only the group with whom the individual identifies but also who an individual is attempting to attract. The increasing importance of these two peer groups is in part why adolescents and young adults are more vulnerable to body dissatisfaction and see ED as an adaptation to the discrepancy between ideal and current body image. Males place greater importance upon physical attraction and are more rejecting of “fatness” than are females (Brochu & Morrison, 2007). This pattern results in heterosexual females feeling considerably more dissatisfied with their bodies than do heterosexual males (Fallon & Rozin, 1985; Morrison, Morrison, & Sager, 2004; Rozin & Fallon, 1988). However, heterosexual boys may also be more vulnerable than previously believed given that screening often does not include dissatisfaction due to inadequate muscularity (Austin et al., 2004).

Lesbian individuals report greater body image satisfaction and less ED than do heterosexual women (Bankoff & Pantalone, 2014). Compared with heterosexual girls, lesbian/bisexual girls were happier with their bodies and less concerned with trying to look like women in the media (Austin et al., 2004). Many lesbians embrace a feminist perspective that recognizes the cultural oppression of unrealistic ideals, which is likely a protective factor. However, bingeing is more prevalent in adolescents who identify with a minority sexual orientation (Austin et al., 2009). This may be the result of a higher rate of obesity and
overweight in this group (Boehmer, Bowen, & Bauer, 2007). Bisexual girls and women have a higher rate of ED than do those who are exclusively heterosexual women (Koh & Ross, 2006). When lesbian and bisexual women are diagnosed with ED, they are also more likely to have a mood disorder than are lesbian and bisexual women without an ED (Feldman & Meyer, 2010).

Sexual minority men make up a disproportionate percentage of men in the United States who are diagnosed with ED and suffering from body image disturbances (Carlat, Camargo, & Hertzog, 1997; Engeln-Maddox, Miller, & Doyle, 2011; Feldman & Meyer, 2007). Survey data from a large number (n = 24,591) of high school students in the United States indicated that gay and bisexual identity was associated with substantially more purging behaviors and use of diet pills. Like bisexual girls, bisexual boys exhibited an elevated risk of obesity when compared to heterosexual boys. Gay and bisexual boys were more concerned with trying to look like men in the media and were more likely than heterosexual boys to binge (Austin et al., 2004).

Feldman and Meyer (2010) examined the prevalence of psychiatric disorders among lesbian, gay, and bisexual (LGB) men with ED. A total of 388 white, black, and Latino LGB men and women were sampled from community venues. Gay and bisexual men with ED were more likely than gay and bisexual men without ED to have an anxiety or substance abuse disorder, whereas lesbian and bisexual women with ED were more likely than lesbian and bisexual women without an ED to have a mood disorder.

Doyle and Engeln (2014) suggested that sexual minority men tend to socialize with those who are similar to them, including body types. In their study, they differentiated between the “twinks” (younger with smaller frames) and “bears” (stockier with more traditional masculine behaviors). On average they found that higher BMI was associated with greater body dissatisfaction and drive for musculosity. This dissatisfaction was less about being fat and more about musculosity. However, BMI also influenced gay community identification and body image disturbance. Those with higher BMI were more interested in musculosity, whereas those with lower BMI reported less drive for musculosity and more drive for thinness. This suggests that, among the gay community, ideal body image may vary depending upon the identification and underlines the importance of allowing for an articulation of the ideal for each person.

**Gender Role Conformity, the Feminist Perspective, and Attitudes Toward Weight**

Gender roles are social constructs based on cultural stereotypes of what is regarded as typical masculine or feminine behaviors, attitudes, interests, and personality characteristics (Hepp, Spindler, & Milos, 2005). Gender role orientation is an individual’s position in this framework of masculine and feminine dimensions. Irrespective of sexual orientation, embracing feminine characteristics is associated with ED in men and women, and conversely masculinity is related
to healthier eating behaviors (Meyer, Blissett, & Oldfield, 2001). Females who score high on both masculine and feminine traits (androgyny) reported lower levels of ED symptoms than did those who scored low on both traits (undifferentiated) (Hepp, Spindler, & Milos, 2005).

Perception of gender roles may contribute to the lower rates of body dissatisfaction in African American females (Striegel-Moore & Smolak, 1996). African American children do not appear as rigid in stereotypical beliefs of masculinity and femininity compared to Caucasian children due to several possible historical factors. They are more likely to be raised by mothers in single-parent homes and to observe their mothers fulfill a multitude of roles inside and outside of the home.

Although both men and women in Western cultures exhibit anti-fat attitudes, men have more negative attitudes toward overweight individuals (Brock & Morrison, 2007). Feminist identity seems to protect women of all sexual orientations from body image dissatisfaction and ED (Murnen & Smolak, 2009). The feminist perspective attunes women to the oppressive cultural message of the thin ideal and thereby, to some extent, frees women from it.

Masculine identity has been linked to body dissatisfaction and a drive for muscularity rather than thinness (Blashill & Vander Wal, 2009; Smolak & Murnen, 2008). At the extreme end of the continuum, an adherence to masculine norms involves identification with dominance, power, status, confidence, sexual success, and physical and emotional self-control (Connell, 1995). Feminine gender norms include agreeableness and deference to others, passivity, and interpersonal dependence (Lakkis et al., 1999). A large sample of heterosexual college males was examined with respect to gender role conformity. Those who endorsed the traditional masculine norms were more at risk for muscularity-oriented disordered eating, whereas those who endorsed feminine norms exhibited both muscularity-oriented and thinness-oriented disordered eating (Griffiths, Murray, & Touyz, 2015).

**Environmental Factors**

The causes of ED, it is widely acknowledged, are heterogeneous and multifaceted (Johnson, Cohen, Kasen, & Brook, 2002), and many of these causes interact with gender. Studies have supported a link between ED and a history of childhood maltreatment (e.g., De Groot & Rodin, 1999), other childhood adversities (e.g., Troop & Treasure, 1997; Welch, Doll, & Fairburn, 1997), and troubled relationships with parents (e.g., Steiger, Feen, Goldstein, & Leichner, 1989). It is critical to be aware of potential risk factors and to include relevant questions as part of a larger assessment when an ED is suspected to evaluate etiology and additional challenges. In addition, an understanding of the association between adverse childhood experiences and ED may prompt clinicians working with at-risk populations (e.g., those with a history of childhood sexual abuse) to be mindful of a possible ED.
In a large community-based prospective longitudinal study, a multitude of experiences presaged the later development of eating problems (Johnson, Cohen, Kasen, & Brook, 2002). Results supported the previously cited research studies, most of which were cross-sectional case controls. Participants included 782 mothers and one randomly chosen offspring (n = 397 males, 385 females), who were assessed for eating problems in adolescence and young adulthood. The most significant factor for males was low parental education, which correlated with higher rates of obesity and physical neglect associated with elevated risk for use of medication to lose weight and engage in self-induced vomiting. Females experienced fasting and strict dieting related to inadequate parental supervision, self-induced vomiting associated with sexual abuse, low body weight with physical abuse, and use of medication to lose weight following high peer aggression and low paternal affection. In addition, in females, higher risk for obesity was found when the environment was characterized by harsh maternal punishment, loud arguments between parents, low parental education, physical neglect, poor parental maintenance of home, and poverty. Information regarding gender identity and sexual orientation was not reported.

A further review of the literature indicates a connection between childhood sexual abuse (CSA) and ED (e.g., Ackard & Neumark-Sztainer, 2003; Korte, Horton, & Graybill, 1998; Romans, Gendall, Martin, & Mullen, 2001; Wilson, 2010; Wonderlich et al., 2000). A history of CSA has frequently been identified in adult and adolescent females who have clinical and subclinical eating disorders and problems (e.g., Johnson, Cohen, Kasen, & Brook, 2002; Neumark-Sztainer, Story, Hannan, Beuhring, & Resnick, 2000). In fact, CSA was reported in 20–50% of adult and adolescent patients with BN and AN (Bulik, Sullivan, & Rorty, 1989; Schmidt, Tiller, & Treasure, 1993; Vize & Cooper, 1995).

Males with a history of CSA may also develop eating problems. In a large survey study in England (Jonas et al., 2011), both females and males with ED reported a sexual abuse history, although the significance level was less for male participants. Results by Zaitsoff and Grilo (2010) indicated that a significant number of adolescent male and female psychiatric inpatients with eating disorder psychopathology had experienced CSA.

Development of an ED is one possible response to the trauma of CSA. Important factors include age at the time of victimization, severity of the abuse, relationship of the abuser to the victim, and the response of others if they learn of the abuse (Worell & Todd, 1996). Theories to explain the relationship between CSA and ED include desire of the person who has been abused to make their body unattractive or nonsexual and perception of the body as a source of shame. The attempt to alter weight may be to get rid of the body and the feelings of self-hatred, disgust, and guilt, and issues of control. The person controls eating behaviors as an attempt to regain control that was lost during the experience of CSA (Andrews, 1997; Schwartz & Gay, 1993; Smolak & Murnen, 2002).
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Two kinds of assessments are relevant to ED. The first measures the presence, type, and severity of symptoms of the various EDs for both research and clinical evaluation by self-report questionnaires (e.g., EAT, EDI) and semistructured interviews (e.g., SIAB-EX). The second are more general measurements of personality functioning. Although these broadband instruments do not specify diagnosis of a particular ED, they measure aspects of the disorders that are useful in evaluating prognosis and planning treatment, such as psychiatric comorbidity (e.g., SCID and SADS).

Self-report measures have the advantage of being economical in the use of professional time and in ease of collection with large community samples. However, there is a widespread belief that ED patients, particularly those who are resistant to treatment, minimize their symptoms. In addition, without the use of careful daily diaries, some symptoms such as binge eating are not likely to be objectively assessed in self-ratings. Some instruments, such as SIAB and EDE, have both a self-report and structured interview version. While there are some minor differences, self-ratings can validly and reliably evaluate patients who are already in treatment for an ED (Fichter & Quadflieg, 2000).

Self-Report Inventories

Eating Attitudes Test (EAT)

The Eating Attitudes Test (EAT) is one of the most widely used instruments for ED. Originally 40 self-report items, it now has 26 items assessing attitudes, emotional states, and behaviors of ED (Garner, Olmsted, Bohr, & Garfinkel, 1982). Each item is rated on a six-point frequency scale (never to always). There are three subscales: dieting and preoccupation with thinness; bulimia and thoughts about bulimia and food; and oral control, self-control about food and social pressures to gain weight (Rosen, Silberg, & Gross, 1988). Higher scores represent more abnormal eating attitudes and behaviors, with a score of 20 or greater associated with ED (Garner et al., 1982).

Adequate psychometrics have been established for males and females, but reliability is higher for women (Robinson, Kosmerly, Mansfield-Green, & Lafrance, 2014). It has been used primarily with high school and college students. A modified version, the Children’s Eating Attitudes Test (chEAT), has been adapted for children as young as age 7 (Maloney, McGuire, & Daniels, 1988; Micali & House, 2011). Only recently has there been research (dissertations) using the EAT in self-identified gay, lesbian, and bisexual groups. Although sample sizes were moderate, psychometric data were not reported, and the instrument was used empirically to examine overall disordered eating attitudes in relationship to internalized homophobia and identity development (Ballantyne, 2012; Jaeger, 2012; Swearingen, 2007).
The instrument was originally developed in English and standardized in the United States and Great Britain (Garfinkel & Newman, 2001). It has been translated into many languages and is widely used in cross-cultural research of eating disorders throughout Europe (e.g., Rivas, 2013; Tomba, Offidani, Tecuta, Schumann, & Ballardini, 2014; von Soest & Wichstrom, 2014), Australia (Lake, Staiger, & Glowinski, 2000), Brazil (Ribeiro & Veiga, 2010), and Canada (Robinson, Kosmerly, Mansfield-Green, & Lafrance, 2014). It has also been used in Asia, including India (Balhara et al., 2012), Pakistan (Musai et al., 2011), China, and Hong Kong (Tseng et al., 2014), and Japan (Nakai et al., 2014; Shimura, Horie, Kumano, & Sakano, 2003; Stark-Wroblewski, Yanico, & Lupe, 2005). The EAT has been translated into Arabic and administered in countries that are less embracing of Western values, such as Iran (Jalali-Farahani, Chin, Mohd Nasir, & Amiri, 2014), Algeria, Jordan, Kuwait, Libya, Palestine, Syria, and the United Arab Emirates (Musai et al., 2013). Psychometric analyses have found similar factor structures to Western samples (Maïano, Morin, Lanfranchi, & Therme, 2013; Berger et al., 2012).

In general, women have higher dieting, bulimia, and food preoccupation scores than do men (Robinson, Kosmerly, Mansfield-Green, & Lafrance, 2014), and this difference is almost universal cross-culturally. Gender differences, some evidence suggests, is greater in those countries where people are exposed to Western culture. However, the research is somewhat mixed in this regard.

The sensitivity ranges from 64–100% and the specificity from 81–96% when the cutoff score is 20/21 (Mintz & O’Halloran, 2000; Nunes, Carney, Olinto, & Mari, 2005). Both specificity and sensitivity are lower when applied to community samples (Garfinkel & Newman, 2001) and higher for at-risk populations (Tseng, Fang, & Lee, 2014). Sensitivity and specificity can be improved by defining the population and setting unique cutoff scores for that sample. For example, Rivas (2013) was able to obtain 94% for specificity and sensitivity in her Spanish group if a cutoff score of 27 was used.

In summary, the EAT is widely used to detect the presence of eating disorders. The simple administration and translation into many languages enables it to be a good tool for primary care screening, the most common setting for mental health detection. It may, however, be best for epidemiological studies and comparative research. As a diagnostic tool, its clinical utility is hampered by high rates of false positives and negatives and its inability to distinguish between AN and BN (Micali & House, 2011). Although research with respect to sexual orientation is beginning, psychometric data are not available. Settings using this test for screening should establish a cutoff consistent with the client demographics.

Eating Disorder Inventory-3 (EDI-3)

The Eating Disorders Inventory-3 (EDI-3; Garner, 2004), along with previous versions, is another frequently used assessment. Reliability and validity have been consistently demonstrated in studies with female participants (e.g.,
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Espelage et al., 2003; Stanford & Lemberg, 2012a). The EDI is a 64-item self-report questionnaire (Garner, Olmstead, & Polivy, 1983) designed to assess psychological and behavioral traits present in both AN and BN. It contains three subscales measuring ED symptoms—drive for thinness (DT), bulimia (B), and body dissatisfaction (BD)—and five subscales measuring general psychological features related to EDs—ineffectiveness (I), perfectionism (P), interpersonal distrust (ID), interoceptive awareness (IA), and maturity fears (MF). Each question is scored on a six-point scale. It differentiates effectively between the new DSM-5 eating disorder categories (Brewin, Baggott, Dugard, & Arcelus, 2014).

EDI-3 profiles should not be used in isolation but must be interpreted with other data from both companion psychological tests and interviews, such as current and past ED symptoms, personality, premorbid functioning, family, interpersonal functioning, physical complications, treatment history, and motivation to change (Cumella, 2006). Correlations with two multifactorial measures of general psychopathology, the Symptom Checklist–90 (Derogatis & Cleary, 1977) and Millon Clinical Multiaxial Inventory–II (Millon, 1987), suggest adequate discriminant validity for most of the EDI-3’s subscales and composites.

The EDI was developed with females. The primary deficit of the Eating Disorders Inventory-3 (EDI-3; Garner, 2004) is a lack of information about its utility with men in clinical and nonclinical populations (Cumella, 2006). Occasionally, it has been used in research with males but with uncertain validity and inconsistent results (Stanford & Lemberg, 2012). However, men tend to score significantly lower than females on the subscales (Spillane, Boerner, Anderson, & Smith, 2004). Reilly, Anderson, Schaumberg, and Anderson (2014), with a sample of over 500 males, completed a differential functioning analysis for each item and found that only one item (laxative use) differed. Overall, the EDI-3 is acceptable for assessment of ED in males, but the subscales tend to be less reliable for men than for women.

Research that included gay, lesbian, bisexual, and transgender participants (e.g., Russell & Keel, 2002) mainly utilized other measures (e.g., EAT, Body Shape Questionnaire) rather than the EDI. However, when EDI subscales for bulimia, drive for thinness, and body dissatisfaction were given as part of a larger battery, gay men were found to have a higher risk for ED symptoms than were heterosexual males (Boisvert & Harrell, 2009). A case study with a trans woman (Surgenor & Fear, 1998) revealed a close link between transgender issues and ED symptoms—scores were elevated to the ED range on the EDI-2. Male sexuality and sexual identity development were found to be important factors for assessment and treatment in a recent study that used the EDI-3 to identify ED symptoms (Weltzin et al., 2012). In the Vocks et al. (2009) study discussed in the BN section, EDI scores for trans women were more elevated on bulimia, restrained eating, weight and shape concerns, body dissatisfaction, body checking, and drive for thinness than for controls. Future research is indicated to determine if the EDI-3 is a reliable and valid measure for sexual minority populations.
The EDE-Q is a self-report measure derived from the EDE (Fairburn & Cooper, 1993) that focuses on the past 28 days and measures core elements of ED psychopathology. It provides four subscale scores: restraint, weight concern, eating concern, and shape concern. A global score is obtained from the average of the subscale scores. Items are scored on a seven-point Likert scale, and a high score indicates greater ED psychopathology. The EDE-Q has good reliability and internal consistency (Luce & Crowther, 1999; Peterson et al., 2007) and differentiates effectively between DSM-5 ED categories (Brewin, Baggott, Dugard, & Arcelus, 2014).

Despite its extensive use in clinical and research settings, male norms for the EDE-Q (Fairburn & Cooper, 1993) are largely absent, with a few exceptions. Normative data on the EDE-Q for undergraduate males ages 18–26 (n = 404) in the United States were obtained as part of two larger survey studies (Lavender, De Young, & Anderson, 2010). Although the overall prevalence of full-threshold ED was lower in males than in females, body dissatisfaction and disordered eating behaviors were fairly common.

EDE-Q scores among a nonclinical sample of normal-weight high school and university Norwegian males were significantly, and almost invariably, lower than for similarly aged young women (Reas, Øverås, & Rø, 2012). The EDE-Q performed less reliably among males than females. As with the EDI-3, reliance upon this single instrument is unlikely to provide a comprehensive assessment of shape, weight, and eating concerns among normal-weight young males in the community.

A literature search for studies that included gay, lesbian, bisexual, and transgender participants tended to utilize other measures. However, in one study (Hospers & Jansen, 2005), gay men scored higher than heterosexual men on all of the EDE subscales, along with the global scale, body dissatisfaction, and peer pressure. Male sexuality and sexual identity development were found to be important factors in a recent study that used the EDE to assess ED symptoms (Weltzin et al., 2012). As discussed in the BN section, EDE scores of trans women were elevated for restrained eating, weight and shape concerns, and body dissatisfaction (Vocks et al., 2009). Future research is needed to indicate if the EDE-Q is a valid and reliable measure for assessment of ED with sexual minorities.

The EDAM is a preliminary assessment tool designed to detect ED symptoms specific to males, such as male body issues, a more comprehensive measure of symptoms of binge eating, and Muscle Dysmorphic symptoms, characterized by an unrealistic perception of the body combined with an excessive pursuit of muscularity (Olivardia et al., 2000). The EDAM was developed in part to address the shortcomings of the EDI, particularly related to body
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Stanford and Lemberg (2012) proposed that the EDAM is better than the EDI-3 for assessing EDs in males. Results indicated that EDs are significantly different in men and women, especially related to drive for thinness, bulimia, and body dissatisfaction. The authors concluded that there is a need to develop a valid and reliable ED assessment tool specifically for men. Published studies that utilized the EDAM with sexual minority populations were not found during a literature search. Continued research with heterosexual and gay males is needed to determine suitability for ED assessment as compared with other more established measures.

**Structured Interview (SIAB-EX)**

The Structured Interview for Anorexic and Bulimic Disorders (SIAB-EX) is an 87-item detailed assessment for adults and adolescents (Fichter et al., 1991). The third revision has been updated to diagnose current and lifetime ED using *DSM-IV* and *ICD-10* criteria (Fichter & Quadflieg, 2000). It has been one of the most extensively validated instruments developed in Europe using both ED patients and community samples (Fichter & Quadflieg, 2000), with high inter-rater reliability (.81–.85). Principal factors include body image and slimness ideal; general psychopathology; sexuality and social integration; bulimic symptoms; measures to counteract weight gain, fasting, and substance use; and atypical binges. The first three factors account for approximately one-third of the variance (Fichter et al., 1998).

Both male and female ED patients were included in the original validation samples of the SIAB-EX, but the number of males was admittedly small, proportionate to the gender differential in other studies. Some studies do not even specify the gender of participants (e.g., Zeeck, Weber, Sandholz, Joos, & Hartmann, 2011). The SIAB does have a question about amenorrhea, but results suggest that this item does not alter the specificity or sensitivity of the interview (Fichter & Quadflieg, 2000).

The SIAB has been compared to the EDE, with the former demonstrating good convergent and discriminant validity (Fichter & Quadflieg, 2001). It explores a broader range of psychopathology that is correlated with EDs than does the EDE, and thus, it is often preferred (Fichter & Quadflieg, 2004; Zeeck et al., 2007; Spindler & Milos, 2007).

**A Case Example**

We provide a case illustration in order to show how different sources of information can be useful in providing evidence of an ED.
**Background**

John is a 23-year-old Caucasian male college graduate who entered treatment at his sister’s urging due to her concerns about his depressed mood. During the initial interview, he identified moderate depressive symptoms (i.e., low mood, difficulty concentrating, lack of appetite, sleep disturbance), which began after his mother’s death from pancreatic cancer a year ago. He presented with flat affect but denied suicidal or homicidal thoughts or psychotic symptoms. During the past year, he had lost about 20 pounds, but he appeared to be average weight. He felt the weight loss was welcome due to significant weight gain in his first year post college. He acknowledged some obsessive thoughts of becoming overweight when he overate and experienced physical discomfort, but he denied bingeing or purging. He identified as heterosexual but had not had a girlfriend since college. He reported friends with whom he played racketball. Occupationally, he develops mathematical models to predict catastrophes for an insurance company. Although he worries that his performance is inadequate, his merit raises suggest otherwise. His initial presentation seemed consistent with an unresolved mourning, R/O a Depressive Disorder. He was referred for psychological evaluation for further diagnosis, assessment of suicidality, and to rule out possible underlying psychosis.

**Test Results**

John was administered the Beck Depression Inventory (Beck, 1961), MMPI-2 (Butcher et al., 1989), Rorschach (Rorschach, 1921), and EAT. In the interview, he revealed that he exercised every day, alternating weight lifting with racketball, and reported that his goal was to be healthy. BDI = 25, MMPI-2 = 7–8–2 with a valid profile. On the Rorschach, the Optimized-R administration was utilized, and interpretation employed both R-PAS and Comprehensive System (CS). Some R–PAS and CS counts, ratios, and constellations are highlighted: R = 20, Y = 2, V = 2, M = 1, T = 2, FD = 2, C’ = 3, GHR = 3, PHR = 4, P = 3, SR = 2, SI = 2.9, H = 2, r = 3, Color shading blend = 1, ODL = 4 (1 dependency related, 2 food related), Complexity = 105, SC = 5, Vcom = 4.7, EGII-3 = 3.5, Afr = .8, DEPI = 5, CDI = 5. WDA% = .80. Of note is his responses on Cards I: “an ominous bat”; III, “two men fighting and one has been bruised with the blood spurting out”; VI, “intercourse with the top a penis entering the vagina.” EAT = 19. A score of 20 for females is associated with ED, but for men with ED scores are more variable and less reliable. He was more preoccupied with fitness than thinness, and this lowered his score somewhat. There were also no purging behaviors, which are more characteristic of men than women with similar scores. His body dissatisfaction was moderately high, but he also had been able to lose 20 pounds during the past year.
Discussion

His BDI score, MMPI profile, and Rorschach scores were consistent with the hypothesis that his difficulties have both depressive and anxious components. High V, FD, and r suggested that his depression is extremely painful, given that there appears to be much critical and self-reflective angst. High scores on MMPI subscale 8 and SUM6 = 6 (all level 1) suggest some unusual and isolating thought processes, even though X+ is relatively healthy. High 8 on the MMPI is due to Harris-Lingoes (Harris & Lingoes, 1968) elevations on social and emotional alienation and lack of ego mastery (cognitive and conative) rather than bizarre sensory experiences. His previous defenses may be overwhelmed by the loss of his mother, which may also have created the foundation for his intense dependency needs, suggested by his high T and ODL scores. At the same time, his low H suggests that he is not likely to seek out other relationships to meet those needs, which has implications for the therapeutic relationship. If only standard testing was completed for John, we might be left with a diagnosis of Major Affective Disorder. ODL provided the only clue that additional pathology might be present.

John did not present for treatment of an ED and did not acknowledge in the initial interview that this could be a significant problem. This presentation is not atypical for males, who present with ED symptoms less often than females. There was even a denial of bingeing and dieting to the interviewer, but the EAT revealed that he does engage in dieting behaviors, and likely the bingeing behavior followed as a result of the restraint. His overall score fell within the mild ED range. Male patients are generally more ashamed than females of these behaviors and are less likely to report them as symptoms in an interview. This possibility was supported by his high V and r scores on the Rorschach, which suggest a painful experience in his self-reflection. He scored within the ED range, although no efforts at purging were evident. In retrospect, administration of the EDAM may have been more advantageous, as his lifting weights may be Muscle Dysmorphia. High scores on the ODL in conjunction with his EAT profile suggested that John is likely to have unmet dependency needs and body image dissatisfaction. The stressor of his mother’s death may have fostered a lack of interest in eating and the initial weight loss. Body image dissatisfaction displaced the focus from his loss. Successful weight reduction supported self-efficacy and replaced previous feelings of loss of control around his mother’s death. The confluence of self-dissatisfaction and previous weight gain fueled a focus on an internalized thin ideal and fit physique. Exacerbated by his mother’s death, this pressure recruited John to engage in negative self-reflections of his body image, food restriction, excessive exercise, and some binging. While initially the result of the loss of his mother, these feelings and behaviors now appeared to be occupying a good portion of his psychic energy.
**Practical Points**

- Many research samples that utilized the major ED assessments (e.g., EDE, EDI) consisted of females, and gender role and sexual orientation information was rarely included. There is a risk when using these measures with sexual minority clients that the cutoff scores and categories of ED thoughts and behaviors may not be appropriate. Therefore, results should be interpreted with special consideration.

- Males may present with a different pattern of symptoms than have been traditionally captured by the most common ED assessments. Use of measures such as the EDAM may be beneficial.

- Since gender role identification, sexual orientation, and gender identity may play a part in issues related to eating disorders (e.g., body dissatisfaction, social and familial factors), evaluators should include questions or measures that directly address gender issues when assessing for eating disorders.

- Providers could consider screening for internalized heterosexism (for brief measures for clinical practice, see Szymanski, Kashubeck-West, & Meyer, 2008) with sexual minority patients to identify individuals who are at potentially increased risk of disordered eating behaviors.

- While individuals may not be willing to disclose disordered eating behaviors, incorporating self-report measures to assess awareness and internalization of norms valuing thinness could allow clinicians to identify clients who are at potentially increased risk.

- In establishing culturally competent practices, providers may consider including items assessing for sexual orientation with their regular intake materials.

**Annotated Bibliography**


*Comment:* The authors noted that most previous research on ED has been conducted with white, heterosexual women and that more empirical studies are indicated with women from diverse backgrounds. They provided a general discussion of methodological issues when studying sexual orientation followed by a review of the literature on the interaction of sexual orientation with ED. Research to date has produced inconsistent results, with some studies noting less body dissatisfaction in sexual minority women, while other studies have found increased ED behaviors related to obesity and binge eating. Several factors to explain differences in disordered eating related to sexual orientation with some empirical support were discussed, including sexual attraction, gender-related traits, and feminist beliefs.

Comment: Jones and Morgan provided a review of the literature about ED in men, including similarities and differences to women and theoretical suppositions regarding gender discrepancies. Issues included age of onset, body dissatisfaction, methods of weight control, sexual orientation, social learning and muscle dysmorphia, bias in diagnosis, biological findings, psychiatric comorbidity, and treatment considerations. The article is helpful as a brief overview of the above issues, to raise awareness regarding signs and symptoms for clinicians working with men both for evaluation and treatment of potential eating disorders, and the references provide ample further readings from both empirical and theoretical perspectives.


Comment: MacDonald presented a literature review regarding ED and queer women, which indicated a scarcity of research and stereotypical ideas. EDs have traditionally been conceptualized as impacting mainly middle- and upper-class white heterosexual women, with the assumption that queer women were insulated. The heterosexism within the ED literature was discussed as related to heterogeneity of gender role orientations, cultural beauty standards and queer women, and the etiology of EDs. The article is beneficial as a theoretical view of the interaction of EDs and gender in women, for clinicians who are interested in a discussion of the possibility of a treatment protocol with the potential for culturally competent modifications, and for researchers who may want to further develop an area with a scarcity of conclusive knowledge. Although assessment was not directly addressed, consideration of issues such as gender role and sexual orientation within the assessment and treatment process would be an essential component adaptation of treatment for queer clients.

Notes

1 Transient feeding disturbances are prevalent in children, including 25% to 40% of typically developing and up to 80% of developmentally delayed children (Bryant-Waugh, Markham, Kreipe, & Walsh, 2010). Although most have underlying medical issues, 80% also have a behavioral component. Thus, problems are complex interactions between organic, environmental, and family systems.

2 Medical disorders such as gastroesophageal reflux disease must be ruled out (Papadopoulos & Mimidis, 2007).

3 In addition, the presence or absence of amenorrhea does not clinically distinguish anorexic women (Attia & Roberto, 2009).

4 For example, Poland (Pilecki et al., 2013), Iran (Jalali-Farahani et al., 2015), Hong Kong (Lai, Mak, Pang, Fong, Ho, & Guildan, 2013), and Norway (Von Soest & Wichstrøm, 2014).

5 Almost all studies assessed only female participants and gender orientation or preference was rarely reported. Where sex was noted, studies required a male-female forced choice selection with such small numbers of males that made separate analyses impossible. In the absence of an empirical framework, we make some inferences from other available literature and suggest how these factors may be involved with gender.

6 Most of these studies calculate their mortality rates by comparing death rates of groups with the disorder and those of the general population. With regard to ED, there is often no distinction between a death due to another comorbid medical condition, medical conditions that are caused or exacerbated by the ED, or suicide.
This quantitative difference may be the result of questions being more focused on “fatness” than “muscularity.” In addition, both overweight and underweight men report increased body dissatisfaction (Frederick, Peplau, & Lever, 2006). This bimodal distribution may weaken the strength of the association.

A valid 12-item version has been developed for populations in Norway (Lavik, Clausen, & Pederson, 1991).

Twenty-six of these item probes are specifically utilized to obtain diagnostic classification for DSM-IV and ICD-10 and are not used in the factor structure.

A detailed manual is available from the authors.

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Assessment of Feeding and Eating Disorders


According to the American Foundation for Suicide Prevention (AFSP, 2010), suicide is the tenth leading cause of death in the United States, and research shows rates of suicide are higher for men (78.9%) than for women (21.1%). Additionally, the Centers for Disease Control and Prevention (CDC, 2013) named suicide as the seventh leading cause of death for males, the second leading cause of death for 10- to 24-year-olds, and the fourth leading cause of death for 25- to 44-year-olds. Furthermore, in 2010, the AFSP reported that someone ended their life as a result of suicide every 13.7 minutes. The National Action Alliance for Suicide Prevention (2012) named a few populations that are at greatest risk for suicide, including American Indians/Alaskan Natives, individuals grieving the suicide of another, previous suicide attempters, members of armed forces and veterans, men in midlife stage, older men, and sexual and gender minorities (i.e., lesbian, gay, bisexual, transgender [LGBT] individuals). Indeed, empirical data show that LGB individuals are about 2.5 times more likely than their heterosexual peers to make a suicide attempt (Bolton & Sareen, 2011). Because of these numbers and far-reaching occurrences, it is imperative to understand what the term suicide means, especially as it applies to the specific sexual minority and diverse gender identity populations.

This chapter begins with a review of the various definitions of suicide and addresses empirically supported predictors of suicide risk. Next is an examination of suicide across gender and sexual minorities, wherein numerous studies have found higher suicide risk for these specific populations (Bolton & Sareen, 2011; Grossman & D’Augelli, 2007). Following this discussion, potential explanations for the increased risk observed across gender and sexual minorities is presented. A case study is offered to supplement the background literature and provide real-world application of the potential causes and correlates. Also, a table
of suicide risk assessment instruments is provided as a helpful and accessible tool to those in the field. Finally, the chapter concludes with a discussion of future directions in terms of research, training, and practical implications.

**Summary of Definitions of Suicide**

Terms associated with suicide, such as attempt, behavior, and self-injury, are difficult to define given the expansive research in this area. *Suicide* can be defined as “death caused by self-directed injurious behavior with any intent to die as a result of the behavior” or as a “self-initiated” attempt on one’s life that results in death (CDC, 2013; Van Orden et al., 2010, p. 576). A suicide attempt is “a non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior” and “may or may not result in injury,” while suicidal ideation is “thinking about, considering, or planning for suicide” (CDC, 2015). Further, suicide-related behaviors include thoughts or ideations and “communications” in relation to ending one’s life (Van Orden et al., 2010, p. 576). Self-harm and self-destructive behaviors differ from suicide attempts largely in intent or purpose, and self-injurers with intent to die may be referred to as suicide attempters, while those without intent as suicide gesturers (Kidd, 2003; Nock & Kessler, 2006).

What is most important in understanding these terms is the continuum of risk associated with suicide or related behaviors. This risk spans from “non-existent to mild, moderate, severe, to extreme as intent emerges and becomes clearer in both objective and subjective indicators” (Bryan & Rudd, 2006, p. 197). This model relies on thoughts, plans, intent to end one’s life, self-control, and mood symptoms, among other indicators to predict risk for suicide (Bryan & Rudd, 2006). Finally, one theoretical perspective includes the interpersonal theory of suicide, which suggests that feelings of thwarted belongingness and perceived burdensomeness increase suicidal desire and affect one’s capability to engage in suicidal behavior (Van Orden et al., 2010). Feeling as though one does not belong (i.e., thwarted belongingness) and as if one is a burden to loved ones (i.e., perceived burdensomeness) can be significant cognitions related to suicide risk assessment.

In terms of predicting suicide risk, one longitudinal study found that, at the multivariate level, being female, having a previous suicide attempt, and nonheterosexual sexual interest predicted future suicide attempts and self-injury without intent to die (Wichstrøm, 2009). Other research shows differences across males and females in suicide attempts, with predictors such as characteristics of anger, victimization experiences, substance use, post-traumatic stress, and previous suicide attempt history (Monnin et al., 2012; Sadeh & McNiel, 2013). In terms of risk factors for reattempting suicide, post-traumatic stress and elevated levels of depression were significant predictors for women, while substance use was a significant predictor for men (Monnin et al., 2012). For men and women who have experienced childhood sexual victimization, physiological arousal
predicted suicide attempts for women, while proclivity for angry behavior predicted suicide attempts in men (Sadeh & McNiel, 2013). Also, one study found identifying with other-sex gender roles to be a significant predictor of suicidal symptoms, accounting for more of the overall variance in suicidal symptoms than sexual orientation (Fitzpatrick, Euton, Jones, & Schmidt, 2005). Being at greater risk for ending one’s life because of sexual or gender minority status warrants further exploration.

**Suicide Across Gender Identity and Sexual Orientation**

To begin with, briefly redefining gender identity and sexual orientation is imperative to understanding suicide-related behaviors within this population. Sexual orientation is often defined in terms of a continuum, where dimensions of sexual behavior, attraction, fantasy, emotional preference, and others can fluctuate across time according to degrees of same-sex attraction or opposite-sex attraction (The Kinsey Institute, 2011; Klein, Sepkoff, & Wolf, 1985). One alternative definition includes categorical labels (i.e., lesbian, gay, bisexual), wherein a respondent chooses a label of best fit (Russell, Clarke, & Clary, 2009). Another alternative definition involves an experiential and multidimensional model of sexual identity based on the various experiences (e.g., disclosure of one’s sexual identity, acceptance, concealment) shared by sexual minority individuals (Mohr & Kendra, 2011).

The American Psychological Association (APA, 2011) defines gender identity as one’s sense of self and identification as male, female, or transgender. Gender may refer to culturally expected norms for one’s biological sex, and transgender describes when one’s biological sex does not match these societal expectations (APA, 2011; Singh, 2013). Sexual and gender identity are often widely described in terms of categories, although the dimensional and fluid natures of sexual orientation have been explored (APA, 2011). Gender roles can also be described in terms of societal expectations of being male or female, while gender identity is a more fluid construct related to the individual’s internal sense of identification along a masculine–feminine continuum (Nagoshi, Brzuzy, & Terrell, 2012). Within the transgender population, there are individuals who are transitioning from their biological sex to their self-identified gender. Transitioning individuals include females at birth who are currently living and identifying as male (i.e., female-to-male, transgender man) and males at birth who are currently living and identifying as female (i.e., male-to-female, transgender woman; National Center for Transgender Equality, 2014).

As previously indicated, suicide represents a concern for the general population, yet individuals with certain gender identities and sexual orientations are at particular risk. Sexual minorities (i.e., LGB) are about 2.5 times more likely than their heterosexual peers to make a suicide attempt (Bolton & Sareen, 2011). For instance, Bolton and Sareen (2011) reported elevated rates of suicide risk (approximately 2.5 times) based on a nationally representative sample of
over 30,000 adults in the community. Suicide attempt history was measured by a single item asking if the participants had ever attempted suicide in their life (Bolton & Sareen, 2011). More generally, Bolton and Sareen (2011) concluded that sexual minority individuals experience greater mental health problems in addition to suicide attempts than do their heterosexual peers. Explanations of this connection will be addressed later on within this chapter.

Other research has also demonstrated higher rates of suicide attempts among sexual minority individuals, inclusive of greater intent to die, resulting injuries, and expectations of death, than among heterosexual counterparts (Plöderl, Kralovec, & Fartacek, 2010). Further, more recent analyses reviewing psychological autopsy studies reveal that sexual minority individuals are also at greater risk for completing suicide as well as attempting to take their life (Plöderl et al., 2013). The results also suggest the ethical importance of targeting sexual minority individuals for suicide prevention strategies (Plöderl et al., 2013). Across cultures, sexual minority males reported higher rates of suicide attempts than heterosexual males sampled from an Internet survey within Asia, Australia, North America, and South America (Mathy, 2002). There is some variation in the link between region, sexual identity, and suicide attempts, as the difference occurred for female sexual minority individuals only in participants from the North American sample (Mathy, 2002). It is important to be mindful of the definitions of suicide, suicide attempt, and related behaviors explained previously in reviewing the literature or applying these terms cross-culturally.

Transgender individuals are also an important population to consider. Kenagy (2005) found that approximately one-third (30.1%) of transgender participants reported “yes” when asked a dichotomous question of whether they had ever attempted to take their own life. Of those who reported attempting suicide, about two-thirds indicated their attempt was related to their transgender identity. These participants were surveyed as part of a larger study of two needs assessments for transgender community members in the northeastern United States (Kenagy, 2005). In another study assessing transgender youth, 45% of participants reported seriously considering taking their life (i.e., suicidal ideation), while 26% reported a history of suicide attempts (Grossman & D’Augelli, 2007). About 70% of those who reported attempting suicide indicated their attempts were related to their transgender identity, resulting from difficulty accepting their own identity or having a more difficult life due to their minority status. Data for this study were taken from a larger study of LGBT youth who participated in two social and recreational agencies specifically for this targeted population. Suicide ideations were measured through three questions asking about specific thoughts regarding taking one’s life, while suicide attempts were assessed through questions regarding seriousness and severity of the attempt (Grossman & D’Augelli, 2007).

Research looking across sexual minority and transgender youths from the community suggests that high levels of psychological distress and suicidality are found within this population (Mustanski, Garofalo, & Emerson, 2010).
Participants were assessed across suicidal ideations, suicide plans, suicide attempts, and lifetime suicide attempts as defined by the Computerized Diagnostic Interview Schedule for Children (Mustanski et al., 2010). Almost half (45%) of transgender participants, 34% of lesbian or gay participants, and 21.4% of bisexual participants reported attempting suicide in their lifetime (Mustanski et al., 2010). Overall, research shows that sexual minority and transgender individuals are at greater risk for ending their own lives than are heterosexual peers, and their identity or minority status plays a critical role within this elevated risk. Assessment of the specific difficulties they may be experiencing related to their sexual orientation or gender identity could prove beneficial.

**Potential Explanations and Correlates**

When determining potential causes and correlates, research demonstrates general explanations for poor mental health seen within sexual minority and transgender individuals. There appears to be limited research examining these explanations as they relate specifically to suicide. One model describes internalized homophobia, or prejudice directed toward oneself that involves accepting society’s negative attitudes toward sexual minorities, as a part of one’s own self-concept and is a form of self-stigma (Herek, Gillis, & Cogan, 2009). Herek and colleagues (2009) utilized a lesbian, gay, and bisexual sample broken into male and female groups. They determined higher levels of internalized homophobia were associated with high levels of psychological distress (i.e., depressive symptoms and state anxiety; Herek et al., 2009). Also, the experience of discrimination based on one’s sexual orientation is associated with sexual minority–specific stress, which has been linked to subsequent suicidal behaviors (Meyer, 2003). It is evident that one’s identity status plays a critical role in subsequent mental health outcomes and suicide risk.

Detailed exploration of sexual prejudice is warranted within the discussion of general poor mental health outcomes and increased suicide-related behaviors for sexual and gender minorities. Sexual prejudice is defined as negative attitudes toward LGB individuals and their sexual minority status or orientation (Her, 2000; Martinez, 2011). These attitudes are what form the basis of internalized homophobia and sexual minority–specific stress mentioned previously. Additionally, transphobia refers to negative attitudes and beliefs about individuals “who do not conform to traditional notions of sex and gender” (Sugano, Nemoto, & Operario, 2005, p. 217). Sugano and colleagues (2005) noted that of the transgender female participants sampled, those individuals over the age of 25 or who were HIV-positive reported higher rates of transphobia than their younger or HIV-negative counterparts. Moreover, transgender male-to-female participants who reported a history of suicidal thoughts also experienced more transphobia, a greater need for social support, and depressive symptoms (Nemoto, 2011).

Though the correlates and consequences have been discussed, it is equally important to consider how the negative attitudes described previously manifest...
in society. Experiences of sexual prejudice and transphobia are often assessed in terms of interpersonal actions or behaviors (e.g., harassment, loss of job/housing, assault); it is therefore important to recognize social media’s role in dissemination of information regarding these events. As an example, online applications such as PrejudiceTracker allow users to view interactive maps of prejudicial events reported by victims or observers from around the globe (PrejudiceTracker, 2014). Though online users can report abusive content from social media sites like Facebook and Twitter, it can be difficult to ascertain the consequences of such actions. Of over 6,000 adults surveyed by the Pew Research Internet Project (2013), 73% use some form of social networking site. Because many people are utilizing the Internet for social media, the potential to find others who share negative societal attitudes appears simple.

The coming-out process is also a significant piece of one’s identity status to examine, as this experience differs from heterosexual peers. During the process of disclosing one’s sexual identity, internalization of negative reactions from others puts sexual minorities at greatest risk for suicide-related behaviors (Igartua, Gill, & Montoro, 2003). Important risk factors for LGBT individuals include “depression and experiences of stigma and discrimination” (i.e., “harassment, bullying and family rejection”) (The Trevor Project, 2011). Mereish and colleagues (2014) determined that substance abuse partially explained the relationship between victimization based on one’s gender or sexual minority status and suicide attempts. Results revealed that substance use significantly explained the relationship between LGBT-based victimization and suicide attempts for sexual minority women but not men (Mereish, O’Cleirigh, & Bradford, 2014). The study included a large and diverse sample of LGBT individuals within a community health center setting and is a recent attempt to explain the connection between higher rates of suicide attempts and sexual minority or gender minority status (Mereish, O’Cleirigh, & Bradford, 2014). In addition, another study determined that symptoms of depression, conduct disorder, hopelessness, and impulsivity were correlated with suicide attempts, while parental support was considered a protective factor among LGBT youths in a community sample (Mustanski & Liu, 2011). Mustanski and Liu (2011) related lack of parental support to feelings of thwarted belongingness, which is further discussed below within theoretical framework explanations. As demonstrated by the literature, internalized homophobia and sexual minority and gender-specific stress are potential explanations for the greater suicide attempt risk observed within these populations.

Sexual Prejudice, Suicide, and Sexual Orientation: A Case Illustration of Tyler Clementi

The infamous case of Tyler Clementi has been sensationalized and newsworthy since his death in 2010. Tyler was a freshman student at Rutgers
University who had just recently begun disclosing his gay identity to close friends and family prior to entering college (The Tyler Clementi Foundation, 2014). His roommate recorded Tyler (without his knowledge) engaging in intimate acts with a same-sex partner while in their bedroom and invited others in the community to view the video on the Internet. His roommate also discussed Tyler’s sexual behaviors on social media, which quickly turned into public scorn and disapproval of Tyler’s lifestyle. Reportedly, as a result of the cyberbullying he experienced, Tyler ended his life shortly after the video was viewed.

Tyler’s case is one filled with lingering questions about the prejudice and potentially negative internalized consequences he experienced. In regards to Tyler’s identity experience in general, he appeared to be disclosing his sexual identity cautiously. He also experienced rejection from his peers, including those on social media. As a result, Tyler may have been experiencing feelings of loneliness and worthlessness as a result of the prejudice he endured. Though Tyler’s case is one of several stories circulated among news sources, it provides examples of critical components to assess when working with sexual and gender minority populations who are at elevated risk for suicide.

An Empirically Based Theoretical Model

Interpersonal cognitions such as perceived burdensomeness partially accounted for the relation between sexual orientation and suicidal ideation (Hill & Pettit, 2012). Furthermore, students who “perceived or anticipated rejection from others due to their sexual orientation were especially likely to experience perceived burdensomeness” and increased levels of suicidal ideation (Hill & Pettit, 2012, p. 576). The interpersonal theory of suicide (IPTS), as described earlier, may involve sexual minority individuals feeling as though they are a burden and do not belong as a result of their minority identity status. Sexual minorities’ perception of their interpersonal functioning seems related to both their sexual identity and suicide behaviors. Elaboration of the IPTS model joins it with the Five-Factor Model of personality (Cramer, Stroud, Fraser, & Graham, 2014). Thwarted belongingness and perceived burdensomeness accounted for the association between certain personality traits (i.e., neuroticism, extraversion, and agreeableness) and suicide proneness (Cramer et al., 2014). Cramer and colleagues (2014) posit that higher levels of neuroticism, lower extraversion, and lower agreeableness “may contribute to, or exacerbate the loss of support, inducing entrenched thoughts of thwarted belongingness or perceived burdensomeness, and resulting in suicidality” (p. 10).

As this study suggests, individual differences appear to play a role in the application of the IPTS model to suicidal risk across the sexual minority population. Also, LGBT youth reported higher rates of bullying than did
heterosexual peers, and persistent bullying has been shown to lead to feeling isolated, rejected, excluded, hopeless, anxious, and depressed, all of which can lead to suicidal behavior (The Trevor Project, 2011). IPTS constructs of perceived burdensomeness and thwarted belongingness may result from these specific discriminatory experiences and provoke subsequent internalization of sexual prejudice.

**Overview of Suicide Assessment Instruments**

Table 14.1 depicts typical suicide assessment instruments used in clinical practice and across the literature base. The table includes a general description of the instrument, validated samples, a brief account of psychometric properties where available, and whether there is an examination of the instrument across diverse sexual orientation or gender identity samples.

Overall, the presented suicide assessment instruments were developed solely in male and female identified reference groups. Of particular importance, these scales all involve variations of self-report. The RFLI takes a different route in obtaining the same information as the other measures, as the questions are related to living rather than ending one’s life. Higher scores on this measure would indicate a greater reason for living, whereas on the other measures, higher scores might indicate greater reasons for ending one’s life (e.g., hopelessness, helplessness, burdensomeness). The INQ addresses the interpersonal constructs mentioned earlier of perceived burdensomeness and thwarted belongingness, which are considered to underlie suicidal desire (Van Orden et al., 2010). Hill and Pettit (2012) suggest “screening for potential suicide risk based on perceived burdensomeness may help identify” those “at elevated risk for suicidal ideation” (p. 576). Determining which measure to choose in evaluating a client’s suicide risk involves a deeper understanding of the client’s presentation and the specific mechanisms or information needed.

A measure by Chu and colleagues (2013) may be the developing link between the assessments presented and consideration of sexual and gender identity. The Cultural Assessment of Risk for Suicide (CARS) measure includes questions related to the stress one experiences in identifying as a sexual or gender minority. Evaluating cultural components such as cultural sanctions, idioms of distress, and minority stress, the CARS was shown to differentiate between individuals with and without history of suicide attempts. Given the various tools available in suicide assessment, the clinical interview is an equally important piece to understanding the client’s presentation. These instruments can be utilized to inform clinical and diagnostic interview questions, to assess aspects of suicide risk, and to especially inform treatment recommendations. The notable limitation must be acknowledged, however, that normative data may be lacking for measures with regard to sexual orientation and special populations (e.g., psychiatric inpatients).
### Table 14.1 Suicide Assessment Instruments

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Description</th>
<th>Validated Samples</th>
<th>SO or Gender?</th>
<th>Psychometrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Behavior Questionnaire (SBQ-R; Osman, Bagge, Gutierrez, Konick, Kopper, &amp; Barrios, 2001)</td>
<td>4-item brief self-report measure of suicidal behavior</td>
<td>Inpatient adolescents, high school students, psychiatric inpatient adults, undergraduates</td>
<td>No</td>
<td>Grouped gender dichotomously male/female Alphas ranged from .76 to .87 for each sample.</td>
</tr>
<tr>
<td>Beck Scale for Suicide Ideation (BSI; Beck, Kovacs, &amp; Weissman, 1979)</td>
<td>24-item self-report measure to assess ideation, plan, and intent</td>
<td>Consecutive inpatient admissions hospitalized for self-destructive ruminations</td>
<td>N/A</td>
<td>Reliability coefficient = .83. Correlation of BSI and BDI $r = .41, p &lt; .001$. Hopelessness and depression positively correlated with suicidal ideation ($r = .47$ and $.39, p &lt; .001$).</td>
</tr>
<tr>
<td>Suicide Cognitions Scale (Rudd, Schmitz, McClenen, Joiner, Elkins, &amp; Claassen, in press)</td>
<td>18-item self-report instrument that assesses unloveability and unbearability dimensions of hopelessness within suicidal beliefs</td>
<td>College students, psychiatric inpatients, emergency room patients</td>
<td>N/A</td>
<td>Alphas ranged from .96 to .97. Shown to add incremental validity beyond the Beck Hopelessness Scale in predicting suicide risk. Also can distinguish between individuals with varying levels of attempt history.</td>
</tr>
<tr>
<td>Modified Scale for Suicide ideation (MSSI; Miller, Norman, Bishop, &amp; Dow, 1986)</td>
<td>Semi-structured interview that assesses severity of suicidal ideation</td>
<td>Samples included inpatients with MDD diagnoses and inpatient admissions</td>
<td>N/A</td>
<td>Screening criteria alpha = .86. Item-total correlations ranged from .57 to .79. Total score alpha = .94. Item-total correlations ranged from .41 to .83. Total score correlated with suicide items from BDI and MHRSD, $r = .60$ and $.34$.</td>
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(Continued)
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Description</th>
<th>Validated Samples</th>
<th>SO or Gender?</th>
<th>Psychometrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Needs Questionnaire (INQ; Van Orden, Cukrowicz, Witte, &amp; Joiner, 2012)</td>
<td>15 items that assess thwarted belongingness and perceived burdensomeness. Assesses causes for suicidal desire and relative areas of intervention.</td>
<td>Undergraduates, outpatient community clinic adult clients, older adults</td>
<td>No Grouped gender dichotomously male/female</td>
<td>Used also UCLA Loneliness Scale, Responsibility to Family subscale of RLI, Self-Liking/Competence Scale, Basic Need for Satisfaction in Life Scale, Belonging support subscale of Interpersonal Support Evaluation List as discriminant with constructs of perceived burdensomeness and thwarted belongingness. Higher levels of thwarted belongingness and perceived burdensomeness from INQ were associated with increased reporting of suicidal ideation. Scales of survival and coping, responsibility to family, child-related concerns, and moral objections are negatively related to recent suicidal behavior and projected future behavior. Survival and coping scale correlated negatively with Depression and Social Introversion scores on MMPI.</td>
</tr>
<tr>
<td>Reason for Living Inventory (RFLI; Linehan, Goodstein, Nielson, &amp; Chiles, 1983)</td>
<td>Derived of beliefs related to not dying by suicide (i.e., “life-oriented”). Degree of importance is rated and attached to each reason for living.</td>
<td>Shopper sample, inpatients from a psychiatric unit</td>
<td>No Grouped gender dichotomously male/female</td>
<td></td>
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</tbody>
</table>

*Note: SO = Sexual Orientation*
Clinical Interviewing and Suicide Assessment

The American Psychiatric Association (APA, 2003) provided recommendations on what to include in a thorough clinical suicide risk assessment. Some of the general topics include current presentation of suicide-related symptoms, psychiatric symptoms, detailed history (i.e., medical, mental health, suicide attempts, and substance use), psychosocial factors, and individual strengths and vulnerabilities. Questions regarding suicide and related behaviors need to be direct and specific. Once a client or patient endorses thoughts regarding suicide, evaluation of intent, plan, and lethality should follow. Bryan and Rudd (2006) offer a hierarchical approach to this line of questioning. It should include specifically asking about the precipitants (e.g., “What has been stressful lately?”), symptom presentation (e.g., “You sound extremely sad. Can you describe that for me?”), hopelessness (e.g., “Do you feel like things will never be better?”), and suicidal thinking (e.g., “Have you thought about killing yourself?”). The APA (2003) also suggests it is important to determine the severity of risk factors associated with increased suicidality, and documentation of this assessment in its entirety is crucial. As research suggests, a few risk factors for suicidality include previous suicide attempts, same-sex sexual orientation, feelings of hopelessness and helplessness, impulsivity, mental health symptoms, and social isolation (Bryan & Rudd, 2006; Van Orden et al, 2010). Assessment of protective factors (e.g., social support, coping skills, religion) is also a critical component (Bryan & Rudd, 2006).

Further, the Collaborate Assessment and Management of Suicide (CAMS) is one model that emphasizes suicidality as a central clinical problem, not a symptom, and involves both a strong therapeutic alliance and interactive assessment process (Jobes, 2012). Utilized in the CAMS model is the Suicide Status Form, a multipurpose assessment tool that includes evaluation of psychological pain, stress, agitation, hopelessness, self-hate, and overall risk of suicide (Jobes, 2012). In sum, the clinical interview for suicide risk involves a detailed and empathic exploration of clients’ history, symptoms, and beliefs regarding ending their own life.

Future Directions

Research

Validation studies should be conducted of internalized homophobia models assessing the role of sexual prejudice in relation to suicide-related behaviors and attempts. Also, studies validating other theoretical perspectives, including the interpersonal theory of suicide, would provide additional support to the literature base. Previous studies by Hill and Pettit (2012) and Cramer and colleagues (2014) are foundational steps toward understanding and managing suicide risk for sexual minority individuals. Perceived burdensomeness partially explained
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the connection between sexual orientation and suicidal ideation, and both this construct and thwarted belongingness accounted for the association between neuroticism, extraversion, agreeableness, and suicide proneness (Cramer et al., 2014; Hill & Pettit, 2012). Comprehending the theoretical frameworks consistently validated within this population would allow for more comprehensive assessment and a better understanding of how societal influences interact with elevated suicide risk observed in sexual and gender minorities. Other studies should include validation of suicide measures (e.g., norms, psychometrics) among LGBT and other gender minority groups. This would foster more inclusive measures with appropriate norm populations.

Additionally, future research should examine multicultural-based studies exploring gender and sexual identity of evaluators and how this identity affects perceptions and outcomes of assessments. One study found that female clinicians viewed clients in general more favorably than did male clinicians, with both groups overall viewing female clients as stronger and more powerful than male clients (Bowers & Bieschke, 2005). Male clinicians also perceived LGB clients as more pathological than did female clinicians (Bowers & Bieschke, 2005).

The vignette utilized within this study featured a client who was experiencing moderate mood symptoms, and this methodology could be applied using a vignette involving assessment of suicide-related behaviors. It should also be expanded to assess a more diverse sample of psychological assessors in terms of their sexual orientation and gender identity. Similarly, a vignette could be used to evaluate a potential client's perspectives of an assessor with sexual or gender minority identity. This research could then relate perceptions of sexual orientation and gender identity of both assessor and client, and how this affects the evaluation process or even treatment recommendations.

In another study, no significant differences were found across male, female, and sexual minority community mental health clinicians regarding secondary stress and feelings of burnout (Connally, 2012). Future research could assess the stress-related consequences for clinicians of diverse gender identity and sexual orientation who have experience with clients exhibiting suicide-related behaviors.

**Training**

Another area of future direction could involve detailed training in intervention strategies and suggested techniques for working with clients of diverse gender identity and sexual orientations. Training could include recognizing and assessing constructs such as internalized homophobia, perceived burdensomeness, and thwarted belongingness. This training would be beneficial to assessors in developing the recommendations sections of their psychological reports, as assessors would be able to identify relevant and useful treatment strategies for sexual and gender minority individuals. In terms of potential interventions and
recommendations, affirmative and acceptance therapeutic approaches involve showing clients an understanding of the sexual minority identity processes, and the coming-out process should be considered during an intake assessment (Johnson, 2012). Affirmative therapy emphasizes sexual identity exploration and acceptance, and competent delivery from the clinician involves acceptance and support, comprehensive assessment, active coping, and social support (APA, 2009; Cramer, Golom, LoPresto, & Kirkley, 2008). Combining acceptance and affirmative therapeutic approaches with possible cognitive and interpersonal facets could improve clinical practice. As addressed previously, sexual minority individuals are at greatest risk for suicidal behavior when the components of perceived burdensomeness and thwarted belongingness are present, which can directly relate to internalized homophobia and discriminatory experiences. Training in affirmative approaches and the assessment of IPTS constructs as well as internalized homophobia would provide clients with the most wide-ranging and complete assessment.

Practical Points

- Practitioners should engage in cautionary application of suicide assessment tools in samples lacking adequate normative and validation data. Where used, these limitations should be noted in assessments, while working with clients, or in communication with other mental health professionals. As stated previously, higher suicide risk is seen in sexual minority individuals across studies (Grossman & D’Augelli, 2007; Mustanski et al., 2010). Because of this, thorough review of the measure in association with background information of the client is necessary to determine the appropriateness of administration for each individual case.

- Assessment for suicide-related behaviors and desire in LGBT persons should include interview-based evaluation of internalized homophobia, experiences of sexual prejudice, feelings of thwarted belongingness, and perceived burdensomeness. This would allow for a more comprehensive understanding of theoretically driven potential risk factors in an observed high-suicide-risk population.

Annotated Bibliography


Comment: The guidelines presented were developed by the APA Division 44 Committee on LGBT Concerns Guidelines Revision Task Force. APA provides guidance on LGB-affirmative approaches to assessment, treatment, research, and education.

Comment: This study assessed IPTS constructs of perceived burdensomeness and thwarted belongingness in prediction of suicidal ideation in a diverse sexual minority community sample. Perceived burdensomeness was found to predict suicidal ideation amongst gay men, lesbian women, and bisexual women.

References


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PART IV

Case Illustrations of Gender-Based Issues
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This chapter provides a detailed clinical illustration in which therapy and personality assessment are integrated with the constructs of gender, sex, and racial identity. The case is discussed in relation to transference and countertransference in what was a cross-racial (White therapist, Black patient) and predominantly supportive, psychoanalytic psychotherapy. There is also a review of the content of Rorschach test responses, transference, and countertransference from the perspective of the psychoanalytic literature on race, gender, sexuality, personality assessment, and supportive psychotherapy. The present case is unique in its effort to bridge personality testing, therapy, and a broad-based intersectional conception of gender, sex, and race within a psychoanalytic framework.

The chapter proceeds as follows: First, I offer a discussion of key terms that frame clinical work in the areas of gender, sexuality, and race. Second, I present a discussion of intersectionality as a clinical-social construct that moves identity away from a conceptual binary (i.e., male–female, Black–White, homosexual–heterosexual) toward a more flexible consideration...
of what constitutes conscious and unconscious self-representations. Third, I summarize some of the post-Freudian psychoanalytic considerations in the areas of sex, gender, and race that frame the discussion of the case. Fourth, regarding race, I focus on the cross-racial, cross-gender psychotherapy dyad as pertinent to the clinical material. The first four parts are foundational to the presentation of clinical material. Fifth, the clinical material is introduced, including referral and assessment findings that preceded the first and second therapies, along with rationales for (a) testing one’s own patient and (b) supportive psychodynamic psychotherapy, each of which are integral to the case. Sixth, I conclude with an integrated discussion of the main points that highlight the utility of intensive case study as a clinical demonstration of the science–practice interface.

**Literature Review**

**Definition of Terms**

The American Psychological Association (APA, 2012, p. 11) has provided guidance for psychologists with respect to gender, gender identity, gender expression, and sexual orientation: (a) gender represents “attitudes feelings and behaviors that a given culture associated with a person’s biological sex”; (b) gender identity “refers to one’s sense of oneself as male, female, or transgender”; (c) gender expression refers to how “a person acts to communicate gender within a given culture”; and (d) sexual orientation “refers to the sex of those to whom one is sexually attracted.” Together, these terms speak to the importance of understanding the way in which differences between people affect their interactions and the meanings derived from these interactions.

The APA (2003, p. 380) has also recommended guidelines on multicultural education, training, research, practice, and organizational change and defined key terms as related to these competencies: (a) “Culture is defined as the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes . . . and organizations.” Culture is seen as a “worldview,” encompassing “religious and spiritual traditions,” “fluid and dynamic,” with constructs that are “universal and specific” or “relative.” (b) Race is described as “the category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result.” (c) Ethnicity is described as “the acceptance of the group mores and practices of one’s culture of origin and the concomitant sense of belonging.” (d) Multiculturalism and diversity are described as having been used “interchangeably to inclusive aspects identity stemming from gender, sexual orientation, disability, socioeconomic status, or age.” These definitions show considerable overlap with The Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-5; American Psychiatric Association, 2013, p. 749) definitions of race (i.e., categorization based on a variety of “superficial physical
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traits”), culture (i.e., intergenerational knowledge, rules, concepts, and practices), and ethnicity (i.e., culturally constructed group identity).

What is noteworthy here is the distinction of concepts. Delineation of terms is an important component of professional exchange, but it may not capture the fluidity of such terms in real time and the manner in which they infuse each other to inform identity. The next section addresses this point as it relates to the concept of “intersectionality.”

Intersectionality

Intersectionality is an emerging area of research that studies the relationship between race, gender, and sex as impacting an individual’s social identity (Warner & Shields, 2013). It focuses on the roles of power and oppression in the marginalization of underrepresented groups. According to Warner and Shields, “The upshot of this for psychologists is that social identities cannot be studied independently of one another, nor separately from the processes that maintain inequality (be it racism, sexism, classism, ableism, or heterosexism)” (p. 804). Thus, from this perspective, categorical designations of race, gender, sex, and class are each subject to different forms of oppression that are internalized in unique ways, receive different degrees of affirmation to buffer (or buttress) obvious and subtle forms of oppression (e.g., Sue, 2010), and affect social identity and perception. Cole (2009) advocated for a more inclusive research methodology that, for example, allows for the study of “groups belonging to multiple subordinated categories” (p. 172), with an emphasis on asking questions about the inclusion group, the role of inequality, and similarities between or among groups at different stages of the research process (e.g., hypotheses, sampling, operationalization, analysis, and interpretation). The goal here would be to minimize discrete categories as confounding independent variables (e.g., race, gender) when the population under study comprises individuals identified with multiple categories.

Graham and Padilla (2014) also described intersectionality: “Sexuality, gender, race, ethnicity, citizenship, and many other socially constructed designations, along which marginalization and privilege play out, are never disconnected from each other” (p. 251). Katz-Wise and Hyde (2014) elaborated the meaning of intersectionality in relation to sex and gender in the following way: “Sexuality and gender are each conditioned by other categories, especially race/ethnicity, social class, and religion” (p. 30). Reid, Lewis, and Wych (2014) addressed the intersection of social identities such as race, gender, and sexuality, noting that gender was “an overarching social construction that represents patterns of social relations and practices” (p. 379). Here, gender was seen as interacting with symbols of class, culture, religion “and other social identities” (p. 387) as a primary concept in the construction of identity. Ferber (2013) described how race could not be understood apart from gender and sexuality, noting that racial differences, gender, and sexuality were each byproducts of inequality and oppression.
In Chapter 2 of this volume, Brabender and Mihura discussed the challenge of capturing the entirety of an individual's identity through psychological assessment and provided assessment examples highlighting the way in which multiple marginalizing experiences tied to such factors as age, developmental disability, gender, and sexual orientation impact one person's psychological adjustment. While an assessor has to titrate diagnostic inferences around referral questions directed toward the patient's needs, the emerging literature on intersectionality suggests that the patient is hardly a discrete entity. Whether implicit or explicit when reporting personality assessment findings, the assessor needs a theory for understanding the patient beyond a series of descriptive statements.

Two main factors affecting a patient's conception of self and others are sex and gender, both of which have been long-standing foci of psychoanalytic theory. The broad scholarship of psychoanalytic theory has moved beyond the original stage-related (e.g., oral, anal, phallic-genital) and outcome-based (e.g., heterosexual-homosexual) binaries articulated by Freud (Archer & Lloyd, 2002; Schafer, 1997). In what follows I present a brief review of some shifts in psychoanalytic theory in the areas of gender and sex.

**Psychoanalytic Considerations**

The psychoanalytic community has made great strides in its understanding of gender and sexual orientation since the early writings of Freud, but Freud, too, despite clear-cut critiques of his work as masculinizing, authoritative, and fraught with binaries, grappled with the nuances of gender and sex. Indeed, Freud grappled with the question of sexuality throughout his writings, moving from theorizing an innate bisexuality to a position in which phallocentrism and heterosexuality were privileged. In his technique papers, he showed a technical forcefulness and lack of empathy associated with a gendered power differential in his case study of Dora (1905/1981), where he wrote about the sexual origins of somatic conflicts. In contrast, his paper on transference love (1915/1981) demonstrated great empathy when describing the way in which, in this case, gender-based power differentials (male analyst, female patient) impact sexual feelings. Freud's “Letter to Anonymous” (1935), written toward the end of his life, highlighted another aspect of his internal dialogue related to sexuality. In his letter, Freud replied to a parent who sought Freud's advice on an analysis for whom Freud presumed to be the parent's homosexual son. In his response, Freud appeared to struggle with the possible outcome of analysis; it was not clear, for example, if he took seriously what he inferred as the parent's request to “abolish homosexuality and make normal heterosexuality take its place” (p. 423). Compassion was expressed in Freud's reply: “It is a great injustice to persecute homosexuality as a crime—and a cruelty, too” (p. 423).

Since Freud, notable psychoanalytic scholars have worked diligently to reframe his position on sex and gender in ways that align with clinical experience. I mention the works of a few such writers to demonstrate efforts to shift
the tide on conceptions of gender and sex. Fast (1990) highlighted flaws in Freud’s phallocentric argument, taking umbrage specifically with his description of the clitoris as a male organ and conception of female gender identity as a default position and also focusing on the boy’s bisexual wishes and the meaning of relinquishing of an omnigendered psychology for both sexes as part of development. In Freud’s model, the male superego, born from castration anxiety and tied directly to the power and authority of the father, was more developed than the superego of the female, internalizing a stronger fear of punishment and consequence than the female superego. Bernstein (1983) took Freud to task on his conception of an underdeveloped superego in the female, drawing on the significant influence of pregenital factors, which Freud had overlooked, and discussing how the strength, structure, and content of the female superego was both mature and modeled on a representation of an omnipotent maternal figure. Schafer (2002) spoke eloquently of the problems with Freud’s concept of non-normative sexuality and, based on studies in postmodern feminist theory, “certain implicit, unexamined, and disruptive preconceptions about gender that we analysts are in danger of imposing on our material” (Schafer, 1997, p. 35). Chodorow (1992) added the notion of heterosexuality as a compromise formation, rather than a discrete outcome, and highlighted multiple variants on an Oedipal resolution. This sampling shows evolving changes in psychoanalytic discourse around sex and gender over the past 40 years or so. Clearly, things are different in terms of the range of constructs from which psychoanalytic theorists can choose when thinking about identity.

With this point in mind, I move next to a brief description of contemporary views on race and racial differences in treatment dyads, with particular attention to the notion of race as a nonlinear construct, much in the same way that gender and sex have proven to be. That is, discussions of race are enriched when gender and sex are also considered as interdependent factors. I present a viewpoint here that is informed by psychoanalytic conceptualizations in these areas.

**Race, Sex, and Gender**

Race, sexuality, and gender intersect as potential vulnerability points for patients who are in the minority for each factor. Writings in the area of multiculturalism have addressed this intersection. For example, in describing the psychology of Black women, Reid (2000) articulated the good-bad polarity that defines a Black woman in the public eye. The “good” female is strong, maternal, hardworking, devoted to family, and quiet,” whereas the “bad” woman is “ugly, lascivious, lazy, negligent, emasculating, and loud” (p. xiii). These views are stereotypical, sexualized, racialized, and gendered but magnified and inaccurate versions of Black women. Reid further noted: “The study of African American women is an understudied, overlooked, and distorted topic” (p. xiii). Shorter-Goeden and Jackson (2000) also made this same point and stated: “The interactive effects of race and gender in the lives of African American women create special challenges
that are unique to them, but rarely discussed in the literature of women or ethnic minorities” (p. 15). Romero (2000) highlighted the “paradox” of strong Black women (SBW) who have difficulty being vulnerable: “So threatening is it to redefine the basic tenets of SBW that many African American women present with and work hard at maintaining the façade” (p. 225).

Jackson and Greene (2000) described the overlapping impact of gender and race by noting how White males have shaped psychological theory and, in doing so, provided a foundation for stigmatization, born from projections, of those individuals outside of the dominant culture. They stated: “These unconscious projections are remnants of a patriarchal, racist, classist, and heterosexist society” (p. xviii). Jackson and Greene further advocated for the reformulation of psychodynamic theory to address omissions in the literature, including “perspectives on class, sexual orientation, and other identities in ways that reflect their true complexity” (p. xviii). Adams (2000) noted that African American women shy from psychodynamic treatment because it is elitist, focused on the individual, deficit-based, historically disregarding of people of color, and an oppressive quality that “is another form of racism” (p. 36). Adams felt that effective treatment required the therapist’s ability to adopt a self-reflective attitude toward race, including openness to the anger of Blacks toward Whites, the overall impact of White privilege, sensitivity to differences related to sexual orientation, gender, and class, and management of other conflictual feelings that emerge in cross-racial dyads.

The actual cross-racial psychodynamic treatment situation poses particular challenges to the cross-racial, cross-gendered dyad that have implications for conflict, transference, sexuality, and conceptualization. To some extent, reactions to a therapist may be transference-based projections that have historical roots in racial divide (e.g., N. Fischer, 1971) and engage sex and gender dynamics in that context; that is, the repetition in the present of past experiences that are unique to the client’s history with significant others, and not necessarily reflective of the therapist’s attitude, thoughts, or feelings toward the client, which would be countertransference-based (e.g., Tansey & Burke, 1989). However, beyond the uniqueness of the client’s past experience as it relates to a particular therapist, is a historical-cultural and reality-based experience of an oppressed-oppressor paradigm. This is the level at which the therapist must consider group-based, historical factors when integrating the immediacy of a potential distortion against a backdrop of cultural reality.

Regarding the clinical interaction, Leary (2000, 2012) discussed race along the lines of a socially constructed gradient rather than a binary. In this framework, the meaning of race is unique to each dyad and analogous to a postmodern conception of gender. Leary (1997a) highlighted the importance of discussing racial differences as a way of promoting an open system in the therapy relationship that might, for example, allow for discussion of transference, whereas Carter (1995) was somewhat more reserved in his approach and felt that the clinician did not have to discuss race directly. Carter stated that “race is always salient in...
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interpersonal relationships and in intrapsychic development, regardless of the specific racial groups involved” (pp. 226–227). The work of D. Sue (2010) has been especially integrative in looking at microaggressions in relation to sexual orientation, gender, and race. Sue discusses the subtle, at times unwitting, but impactful experience of microaggressions directed toward particular targets from underrepresented groups, and classifies microaggressions as microassaults, microinsults, and microinvalidations. However, Owen, Tao, Imel, Wampold, and Rodolfa (2014) found that stronger therapy alliances were associated with fewer racial microaggressions, irrespective of therapist race, and that discussion of racial microaggressions strengthened the therapy alliance. This finding would appear to support the importance of alliance and Leary’s (1997b) questioning the assumption that same-race matching is always to the patient’s benefit.

Other literature that lends support to the notion of the therapist’s ongoing mindfulness about how to think about race and culture as part of the cross-racial or cross-cultural dyad includes Comas-Díaz’s (2012) attention to the roles of White privilege, power differentials, and “color blindness” (c.f., Shorter-Gooden & Jackson, 2000, “disavowal of the real relationship”). Additional insights are offered in Jordan’s (2001) comments about the role of empathy in a relationally oriented and culturally sensitive treatment; Gump’s (2000) attention to the patient’s shameful feelings in cross-racial dyads; Altman’s (2000) recognition of how the analyst’s shame and guilt are factors inhibiting comfort with the topic of race; Coleman’s (2000) observation that patients whose cultures differ from their therapist may find the new object relationship offered by the therapist to be “incomprehensible” (p. 71); and the early work of Jones (1978), who found that Black clients reported that race was a more salient theme than did White clients, and were more likely to express hostility toward their White therapist after the first session as the therapist became more sensitive to racial differences (i.e., an increasing openness to transference and countertransference). With this level of inquisitiveness about the role of race, sexuality, and gender in therapy (and assessment), the therapist has a clearer vantage point from which to understand how these variables serve a defensive function, shape symptom presentation (Thompson, 1987), and affect transference-countertransference in a psychodynamically informed treatment (Comas-Díaz & Jacobson, 1991; Shorter-Gooden & Jackson, 2000; Thompson, 1995; Yi, 1998).

In what follows, I use the concept of intersectionality as it relates to race, gender, and sex as a focal point for understanding the personality assessment and treatment of a female patient in a cross-race, cross-gender dyad (White male therapist, Black female patient) that involved power differential, unconscious themes of bias sensitivity mixed with what was consciously experienced as a positive paternal transference over the course of two different therapy experiences. The patient’s history brings multiple points of identity intersection with aspects of social bias or, worse, social oppression—minority race, minority gender, a time of questioning sexuality, and majority social status with minority racial status—into the case material.
Clinical Case Illustration

Referral Considerations and Treatment Planning

The patient, an adult Black female, lived with her maternal aunt. She was close to her aunt. Her parents were divorced. She saw her mother, who lived in a neighboring state, regularly, but she did not have a relationship with her father. Her aunt, who worked in the mental health field, had gotten my name from a colleague and asked if I would meet with the patient, which I did. Presenting problems included depression, anxiety, inattention, difficulty managing tasks, weight gain, and suicidal ideation. The patient was also struggling with career choice and whether or not to take college classes (the patient had taken a few classes, interspersed with taking semesters off, but she did not have an academic major or career path). I felt that it would be helpful to evaluate the patient, and decided to do this evaluation myself at the start of treatment. The decision to test (or not to test) one’s own patients has been a subject of discussion within the field of personality assessment. I offer a summary of this literature below.

Testing One’s Own Patients

Historically, the notion of testing one’s own patients has been criticized on the grounds, mainly, of disturbing the transference and distorting test findings (e.g., Exner, Armbruster, & Mittman, 1978; c.f., Finn, 2007a), both of which would compromise treatment efficacy (see Finn, 2007b). More recently, the works of C. Fischer on Collaborative Assessment (1994) and Finn on Therapeutic Assessment (2007b) have provided support for the potential benefits derived from testing one’s own patients. Exemplifying the benefits of evaluating one’s own therapy patients (e.g., alliance building, using the testing as part of therapy) are the works of Lerner (2005), Finn, (2007a), and Bram (2010, 2103, 2014). There remains a sensitivity to how the transference might be affected by the clinician who is also serving as evaluator, but the unconscious meaning of any evaluation to a patient, even when tested by someone other than the therapist, also carries implications for the transference (e.g., “Why did you refer me out?” “I really can’t separate the person who did the testing from you?”). Indeed, Finn (2007a) reminds us to heed Schafer’s (1954) observation that the assessor role can evoke transferences involving experiencing the clinician as voyeuristic, autocratic, oracular, or saintly and can lead the unwitting assessor to adopt these roles in the countertransference. The growing appreciation of the intersubjective nature of all clinical encounters (e.g., Yi, 1998) alerts us that whatever the clinician does (or does not do) impacts and co-creates the transference, and tracking this is part of the therapeutic task. Such a perspective does not imply carte blanche acceptance that fluidity between assessment and therapeutic roles makes no difference and thus can be undertaken capriciously. Thus, while there is a need for thoughtfulness regarding potential therapeutic
advantages, such as intensifying the therapy (Finn, 2011), disadvantages may accrue as well, such as when the client feels subjected to the therapist's power and authority (Schafer, 1954).

The following case material offers an example of how to think through the implications of intersectionality for testing one's own patient, including the way it affects transference, alliance, and countertransference, and informs the overall process of therapy.

**Results of the Assessment at the Start of the First Therapy**

Soon after the initial consultation, the patient was administered the Conners’ Adult Attention Rating Scale (CAARS; Conners, Erhardt, & Sparrow, 1999), Behavior Rating Inventory of Executive Functioning–Adult Version (BRIEF-A; Roth, Isquith, & Gioia, 2005), Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996; Sashidharan, Pawlow, & Pettibone, 2012), Beck Anxiety Inventory (Beck & Steer, 1993), and Rorschach (R–PAS; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011). The reasons for the decision to use these tests were (a) to clarify the presenting symptoms (i.e., the rating scales), (b) to gauge their impact on the client's everyday functioning, and (c), as it pertains to the Rorschach, to evaluate the client's personality structure. The patient was cooperative, friendly, and very easy to evaluate. In the present case, for example, the patient’s compliance might have been affected by an obeisance tied to a power differential associated with gender and race difference as much as by the strength of treatment alliance.

Results of rating measures were reflective of severe symptomatology. CAARS scores were markedly elevated (T > 70) in five of eight scales, with particular loading on inattentiveness. Almost every BRIEF-A scale had a T score > 65 (significant), with the main indices of Behavioral Regulation (T = 65), Metacognitive (T = 80), and overall Global Executive Composite (T = 77) each significant. The BDI-II score of 50 and BAI score of 32 were in the severe range. These findings supported the intensity of symptom presentation and disruptive ego functioning on initial consultation and highlighted the patient’s level of distress.

I administered the R–PAS with a sensitivity to implications of cross-cultural Rorschach applications (e.g., Constantino, Flanagan, & Malgady, 1995; Dana, 2005; Frank, 1992; Presley, Smith, & Exner, 2001) and present elevated scores that are clearly outliers (standard scores at or above 115). Examples include: (a) WSumC (affective reactivity; T = 128); (b) Critical Contents (i.e., possible trauma history or the presence of primitive thinking; T = 136); (c) Aggressive Movement (i.e., aggressive intent or action; T = 121); (d) Aggressive Content (i.e., content with aggressive themes; T = 116); (e) Anatomy (i.e., bodily concerns; T = 116); (f) MC–PPD (dysphoric mood; T = 122); (g) EII–3 (i.e., measure of thinking disturbance; T = 130); (h) TP– Comp (i.e., logical reasoning and reality testing composite; T = 128); (i) FQ– (i.e., distortion and misperception;
T = 135); (j) MOR (i.e., morbid, pessimistic, or damaged themes; T = 133); and (k) PHR:GHR (i.e., intactness of representations of self and other; T = 133).

These findings indicated generalized problems in the area of reality testing, affect regulation, self- and other perceptions, mood, and anger. Clearly, the patient was having serious problems coping on a daily basis, both in terms of self-report and quantifiable scores. In addition, a sampling of Rorschach responses anticipated core psychotherapy themes. For example, the response to Card II of “Two guys fighting . . . touching, pushing up against each other, and there’s blood . . . Red and coming from them,” suggested that anger and closeness were connected intimately, with both parties being damaged in the process. A second response to this card of “Someone bending down on their hands and throwing up . . . blood” speaks also to an internal disturbance and need to rid oneself of something toxic. In sequence, these two responses frame a basic conflict: How close can the patient get before someone (or both parties) gets hurt, “bloodied,” and damaged? Can she be contained and can I contain her?

Other responses speak to themes of gloom, vulnerability, and fright, including: (a) “Morbid . . . just how dark it is” (Card IV). (b) “Dead animal . . . deformed. . .” and “Smoker’s lungs . . . black and cloudy” (Card VI). A configurational analysis (Bram & Peebles, 2014) of structure and content revealed few respites from internal distress. For example, on Card VIII, there were color-form two responses with FQ- (“Demon . . . dancing in fire:” Ma.CF-; and “Plane crash . . . fire:” ma.CF-) followed by two responses with improvement in coding (“Volcano . . . lava around it:” FCu; and a “flower with petals falling:” mpo). This sequence suggested that reality testing was compromised when things heated up and felt out of control, but improved (i.e., form dominance suggesting greater ego control) when there was either some distance from the affect (e.g., volcano surrounded by lava, but not currently erupting and no one is hurt) or when she felt depleted or helpless (e.g., petals falling) but not enraged.

These (and other) responses were stunning in their rawness. No amount of interview data would have unearthed this content. The patient’s friendly nature did not begin to approximate the aggression, fear, and sadness of the Rorschach content, which was delivered without any obvious unsettling emotion. The patient was not aware of what these responses might imply, but I felt anxious, anticipated danger, and saw this as a different component of the transference-countertransference in which I felt less in control and unsure about what this implied for therapy. In other words, the patient’s unconscious use of power, privilege, sex, and agency as a Rorschach respondent left me feeling unsteady. The patient’s responses could have been understood as unconscious efforts to bring me closer, create intimacy, heal her wounds, stop her free-fall, and so on. Several responses, for example, can also be interpreted as speaking to gender (e.g., responses of people touching, pushing up against each other; a man being electrocuted), and both sexuality and marginalization (note the symbolism of “a volcano with lava around it”). The main point here is that response content embeds or condenses multiple dimensions of a patient’s experience.
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A cautious but open-minded reading of responses with this point in mind allows for a broader appreciation of how gender and race might find expression in Rorschach response content.

Beyond this sampling of structural, content, and configurational analyses, the Rorschach allows us to conjecture how the patient’s race-based sensitivities might also be present in the response content. Here are a few examples that provide insight into how the literature on cross-racial dyads, White privilege, and power differentials might factor into the way the patient views her world and the sensitivities that she brings to treatment. The patient’s first response of a “Jack-o’-Lantern” draws attention to the white-black distinction (eyes and “fangs” are the white areas, with fangs as aggressive content, raising a tentative hypothesis about the projection of aggression and anticipated counterprojection), as does the response of “invertebrate,” but in a more conflicted way in which the light-dark distinction is presenting as a color gradient, rather than absolute (“insides are clear and dark”). Here, the “invertebrate” response content might reflect a condensing of different themes, including the light-dark difference between patient and therapist and the patient’s internal conflict between White and Black psychic identifications and cultures. Other responses that may embed racial sensitivity include surrender-compliance (“two guys putting their hands up”), aggression (“gun . . . bloody”), the totality of darkness (“death . . . just how dark it is”), and a sense of damage secondary to the internalization of a toxic substance (“smoker’s lungs . . . black and cloudy”; [note here the association between blackness and danger]).

Taken together, results of the interview and assessment suggested that the patient had more going on than met the eye and that an interpretive approach might agitate an already vulnerable psychological system. Thus, a supportive-exploratory approach to psychotherapy appeared to be indicated. In the following section, I summarize the literature on supportive psychodynamic psychotherapy and then discuss the patient’s treatment.

Supportive Psychodynamic Psychotherapy

Supportive psychodynamic therapy is one of three modalities of individual psychoanalytic treatment, with the other two treatments being psychoanalytic psychotherapy and psychoanalysis proper (De Jonghe, Rijnierse, & Janssen, 1984; Kernberg, 1999). Supportive therapy is distinguished from the other two therapies by its emphasis on symptomatic improvement as opposed to structural change (Kernberg, 1999) and focus on strengthening weaker ego functions without an emphasis on interpretation (Kernberg, 1999; Werman, 1984). Supportive interventions have the goal of lessening the patient’s anxiety (Miller, 1969) by focusing on clarifying and validating feelings, helping the patient regulate affect, and providing a holding environment (Holinger, 1999) without emphasizing interpretation and transference-based interventions. Hollinger stated that the change process in a noninterpretive approach “seems to involve
an organizing, tension-regulating, pattern-matching effect in the pre-verbal developmental domain” (p. 248). Rockland (1989) elaborated supportive interventions to include praise, limit-setting, psychoeducation, advice, gratification of drive derivatives, maintaining a positive transference, strengthening defenses, and interpretations that keep material at the conscious and preconscious levels.

In what follows, key moments in the patient’s first therapy and second therapy are described, integrating personality assessment findings with principles of supportive psychotherapy. In this case, the patient’s needs were extensive, necessitating a high level of detailed documentation. It tells you something about the patient, the therapy, and the therapist, as discussed in the following two summaries.

**The First Therapy**

In the first therapy, which covered one year at two to three “scheduled” sessions per week (i.e., there were many cancellations and lateness), the patient presented as highly symptomatic. However, she was also open, able to explore issues with some insight, and had an expressed desire to move forward. The overarching treatment goal was to help her improve her quality of life, being mindful of her being at a developmental level of emerging adulthood while also expressing serious psychological symptoms.

The therapy approach was designed to help her cope more effectively with her conflict over dependency, figure out what to do about career and school, and explore thoughts and feelings about relationships in a supportive manner, while also monitoring her symptoms and regressive behaviors. The results of the BDI-II, BAI, and Rorschach in particular guided the treatment. Transference was addressed directly only on rare occasions. Most of the interpretive work was done extratransferentially, with the intent of supporting the patient’s reality testing through empathic comments (e.g., “Yes, I can understand why you would feel . . .”) while also gently inviting her to look at her contributions as to why she felt stuck.

Initially, I noticed how the patient came across as quiet, easy to talk with, and not with any obvious indications of the level of need manifested on the R-PAS. At one point, I began to question the validity of the R-PAS findings; it was as if there was one patient who carried a deep but buried layer of conflict and another patient who was quiet and collaborative in session with a good alliance. She had a good support system and a desire to improve her situation. In fact, I wondered, is this not the person I knew in years past. Maybe she had more ego strength than was suggested by the Rorschach? Maybe the testing had overestimated her needs?

I soon came to recognize the transference-countertransference enactment at work through a projective identification (Tansey & Burke, 1989). Here, the patient was projecting into me an almost dissociative state—she would later talk about what sounded like dissociative episodes—in which I imagined myself
working with two patients: one who was calm and one who was in turmoil. Race, gender, and sexuality were not obvious, but they were present through the transference-countertransference. It was as if I was encountering two people: one who was anxious but allied with me and one who was angry, provocative, and ready to strike. However, after I recognized the countertransference, it became clearer that I was feeling at risk, that my identities as assessor and therapist were now marginalized. Should I have tested her versus just keeping things on the surface? This is the language, as I now hear it, of oppression—hear no evil, speak no evil; comply but feel enraged. How would this play out in the treatment? Note here the Rorschach response to people touching but pushing away from each other. Indeed, this is what happened.

The core conflict that emerged for the patient was one of intimacy; that is, how close could she be with her therapist without feeling that something would be damaged in the process? The Rorschach findings in particular, as discussed above, alerted us to this type of conflict through the imagery of damage, death, closeness tied to aggression, and so on. The enactment of the conflict in therapy, however, was very significant, with multiple cancellations, lateness, and texting to clarify schedules, oversleeping, mismanagement of her medications, and variable follow-up with her White female psychiatrist. These behaviors were consistent throughout the first therapy and would carry over to the second therapy.

Coinciding with the resistance, however, was a deepening sense of closeness, illustrated by such comments as: “I have a hard time imagining someone who can talk to me like you. It must be your training”; “Not meeting three times last week felt like losing time”; “If I crash my car, can I call you?” “It’s weird that I can talk to you.” The patient also had a fight with a boyfriend and was able to tie it to anger at my being away for a few days. There were other similar indications of a primarily positive maternal transference (i.e., the patient’s aunt was her primary source of emotional support). For example, she made it a point one day to show me a picture of one of her pet animals and stated: “We love each other.” Here, the themes of intimacy and sexuality enter the treatment but in a displaced way and without the aggression that marred other intimate relationships. This was different from her Rorschach response to Card II of “Two guys fighting . . . touching, pushing up against each other, and there’s blood . . . Red and coming from them,” and suggested the capacity for closeness, as long as she felt safe; otherwise, all bets were off. The first therapy ended rather abruptly, with the patient returning to her boyfriend after one of their several breakups and many cancellations and lateness. The patient feared closeness, pulled back, but projected split-off parts of herself tied to anxiety around intimacy, leading to a countertransference reaction (Tansey & Burke, 1989) organized around my efforts to reach her, not knowing if she was coming to the session or not and worrying about her mental status. Dynamically, this type of interaction might relate to her wanting, but having to deny (“I never felt a need for a father figure”), a paternal figure who could sustain interest in order to minimize disappointment and guilt associated with the longing (expressing a desire toward
the end of the first therapy that she wished she had a father). In other words, I had to work extra hard to keep her (and me) engaged, and it might have been overstimulating, overwhelming, and, in the end, too much for her to process emotionally.

The transference is noteworthy for the emergence of a longing for a male/father figure and rigid denial of this longing. One might speculate that she wanted this type of relationship; was excited but overstimulated by its prospects; felt shameful, guilty, and undeserving; was angry at me for offering her this level of support because, as therapy, it would inevitably end; and denied her feelings as if there was something wrong with what she felt. Could she, a Black female, allow herself to have these feelings for me, a White male, and what would it mean for us if she did? Would I disappoint? Get angry? Take advantage by marginalizing her feelings?

Toward the end of the first therapy, she came to my office early, acknowledged a substance problem, and wondered if she was trying to kill herself (i.e., note here her Rorschach responses of “Morbid,” “Dead animal,” and “Plane crash”). Although she had expressed positive feelings about her ability to talk with me, the ending was in sight. She missed several sessions, and therapy ended with her aunt calling me, apologetically, about the patient’s wanting to stop her therapy. I wrote a note indicating that her decision to leave was against my recommendation but also inviting her to contact me again, if needed. Even with this invitation, I was quite surprised when she returned a few months later under very different circumstances.

The Second Personality Assessment and Second Therapy

I received a phone call from the patient’s aunt asking me to see her again. The patient was anxious, panicked, depressed, and not taking medication. I agreed to see the patient, who had regressed; she was cutting her legs, feared having brain damage, had mild paranoid ideation, and was very angry at one person with whom she was in conflict and feared would retaliate. I evaluated her again as part of restarting a stalled therapy (Bram, 2014; Bram & Yalof, in press). I decided not to administer the Rorschach because the previous findings were still relatively recent. She completed the BDI-II (score of 49) and BAI (score of 26), scoring in the severe range on both scales, and the PAI (Correa & Rodgers, 2010; Morey, 1991), which was not administered initially but would provide a very helpful updating of psychometric self-assessment in conjunction with the clinical interview data. On the PAI, her Negative Impression Management T score of 81 indicated that she was very sensitive to what was not right in her life. Many of the clinical scale T scores were quite high, including Anxiety (87), Paranoia (92), Suicide (97), Stress (84), Schizophrenia (100), and Borderline (97). Subscales were also elevated, including Traumatic Stress (99), Self-Harm (99), and Thought Disorder (99). Interestingly, she showed a high motivation for treatment (RXR = 27), which gave me hope that she would be able to
move forward. She had done some reading about her symptoms and wondered prior to testing if she would be diagnosed with “borderline personality and depression.” We later went over the results and reflected on how the scores fit into her life.

After the testing, I had a joint session with the patient and her aunt, who saw me as “a member of our family,” during which we talked about the patient’s behavior, set up two to three meetings per week, and highlighted her need to take her medication. She was somewhat resistant to seeing her psychiatrist, feeling embarrassed and fearing that she would be angry, even though her initial reactions to her were very positive. I also talked with her individually about her pattern of engaging, pulling back, and history of not feeling supported by men in general in an attempt to move her closer to the transference, but in an implicit and supportive way, while also noting how she might even pull back from me if she felt too uncomfortable, which we both knew was a distinct possibility. She was still struggling with career, relationships, and a host of other problems, but she seemed ready to try and make therapy work.

After much delay, she eventually saw the psychiatrist, who again assiduously and sensitively worked with her medications and some side effects, despite some of her resistances to help. The patient’s relationship with me remained primarily positive, notwithstanding the scheduling issues that were an ongoing problem area and related to the resistances identified in the first therapy. She presented a dream two months into the second therapy in which a White male, who she presumed was me, protected her from acting on her anger toward others. She talked more openly about her feelings about whether or not to call me when she felt highly stressed. She lost weight and began to dress stylishly. She was also very supportive of her sister, who was having some school-adjustment issues. Her BDI-II remained high (score of 47) three months into the second treatment, but it soon dropped (score of 12) significantly one month later. Clearly, positive changes were occurring, but her mood was easily affected by stresses, and I had the feeling that her BDI-II score could increase or decrease dramatically on any given day.

The main conflict that framed the second therapy was her complicated, intimate relationship with an older Black male, but she was able to assert herself and move away from the relationship. There were a few other positive changes, including (a) decreased use of alcohol, (b) more openness about race differences and how they affected her (e.g., how she felt distanced when she raised the issue to a former teacher who had been insensitive in his presentation), (c) talking more openly about her father, who was a mercurial figure in her life, living in a different state and only sporadically in contact, (d) a seemingly committed decision to pursue a specialized training program geared toward gainful and sustainable employment, and (e) feeling that her relationship with her on-and-off boyfriend might have a chance to succeed. She had stopped taking medication against medical advice, but she felt she was handling anxiety, even though it was uncomfortable.
My intervention style remained stable across the two therapies; that is, primarily supportive but with slightly more exploration of the transference in the second therapy, given the stronger alliance. The second therapy ended differently than the first therapy. In the first therapy, there was an almost abrupt ending. In the second therapy, she felt the need to come less often, was not responsive to recommendations to the contrary, raised the possibility of coming once per month, and felt guilt over her aunt’s paying for therapy; these were all positive signs of independence, but they provided minimal room to discuss options for continuation on a steady basis. The countertransference remained the same as in the first therapy: tracking her down, dealing with frustration over missed sessions, getting hopes up only to be disappointed, and self-analyzing this in the context of the enactments.

Discussion

Distilling essential information from notes that cover many sessions over a several-year period is not a simple task; it can be an eye-opening experience when one revisits a long-term treatment from a different perspective. Memories are revived, reflections on what worked and what could have been handled differently emerge, new knowledge fuels new insights as the material is reviewed afresh, and the importance of understanding the patient from multiple perspectives and what can be learned from new knowledge becomes clearer. In the Discussion section, I integrate the patient’s therapy with the literature on (a) using assessment findings to guide treatment, (b) cross-racial, cross-gender therapy dyads, and (c) transference, countertransference, and sexuality.

The Use of Testing to Inform Therapy

This was a case where the assessment was both helpful in a formal diagnostic sense, highlighting a level of ego functioning that was most likely a borderline-level ego structure (Kernberg, 1975), but also elevating the value of looking at response content as a window into the patient’s internal experience. BDI-II, BAI, CAARS, and BRIEF results were reflective of severe and generalized symptomatology that could render the patient overwhelmed on a daily basis. Examples were provided of structural, content, and configurational Rorschach data that anticipated the patient’s treatment’s visage: anxious, emotional, scared, angry, and quite vulnerable. It would take much courage for her to move forward, and there were bound to be points of strong resistance, notably around dependency-autonomy and intimacy-distance themes, along the way.

From this vantage point, a supportive therapy approach made the most sense. From a technical standpoint, she appeared to need encouragement, perspective-taking, affect clarification, and extended time to develop an alliance. Developing an alliance that allowed for a deepening of the therapy relationship, even though this deepening would likely correspond to anxiety about
dependency fears in general, and ability to trust men who want to get close, in particular, would be most important. This was indeed the case; the patient needed two therapies with a period of separation between them in order to gradually gain a foothold in staking out her independence. She had weathered considerable crises with the support of therapy, but she seemed unable to say goodbye directly, lest she likely feel guilt over leaving and mourn the loss of her therapist and, possibly, her father whose presence mirrored her variable therapy attendance. Her father was an enigma, both to the patient and me. He was not emotionally available, only occasionally in contact with her, and not reliable, but still a presence, part of her life, and a figure on whom anger and a longing for an intimate relationship could be displaced onto other, older men. Her fear of separation was expressed through an anxious and conflicted dependence on her mother. Both of these themes were played out in the transference.

**Transference, Countertransference, Gender, and Sexuality**

As noted above, there appeared to be two core transference themes that framed the treatment: a conflict over dependency and a conflict over trusting males. These conflicts were enacted behaviorally through resistances and expressed derivatively in comments about all the significant males in her life, who were portrayed as conniving, disinterested, aggressive, assaultive, or controlling. One older male in her life, someone with an advanced degree, was a source of support, but he was clearly outnumbered. In both therapies, the patient would move close but then move away and play hard to get. The texts and other prompts were ways of keeping me interested, stimulated, anticipating, and convincing herself of my interest, but also keeping me at arm’s length and not sure she could trust her feelings and my intent. Her Rorschach responses and PAI scales predicted the closeness-distance conflict; that is, her need to engage but her fear of becoming too intimate and without being confused, depressed (see the BDI-II scores), or hurt in the process. Her friendship with another woman had these same elements of closeness and disengagement, but her ability to reconcile the friendship over time reflected some working through of the intimacy conflict with a lessening of aggression.

Sexual feelings were tinged with aggression with older men (one notably older), played out in complicated relationships where she felt close but was afraid of being hurt by men who had controls over anger (though her relationship and self-advocacy improved over time). In theory, transference displacements could be understood as tied to feelings of disempowerment, disrespect, and marginalization, most of which was expressed behaviorally around her overt resistance to her White, older, female psychiatrist. With men, sexuality was complex; she felt vulnerable and not always safe, but she was able to stand up for herself in a relationship that was not working, using the therapist as a supportive male/father figure, rather than hold herself responsible, and feel protected in the process of self-advocacy.
There were few references to race differences during the two therapies. In line with Carter’s (1995) suggestion about not feeling pressured to raise race differences as a therapy issue, but remaining mindful of it as a core variable in all aspects of life, I followed her lead. Was not raising it an enactment? A microaggression? Guilt driven? These are points to consider, but the larger question was whether raising it would have facilitated or impeded her comfort level in therapy. The patient downplayed differences when I did bring them up (once or twice), her mother saw me fondly as someone who understood her daughter, and my own preference was to follow the patient’s lead and comment on what she brought up. Her comments in this regard were minimal: a dream about a White male who helps her, which she saw as a reference to her White therapist; a sensitivity to racial differences in her early and later school years, but feeling comfortable with White classmates; and a White teacher who was not sensitive to the patient’s wanting to address what sounded like racial microaggression (Sue, 2010). From these observations, one might wonder if she felt comfortable with her therapist but not comfortable enough to raise these issues, reacting more to anxiety associated with the male-female power differential, or compliance, or a fear of not being heard, or a fear of actually being understood (or a combination of these and other considerations). She was proud of her skin color, identified with a very strong maternal figure, but she was also raised in an upper socio-economic household and community, and therefore possibly not as sensitive to racial differences, although we speculate here that inhibitions associated with the cross-racial, cross-gender dyad were primary in her reluctance to raise these issues directly. However, they were raised indirectly through the displacement onto the White female psychiatrist, whom she liked initially and who was quite dedicated to her care, but who later became a gendered source of anxiety and danger (she could control her through prescriptions) from whom she needed to distance and fight at different points in her treatment. Thus, while there was no open discussion about race, a different type of collaborative dialogue about it was occurring through the displacements and integrated into the supportive treatment without explicitly drawing it into the transference. Here, one speculates again about the split transference manifested by a need to see the therapist as good and caring, while questioning her relationship with another helper.

**Practical Points**

- Assessors should be familiar with APA guidelines for working with a diverse patient population.
- The concept of “intersectionality” is important for appreciating the multiple factors that affect a patient’s social identity. This may be especially important when the patient is a member of one or more marginalized groups in which there could be an additive effect that compromises agency and heightens feelings about power differentials.
Aspects of Multicultural Diversity

• The question of whether or not to evaluate one’s own patients has been a long-standing debate, voiced by therapists with a psychodynamic/psychoanalytic orientation. Does the assessor who is also the therapist compromise the transference? Or, is the assessment used in a collaborative way to build alliance? Another question that emerges from this debate involves the roles of power, gender, and culture. Does, for example, a male therapist who tests his own female patient elevate the power differential to a different level, given the knowledge gained from the assessment? Are there different implications for the meaning of this differential in cross-gender and cross-racial dyads? Can the Rorschach highlight these subtle meanings by analyzing response content? Are there other performance-based measures, such as thematic tests or figure drawings, that can lead to speculation about the patient’s deeper thoughts and feelings about gender, culture, sexuality, privilege, and power when the therapist tests or refers out for testing? How might these meanings inform the transference and heighten awareness of transference-countertransference sensitivities in these areas?

• Assessors and therapists with psychoanalytic orientations should be familiar with the literature on cross-racial, cross-class, and cross-gender dyads, and with contemporary psychoanalytic considerations in the areas of sexuality. There have been shifts in this literature over time, with many contemporary analytic scholars weighing in with a voice that challenges the initial positions outlined by Freud.

• Rorschach content analysis in particular holds much promise for understanding how a patient’s feelings about identity facets tied to gender and sex are expressed in test responses and how responses with an interpersonal focus might provide additional information related to how themes of power, privilege, and marginalization influence a patient’s conscious and less-conscious representations of self and other.

Annotated Bibliography


*Comment:* This article provides superlative illustration of using psychodynamic theory and supportive therapy in conjunction with personality testing as a way of organizing, guiding, and evaluating treatment. It includes extensive case material, rationales for the author’s intervention approach, and educates on how the nuancing of Rorschach test data can serve as a companion guide to the therapist who navigates the challenge of testing one’s own patients.


*Comment:* This edited book provides a wealth of information on psychotherapy with African American women. Chapters cover a wide range of topics, are educational and clinically relevant, and condense a knowledge and experience base under one cover that is orienting, enlightening, and hard to find elsewhere.

Comment: This chapter outlines the concept of intersectionality with a focus on gender, gender and race, power, production, emotion, and symbolic relations in relation to cultural background. It is noteworthy for its attempt to bring gender into a multicultural framework, which the authors state: “relatively little theory or empirical research has examined gender within multicultural contexts” (p. 379). For researchers who need an introduction to the field of intersectionality, the chapter is well organized and easy to read.

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Aspects of Multicultural Diversity


FEELING GRAVITY’S PULL
Answering Unasked Questions of Gender and Sexuality in Two Collaborative Assessments

Stacey M. Boyer, Alan L. Schwartz, and David J. York

“In all affairs . . . it’s a healthy thing now and then to hang a question mark on the things you have long taken for granted.”
Bertrand Russell, as cited in Molczanow, 2012, p. xi

In today’s clinical climate, assessors are often tasked with formulating a differential diagnosis or understanding a particular client problem that may be acting as a barrier to progress in psychotherapy. Unless in a highly specialized role (e.g., sex reassignment surgery evaluations), it is rare that assessors receive referral questions regarding gender or sexuality. In fact, of the 183 referral questions we received over the past seven years in our outpatient hospital-based practices, only 1% (n=2) inquired about gender identity, gender dysphoria, or sexuality. Notably, these two referrals listed gender and sexuality concerns almost as an afterthought and not as a primary referral question. In contrast, 50% of the referrals focused on differential diagnosis; 15% on personality functioning and its implications for psychotherapy; 15% on factors giving rise to academic, learning, or professional performance problems; 8% on cognitive or memory impairment; 6% on intellectual and personality functioning; and 3% on assessment of risk for suicidality or homicidality. These findings highlight the extent to which sexuality and gender as constructs relevant to routine clinical care have been relegated to the periphery in favor of a strong focus on symptomatic behaviors.

Gender and sexuality can be understood as core experiences that are intersubjectively configured or formulated via the intersection of numerous factors. These factors include, but are not limited to, the individual’s interaction with their culture, caregiver-child interactions,1 other social exchanges, race, ethnicity, class, generation, geographic location, and biology. While gender and sexuality are not often the reason for referral, as assessors we strive to understand our
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clients to the fullest extent possible. In appreciating the multifaceted individuals sitting in front of us, we often begin to feel pulled in certain directions. One such pull may be toward experiences of gender or sexuality, for like gravity, gendered and sexual identity dimensions are fundamental forces that cannot be ignored. Thus, to provide quality assessment services, assessors should consider gender and sexuality throughout the assessment process. Gender and sexuality awareness includes a commitment to curiosity about (a) the various manifestations of conflicting gendered and sexual selves that may act as vehicles through which other personality and identity issues are expressed, (b) the possibility of gender or sexuality issues that may underlie more salient problems, and (c) openness to considering our own gender and sexual identities, experiences, beliefs, and biases, as well as how these self-aspects might interplay with those of the assessee to create a unique understanding of that client’s identities. If we can maintain a stance of openness and curiosity about our client’s gender and sexual identity dimensions and our own, we have the potential to reach a deeper understanding of the client’s situation, including his or her presenting problem.

In this chapter, we offer two clinical vignettes in which gender and sexuality were not included in the initial referral questions but were discovered during the assessment process to be salient aspects of the individual’s experience that greatly affected the client’s current functioning. In each vignette, we articulate (a) the initial referral questions posed, (b) the client’s questions about him or herself, (c) information gleaned from the clinical interview and behavioral observations, (d) general assessment findings, and (e) specific gender and sexuality findings. The reader is then offered an integrated view of the findings and an explanation of how the client engaged with the assessor during feedback.

Vignette One: Mr. Castel and Dr. Rigby

Referral Context

“Will Castel,” a 31-year-old, single, biracial male, was referred for an assessment by his primary care physician to inform his treatment. Mr. Castel’s physician noted a recent increase in depressive symptoms, as determined by a brief depression screen (i.e., PHQ-2, Kroenke, Spitzer, & Williams, 2003; PHQ-9, Kroenke & Spitzer, 2002) and by Mr. Castel’s readily observable low mood and energy. Mr. Castel had experienced dysphoria and anxiety for many years, but his depression and anxiety noticeably worsened after recently being fired from a lucrative and coveted administrative support job with a professional sports team. Mr. Castel noted that he was terminated for violating a workplace personnel policy, but he felt that he was fired capriciously due to a personality conflict between him and his manager. Suspicion around the true motives of his firing and unresolved emotions continued to trouble Mr. Castel. In light of this context, it was curious that Mr. Castel’s primary concerns in his initial meeting with the assessing psychologist, Dr. John Rigby, were his problems with attention,
Mr. Castel reported his learning history was unremarkable. He was a solid B student, was never held back, and he did not require special education or additional tutoring.

Mr. Castel and Dr. Rigby agreed to proceed with the assessment from a perspective that incorporated some of the core features of Finn’s (2011) Therapeutic Assessment Model. These features include fully elucidating the client’s areas of concern that may be addressed by the assessment, providing ongoing feedback about the assessment process and the client’s experiences, and potentially using the assessment as a springboard for a psychotherapy relationship. Collaborative learning that occurs in the course of the assessment and feedback process can be immediately incorporated into psychotherapy.

**Clinical Interview**

“Dr. John Rigby” was a 40-year-old married Caucasian, heterosexual male, of tall height and broad build. Dr. Rigby’s physicality and outgoing personality often led others to experience his presence as filling the room. In contrast to Dr. Rigby, Mr. Castel was quietly amiable, deferential, and anxious during the initial meeting. His eye contact was spotty, and it sometimes appeared that he was trying to avert his gaze. Physically, Mr. Castel was just under six feet tall with a thin build that he accentuated by sitting tightly and compactly in the chair; it was as if he was trying to take up as little space as possible. In fact, his success in this endeavor was noticeable when he stood up at the end of the session and his height surprised Dr. Rigby. Mr. Castel dressed casually in jeans, a mildly wrinkled Polo shirt, and tennis shoes. His short-cropped dark brown hair and shaven face suggested that he was attentive to his appearance.

Mr. Castel began by describing that over the previous months, he had felt as if he was unable to bring to bear the psychological energy required to pursue another job. Initially, he had enjoyed the respite from work, particularly from a job that he felt placed high demands on his time and emotions. Yet he now found it extremely difficult to find the desire and garner the focus to look for work, even for a few minutes a day. Mr. Castel described this paralysis as adding to his negative feelings about himself and compounding his depression. In discussing these experiences, Mr. Castel connected some of these concerns with past work issues: feeling distracted, trying to do too many things at once, and frenetically racing to meet deadlines at the last minute. Mr. Castel painted a picture of himself as a young man who had gone from a high-energy, fast-paced routine to one now of quiet inertia.

Mr. Castel reported brief contact with a psychologist as a young adult to explore issues related to being bullied during high school and college. He described his psychotherapy experience as “difficult” because he found it challenging to “open up” to his therapist. Ultimately, he attended only four sessions before dropping out. When Dr. Rigby inquired whether Mr. Castel also found it
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challenging to “open up” to family and friends, Mr. Castel grew quiet and began to exhibit some subtle reticence.

Mr. Castel reluctantly described his family, beginning with their ethnicities. He labeled himself as “biracial” with his ethnicity reflecting a blend of his father’s Latino and his mother’s Midwestern-Caucasian identities. Mr. Castel was aware that there was tension early in his parents’ relationship involving ethnicity. While tension diminished over the years, he noted that it was not a coincidence that his father took a job that required the family to relocate from the Midwest to the East Coast soon after Mr. Castel was born. Mr. Castel indicated that he viewed himself as “mostly white” in that most people did not readily associate him or his name with being Latino “unless they meet my father and then it is obvious.” On the rare occasion that he identified himself as Latino, others appeared surprised. Dr. Rigby noted the same, stating that Mr. Castel’s Latino lineage seemed to be suggested only in his slightly tan skin, dark hair, and prominent eyebrows. Mr. Castel expressed that while he felt comfortable with his mixture of ethnic identities, he did not experience them as a prominent or influential identity dimension. Mr. Castel denied any significant negative experiences associated with his culture or ethnicity.

Mr. Castel’s responses to open-ended questions about his social network (“Tell me a little about your friends and the people that are important to you”) were met with vague, almost impressionistic answers. Follow-up questions about specific individuals (“Who would you say you are closest to?”) resulted in even more ambiguity and anxiety. Although Dr. Rigby recognized that Mr. Castel’s anxiety and lack of detail likely represented an area of sensitivity and clinical interest, he deemed further pursuit of this line of inquiry unwelcome. Mr. Castel ultimately described his interaction with his parents and sisters as minimal. He reported having one or two close friends over the years, though neither of them were in his life now. He had some post-college friends with whom he worked, but he had distanced himself from them, citing his unemployment and that they were avid “partiers.” Mr. Castel denied any serious romantic relationships and stated he had never gone out with any one person for more than a few dates.

Dr. Rigby asked Mr. Castel, “How would you describe your sexual orientation?” Mr. Castel reluctantly answered that he had not thought much about this before, though he disliked sexual labels. He stated, “People can be whoever they are and call it whatever they want.” Mr. Castel then seemed to divert the conversation by spontaneously sharing that family and friends frequently comment that he is an “extraordinarily critical person,” which may account for his lack of friends and relationships. In this moment, both Mr. Castel and Dr. Rigby felt uneasy and anxious. Noticing Mr. Castel’s discomfort, Dr. Rigby elected to follow Mr. Castel’s lead to explore Mr. Castel’s lack of relationships rather than his sexual orientation, sexual behaviors, and desires in relationships. As they discussed Mr. Castel’s critical nature, Dr. Rigby noticed that Mr. Castel often referred to others, including friends, with the nongendered pronoun “they” or “some of them.” When he did refer to gender, Mr. Castel indicated that men
populated the majority of his social network. It was clear from the shift in tone and topic at this point in the interview that Mr. Castel was reticent to delve further into issues around sexuality and gender.

Mr. Castel’s vagueness regarding his sexual orientation, gender identities, and the genders and sexualities of the important people in his life struck Dr. Rigby as an area around which Mr. Castel was drawing boundaries, in a sense cor-doning them off from their discussion. Though clearly an area that raised some concerns in the interview and speculatively for Mr. Castel, Dr. Rigby proceeded to focus on the referral questions posed by Mr. Castel and his physician, respectively. That is, they wanted to understand and address the obstacles to his ability to focus, concentrate, and motivate himself to look for work, as well as more fully grasp the emotional landscape of his dysphoria and lack of energy. Mr. Castel agreed that this would be a helpful path to follow for the assessment.

Tests Administered

In order to answer the questions articulated by Mr. Castel and his physician, Dr. Rigby reviewed Mr. Castel’s medical records, conducted a comprehensive clinical interview, and selected the following psychological tests for administration: the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999), California Verbal Learning Test II (CVLT-II; Delis, Kramer, Kaplan, & Ober, 2000), Integrated Visual and Auditory Continuous Performance Test (IVA-CPT; Sandford & Turner, 1995), Conner’s Adult ADHD Rating Scales (CAARS; Conners, Erhardt, & Sparrow, 1999), Minnesota Multiphasic Personality Inventory-Second Edition (MMPI-2; Butcher et al., 2001), and the Rorschach Inkblot Test (Rorschach, 1921) using Exner’s Comprehensive System (CS; Exner, 2000).

General Assessment Findings

Mr. Castel’s performance on the WASI, CVLT-II, IVA-CPT, and CAARS did not suggest any attention issue. Therefore, the assessment shifted to understanding potential contributions of emotional and personality factors.

Mr. Castel completed the MMPI-2 with deliberateness. His resulting MMPI-2 profile shows a flat, rather surprisingly low level of symptom reporting (F=46, FB=46), with a thread of self-criticalness and lack of confidence in his ability to cope (L=43, K=43). Mr. Castel’s 2–5/5–2 codetype (Scale 5=72; Scale 2=68) appears to accurately reflect his behavioral presentation of dysphoria, reticence, and lack of assertiveness and openness. While his profile showed only a mild Scale 7 elevation (63), a pattern of anxious self-consciousness and shyness is likely. This codetype also suggests some concerns about typical heterosexual contact and dating, possibly due to the combination of social anxiety, self-consciousness, and lack of assertiveness (Friedman, Lewak, Nichols, & Webb, 2001). Combined with a low Scale 3 (43), we get the sense that Mr. Castel has
an acute awareness of his internal distress and has difficulty distancing himself from the related thoughts and feelings. The combination of this intense and consuming anxiety and his lack of assertiveness likely results in social isolation and the inability to act with personal agency to change his circumstances.

To further explore Mr. Castel’s internal world, Dr. Rigby administered to him the Rorschach (Comprehensive System; Exner, 2000). Unlike his approach to the MMPI-2, Mr. Castel appeared to psychologically withdraw from the task, shutting down his emotional and ideational processes while producing a record of average length \((R = 24, L = 1.4)\). Dr. Rigby noted that Mr. Castel was reluctant to take the cards from him, and when he did, Mr. Castel placed the card on the table and sat back in his chair. While this maneuver was ostensibly to obtain a better perspective on the blot, it appeared as if he was quite literally moving away from the card. The affect shifted to that which had initially permeated the space between Mr. Castel and Dr. Rigby when sexual topics were discussed in the interview, leaving Dr. Rigby with the sense that “the assessment is venturing into an area that is better avoided.”

The results of the Rorschach suggest that Mr. Castel has limited psychological resources \((EA = 1)\) and thus is likely to feel overwhelmed. Yet, Mr. Castel is someone who keeps his emotions within, rarely showing them to even those close in his life. The few responses on which he did elaborate are consistent with other aspects of the assessment. An image of a “statue of a white angel” on Card VI suggests both a detached, ideal self-representation of purity while simultaneously reflecting the immobility of a statue. Similarly, the preponderance of passive movements, with a sprinkle of a Food response (“chicken”), hint at a reluctant, unassuming, and dependent style. His two Texture responses suggest the desire for affiliation evident in the MMPI-2. While his perceptions do not have a pallor of negativity or morbidity, his closing response of insignificant, microscopic bugs “like dust mites” seems to reflect some diminished view of self.

Mr. Castel’s thinking, processing, and perceptual accuracy on the Rorschach were considered given his questions regarding focus and concentration. No serious thinking disturbances were noted. In providing his responses, Mr. Castel did not engage in effortful organization of his perceptual field and, instead, focused on discrete unusual details \((i.e., Dd99\) responses). At times, this response style can reflect someone who is reluctant to venture out into the perceptual field and, speculatively, into the wider behavioral world as well. Like his closing response of “dust mites,” Mr. Castel appears to seek comfort in unassuming, small places, which is consistent with his behavioral presentation during the assessment.

**Specific Gender and Sexuality Findings**

While the stated focus of the assessment was not on gender or sexuality issues, some findings emerged that pulled them to the fore. Most notable were
Mr. Castel’s MMPI-2 Scale 5 elevation and the configuration on Peterson’s gender role identification scales—GM and GF (Peterson & Dahlstrom, 1992)—that portray distinct attributes of masculinity and femininity in his self-description and provide helpful nuances to his Scale 5 elevation. Mr. Castel’s elevation on GF (73) suggests that he identifies with what the MMPI-2 defines as traditionally “feminine” attributes (including conflict avoidance, agreeableness, and reliance on affiliation), while eschewing the traditional MMPI-2 defined “masculine” attributes described as persistence, self-assuredness, and lack of anxiety. In the context of the 2–5/5–2 codetype, Mr. Castel appears to identify with the more traditionally “feminine” personality attributes, which, in his current presentation, are concomitant with a sense of discomfort (SOD2=57), passivity, and social awkwardness (Do=38), as well as an acute self-consciousness (Si1). Here, Dr. Rigby began to wonder about Mr. Castel’s experience of his gender and his anxieties about relationships that it may impact. It is interesting to note that Peterson’s scales are rarely found to be elevated in this clinical setting, which further suggests their unique value as a meaningful finding to aid in understanding Mr. Castel’s psychology.

Additional information evident in the assessment addressed aspects of Mr. Castel’s personality that ventured into more ambiguous and anxiety-laden clinical waters. These issues involved Mr. Castel’s gender identification, gender expression, and sexuality. Standard assessment measures are generally not well defined for understanding these areas (Egan & Perry, 2001). In most cases, information gleaned from clinical interviews can be useful in promoting additional clarity. However, factors that arose during this assessment (e.g., Mr. Castel’s reticence to discuss gender and sexuality, Mr. Castel and Dr. Rigby’s experiences of each other’s gender and sexuality) appeared to weave an intersubjective space between Mr. Castel and Dr. Rigby in which gender and sexuality were to be avoided. Additionally, we must consider the potential role that the field of clinical psychology might have played in Mr. Castel’s reticence to discuss his gender and sexuality. Those with non-normative gender or sexual identities have good reason to be wary of assessment given the field’s history of pathologizing differences in these realms. That is, Mr. Castel’s avoidance of discussing gender and sexuality may have been co-created by his interaction with Dr. Rigby and in his interaction with the profession of clinical psychology generally. Moreover, it is possible that Dr. Rigby’s own anxiety about his profession’s history and/or his own anxiety about exploring topics of gender and sexuality may have foreclosed the space for this discussion.

Dr. Rigby, noting Mr. Castel’s sensitivity to topics involving gender and sexuality, was aware that active probing in these areas was likely to be perceived as provocative and potentially aggressive. Conscious of the importance of the therapeutic alliance and the prospect of his ultimate role as Mr. Castel’s therapist, Dr. Rigby deferred exploring Mr. Castel’s gender and sexuality. While the most notable issues that emerged had to do with Mr. Castel’s sexual orientation and the sex and sexual orientation of his partners, Mr. Castel had also been opaque
with respect to his early bullying experiences, his relationship with friends, and even interpersonal details about his interactions with co-workers. The assessment data suggest that Mr. Castel's personality style has strong elements of passivity and dependency and that he diminishes himself in regard to his place in relationships and his ability to advocate for himself in the world. Ambivalence in men about dependency is not uncommon (Rabinowitz & Cochran, 2002). Along with his identification with traditionally identified feminine qualities (his highest MMPI-2 elevations occurred on Scale 5 and GF), Dr. Rigby wondered about Mr. Castel's comfort with these—albeit stereotypic—gender attributes and whether his anxiety and negative self-concept were connected to gender and/or sexuality. While the assessment had not focused on these areas, Dr. Rigby and Mr. Castel now had hints as to areas for additional exploration.

**Integrating Subjective and Objective Findings**

The evidence from the cognitive assessments did not support the presence of an attentional disorder. While timely and vigilant focus and short-term recall were not among Mr. Castel's strengths, neither were they discrepant from his overall level of cognitive functioning. Second, some evidence suggested that Mr. Castel had experienced a significant decline in his mood, energy, and motivation as a result of his jarring job loss that triggered a preexisting vulnerability to a ruminative depressed mood state. These two conclusions appeared to be well supported and likely consistent with Mr. Castel's conscious attributions about himself. In working to understand the role of gender and sexuality in the findings, the assessor can explore the respective elements of the interview, behavioral observations, and specific findings. Mr. Castel's personality style was imbued with a global reticence for engagement with others and the world, despite his desire for close connections. He appeared to be an unassertive and self-conscious man who emotionally withdrew from opportunities to fully express his true thoughts, beliefs, and emotions. Mr. Castel seemed not only identified with traditionally ascribed feminine attributes, but he also was uncomfortable possessing them and having them acknowledged by others. The interview questions posed by Dr. Rigby—although not as incisively direct as they could have been—still inspired Mr. Castel to marshal his defenses and withdraw in the assessment space (as he subsequently did in response to the Rorschach as well). While the assessment data were certainly not able to answer definitive questions regarding the full landscape of Mr. Castel's perspective on his gender role or sexuality (nor would it be expected to), it appeared to sufficiently raise some provocative questions to be explored in the feedback session and subsequent psychotherapy.

**Feedback Session**

The feedback session with Mr. Castel afforded Dr. Rigby the opportunity to summarize and explore the findings of the assessment. In approaching the
feedback session, Dr. Rigby initially focused on the referral question with the data that were most empirically supported. While answering the diagnostic question is often the key piece of information desired by the client, providing a context for the meaning of the data and their implications for the client’s life expands the utility of the assessment. Mr. Castel found the data regarding the absence of a formal attentional disorder to be convincing, though he was disappointed that there was not an easy remedy to his problems. Once Mr. Castel and Dr. Rigby discussed some of the personality findings, Dr. Rigby felt that the alliance was sufficient to raise questions and possible connections between his personality style, gender identification, and sexuality. It was important to frame this data as a series of hypotheses and to allow sufficient room for Mr. Castel to question, discuss, and process their impressions of the findings.

Dr. Rigby shared his observations about Mr. Castel’s reticence to talk in detail about certain aspects of his interpersonal life and wondered about his sensitivity and negative associations with those aspects. Mr. Castel became reticent once again, but he was able to share that, for him, these were the most personal of thoughts and feelings that troubled him. Mr. Castel was able to share that his conflicted feeling was about his place in the world. He had long felt out of place and different from others, a feeling that was exacerbated by pressures to conform to heteronormative roles. Interestingly, the perception of being different is often not a contributor to difficulties, but rather the myriad of pressure for conformity along gender expression is the issue (Egan & Perry, 2001). When asked about the nodal event in Mr. Castel’s recent past (the loss of his job) in the context of feeling pressure, Mr. Castel noted that one of the most difficult aspects of the loss of his job was the comfort he felt in being who he was there. Specifically, Mr. Castel experienced his job at a sports franchise as undoubtedly “masculine,” with masculinity functioning almost as ambience. Mr. Castel never felt he had to prove himself, as if being in the atmosphere of such masculine traits (e.g., physicality, aggressiveness) was sufficient. Countertuitive as this initially appeared, it highlights the importance of understanding the cognitions associated with the client’s gender, work, and their connections (Cochran 2005; Mahalik, 2001). Thus, the loss of his job seemed to upset the balance that had been set, reviving long-standing pressures to conform to heteronormative gender and sexuality expressions or hide his psychology. Moreover, the two discussed possible preoccupations with gender and sexuality as contributing to Mr. Castel’s presenting concern of inattention.

At the conclusion of the feedback session, Dr. Rigby offered Mr. Castel several avenues for treatment. The two discussed their experiences of the assessment process and the possibility of a propitious working relationship. Mr. Castel was offered an opportunity to continue the discussion of the assessment process and results as a way to transition into individual therapy with Dr. Rigby. Mr. Castel called within the week to schedule a follow-up session to begin psychotherapy.

Mr. Castel began a measured but steady involvement in individual psychotherapy. While issues around employment continued to be the focus of
psychotherapy, both Dr. Rigby and Mr. Castel were now more able to engage in explorations of his conflicting self-states and interpersonal issues. Mr. Castel rarely raised issues related to sexuality and gender, though he became less reticent and anxious when Dr. Rigby mentioned them. Aware of Mr. Castel’s sensitivities, Dr. Rigby was able to provide an empathic and supportive frame when approaching areas that had previously been off-limits. For example, when Mr. Castel described plans to travel to a beach resort well-known to be frequented by the LGBTQ community, Dr. Rigby offered:

So this might be an area which you may be less inclined to talk about, but I’m going to take a shot because you were saying recently how feeling connected to other people helps you feel more grounded. I wonder if you feel a sense of community, being with people that you have more in common with, because of how you express your sexuality. Tell me a little about what you expect from your time there.

Interestingly, Mr. Castel found it easier to talk about sexuality and his sexual orientation than about gender identity issues per se. Mr. Castel downplayed the effect of his culture and seemed to feel that issues related to gender identification and expression were helpful to understand, though ultimately difficult to change. He saw opportunities for changes in his behavior around sexuality and how he interacted with individuals through intimacy. Thus, feeling more confident in his sexual orientation, Mr. Castel came to feel, was far more meaningful and more accomplishable than changing his ideas about gender expression. It was as if the seed of his self-confidence lay in his sexuality.

Vignette Two: Ms. Hill and Dr. Diaz

Referral Context

“Ms. Jennifer Hill” was a 30-year-old, single, African American female who was referred for psychological assessment with Dr. Melissa Diaz by her outpatient psychotherapist of three years, Dr. Jason Smith. Dr. Smith described Ms. Hill as a “difficult client” with whom he felt “stuck.” He frequently found himself surprised to see her on his schedule after not thinking of her between sessions. During sessions, Dr. Smith experienced Ms. Hill as relatively superficial, discussing her symptoms but resistant to exploring their potential underpinnings, and consequently, he felt it challenging to connect with Ms. Hill. Consistent with this experience, Dr. Smith recognized that his progress notes had become sparse and that he struggled to recall the details of their work.

Dr. Smith described the nature of their work as having focused on Ms. Hill’s depressed mood, anxiety, and her long-standing tendency to privilege others’ needs before her own. He noted that Ms. Hill had been diagnosed with Bipolar II Disorder, and she was taking mood-stabilizing medications to manage
her symptoms. In contrast to their extensive discussion of psychiatric symptoms, Ms. Hill’s gender and sexual identities were not explored in the therapy. Dr. Smith made no reference to gender or sexuality when discussing Ms. Hill with Dr. Diaz. Rather, Dr. Smith stated that although Ms. Hill had made some treatment gains in her mood stability and her ability to assert her needs, she continued to experience moderate anxiety, depression, and interpersonal difficulties. He noted Ms. Hill’s frustration with a lack of progress in psychotherapy. Dr. Smith hoped that the assessment might enhance his work with Ms. Hill, assist them in understanding her psychological issues, and illuminate potential impediments to her progress.

**Clinical Interview**

“Dr. Melissa Diaz” was a tall, slender, heterosexual, married Latina female in her late thirties. She greeted Ms. Hill in the waiting room; Ms. Hill peered up through the dark bangs that encapsulated her face and followed Dr. Diaz quietly to her office. Dr. Diaz observed that Ms. Hill was of average height, overweight, and dressed neatly, but in a style more characteristic of a younger woman. She wore jeans with Doc Martens boots and a T-shirt that stated, “No chick flick moments.”

Within minutes of their initial contact, it became evident that Ms. Hill was both uncomfortable and skeptical of testing. To address this discomfort and to facilitate the development of a trusting, collaborative assessment relationship, Dr. Diaz spent considerable time describing the assessment process and engaging Ms. Hill as an active participant in her own assessment. Ms. Hill began to express certain curiosities about herself. She wondered, for example, why she felt so “emotional” and “guilty” in relationships. Ms. Hill described feeling frustrated that after participating in psychotherapy on and off throughout adolescence and adulthood, she continued to struggle with these issues. Her capacity to verbalize her concerns to Dr. Diaz allowed the two to identify several client-specific goals for the assessment, including (a) helping Ms. Hill to better understand herself (particularly her guilt and emotional reactivity) and (b) using assessment-derived insights to facilitate Ms. Hill’s work with Dr. Smith.

Over the course of their interview, Ms. Hill shared that she worked as a sales representative for a plumbing company, which she enjoyed because she worked almost exclusively with men. Dr. Diaz noted Ms. Hill’s “No chick flick moments” T-shirt and inquired about Ms. Hill’s preference for men and her experience of women. Ms. Hill stated she found women frustrating because she believed them to be “too emotional,” “needy,” and often lacking a sense of humor. She described preferring men and aspiring to embody what she considered to be more “masculine” traits of “confidence, assertiveness, and sarcasm.” Ms. Hill articulated her admiration for female characters who seemed able to embody these “masculine” traits as “gender rebels” or nonconformists with their quite bold, outspoken presence (Harris, 2009).
Ms. Hill went on to report that she was the eldest of two daughters and one son to middle-class parents with an intact marriage. She resided in an apartment with her younger sister near her parents and brother. Ms. Hill described her family as “Army brats.” Her mother worked as a preschool teacher and her father worked as a United States Army mechanic. While her father was never deployed, Ms. Hill stated that his active military status necessitated the family’s frequent relocation across the United States during her elementary and middle school years. She recalled feeling as though she and her family “only had each other,” but she characterized her family relationships as having poor interpersonal boundaries that left her feeling simultaneously close to them while also lonely and frustrated. Ms. Hill stated she felt closest to her father, particularly because they enjoyed “the same sarcastic humor.”

Ms. Hill associated her long-standing feelings of shyness and loneliness, as well as her circumscribed network of friends, with her experience of transience during childhood. She recalled having few friends as a child and adolescent. Despite her stated preference for men, she denied any close friendships with men and noted only a couple close friendships with women. She stated, “I feel like I have no true friends.” Ms. Hill described finding herself in caretaking roles with friends, which she enjoyed but sometimes resented.

Ms. Hill identified her sexual orientation as heterosexual and stated her sexual behaviors had been limited to men. She reported having recently broken up with her boyfriend because his employment required that he travel often and they rarely saw one another. Ms. Hill shared that her romantic relationships had been complicated by her ethnicity, as she preferred to date Caucasian men, but she often felt as if she was “not good enough” for them. When Dr. Diaz inquired about Ms. Hill’s experience of her ethnicity, Ms. Hill described numerous experiences of discrimination, from being followed in stores by sales clerks who thought she might steal something, to being overlooked, to being denied access to certain services or social groups. Although Ms. Hill understood her experience of her ethnicity to be an important aspect of her identity, she had never discussed this with Dr. Smith. She relayed that the two had also neglected to discuss her medical issues.

Ms. Hill reported severe asthma that had precipitated several pneumothoraces. As a young adult, Ms. Hill had suffered life-threatening complications following pneumothoraces. She was hospitalized for weeks at a time, feeling “terrified and alone.” Subsequently, Ms. Hill described experiencing symptoms of posttraumatic stress disorder, including intrusive memories, nightmares, hypervigilance to bodily sensations, and avoidance behaviors. Having experienced health problems of her own as a child, Dr. Diaz identified with Ms. Hill’s feeling of terror about these incidents and the fear that they could happen again. This sensitivity led Dr. Diaz to inquire further about Ms. Hill’s relationship with her body, something Dr. Diaz later learned had never before been explored in Ms. Hill’s individual psychotherapy. Ms. Hill responded, “I despise my body.” Dr. Diaz commented on the intensity of this statement, and the two discussed
Ms. Hill’s anger that her body had continually “betrayed” her, both in looks and “weakness.” Ms. Hill joked that she liked nothing about her “festively plump” body. She noted her disgust with her large breasts and commented sarcastically about Dr. Diaz’s smaller breasts.

Dr. Diaz inquired about other possible traumas over the course of Ms. Hill’s life. Ms. Hill denied any sexual, physical, or emotional abuse and neglect. She noted no significant symptoms of dissociation, with the exception of depersonalization during medical traumas.

Ms. Hill’s openness left Dr. Diaz feeling a myriad of emotions. She really liked Ms. Hill and found herself enjoying Ms. Hill’s jovial nature and wittiness. She felt privileged to receive Ms. Hill’s trust and honesty, but she was also skeptical and concerned. Dr. Diaz found herself wondering why Ms. Hill was sharing these important aspects of herself with her and not with Dr. Smith, her therapist of three years. Was Ms. Hill more open with Dr. Diaz due to their shared gender identities and experiences as ethnic minorities? When Dr. Diaz explored Ms. Hill’s pattern of withholding information concerning her gender identity, ethnicity, and body image from Dr. Smith, Ms. Hill noted that she had experienced fleeting thoughts that she wanted to tell him, but she could “not seem to remember to bring [these issues] up during sessions.”

**Tests Administered**

In order to answer the questions articulated by Dr. Smith and Ms. Hill, Dr. Diaz reviewed psychotherapy and pharmacotherapy progress notes, conducted a comprehensive clinical interview, and selected the following psychological tests for administration: the Personality Assessment Inventory (PAI; Morey, 2007), Bell Object Relations and Reality Testing Inventory⁵ (BORRTI; Bell, 1995), Rotter Incomplete Sentences Blank—Adult Form (RISB; Rotter, Lah, & Rafferty, 1992), Rorschach Inkblot Test (Rorschach, 1921) using the Rorschach Performance Assessment System (R-PAS; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011), and the Thematic Apperception Test (TAT; Murray, 1943).

**General Assessment Findings**

Ms. Hill’s PAI scores indicate she experiences herself as both significantly impaired in her functional capacities and interpersonally challenged due to severe disruptions in physical functioning (ANX: t=85, SOM: t=82). Secondary elevations on ARD (t=74) and DEP (t=73) indicate that at least some of Ms. Hill’s physical symptoms and distress are related to a broad pattern of neurotic functioning, and Ms. Hill’s pattern of ANX subscale scores (ARD-O: t=49, ARD-P=67, ARD-T: t=84) indicate ongoing, recurrent distress due to the presence of symptoms associated with experience of traumatic stress. Ms. Hill’s scores of t=33 and t=42 on the DOM and WRM scales, respectively, place her within the “hostile submission” quadrant of the interpersonal circumplex.
In addition, Ms. Hill’s elevated SUI score ($t=72$) indicate preoccupations with suicide (SUI: $t=72$) within the context of average general impulse control (BOR-S: $t=57$).

Ms. Hill’s BOORTI Reality Testing Domain scale scores indicate perceptions of her own reality testing abilities as intact (RD: $t=56$, UP: $t=53$, HD: $t=35$). In contrast, her Object Relations Domain scores indicate that while she does not fear outright abandonment (IA: $t=59$) and is able to recognize others’ needs (EGC: $t=54$), Ms. Hill views herself as shy, nervous, and socially awkward (SI: $t=65$), as well as uncomfortable with her wishes for emotional intimacy (ALN: $t=65$).

Twenty-three (58%) of Ms. Hill’s 40 RISB responses are appropriately stimulus-related, while 17 responses (42%) included unique ideational, mood, or relational elements. Most of the ideographically informative responses were organized around two broad themes: her preoccupation with being good and helpful to others and associated feelings of marked guilt. A smaller cluster of ideography-laden responses communicate perceptions of others as emotionally hurtful or dangerous and herself as alienated or seeking distance.

Ms. Hill’s profile of standardized R-PAS scores reveals normal-range functioning (SS: 80–120) on most of the variables related to motivation, productivity, coping resources, and psychological complexity; the presence of stress and distress; and those related to an individual’s understanding of herself, beliefs about others, and expectations regarding interpersonal relationships. In contrast, Ms. Hill’s scores on a number of variables within the Perception and Thinking Problems domain are elevated (EII-3: $t=128$, TP-Comp: $t=124$, WSumCog: $t=127$, SevCog: $t=113$, FQ-%: $t=124$ juxtaposed with FQo%: $t=85$), indicating problems in her capacity to perceive events accurately, take others’ perspectives, and engage in effective reasoning and use of judgment. These findings were tempered by findings that Ms. Hill is as able to arrive at conventional interpretations of events as often and as well as others (P: $t=111$, all Ps of FQo) and that disturbances in her thinking were odd, oblique, and immature rather than severely pathological (eight Level 1 codes versus one Level 2 code).

Additional findings (AGM: $t=131$, AGC: $t=116$) indicate that Ms. Hill expects aggression to occur as a regular component of routine interpersonal exchanges. Yet, other scores (NPH/SumH: $t=121$) indicate a marked tendency to conceptualize relationships via wishes and imagination rather than the real qualities of herself and others. Review of the content and sequence of Ms. Hill’s eight human responses (seven of which were fictional or detail responses) revealed a thrice-recurring pattern in which percepts shifted from idealized or healthy to damaged, monstrous, or alien, indicating struggles with conflicts around intimacy, with prominent concerns regarding the safety of interpersonal closeness.

Ms. Hill’s TAT responses are notable for her use of clichéd, dramatic elements that were often absurd or magical (and frequently spilled over into satirical depictions of caregivers who failed to attend to their dependents), her often-theatrical style of delivery (e.g., foreign accents), and indications of discomfort in
relation to the experience of being closely attended to. These themes are exemplified by TAT responses (such as to Card 7GF) that center around a “lonely” and “resentful” girl from a privileged and/or influential family who has terribly emotionally neglectful parents. Other responses convey wishes for mastery over adversity and a desire to attain meaningful and satisfying relationships with others. For example, in response to Card 2, Ms. Hill described a poor girl who lacks external resources but who rallies her internal resources of strength and determination to obtain an education and return to her hometown to help others.

When synthesized with her developmental history, pattern of response to treatment, and behavioral presentation, Ms. Hill’s test responses reveal the picture of a young woman whose cognitive, affective, and interpersonal functioning has been compromised by the presence of enduring anxious and depressive features related to prior physically threatening and emotionally overwhelming episodes of severe medical impairment and perhaps past interpersonal traumas. While Ms. Hill demonstrated a healthy interest in interpersonal closeness with others, she anticipates that others will seek to control and dominate her in relationships. She views her own needs as burdensome and worthy of guilt and self-recrimination when expressed, and she views herself as neither good enough nor sufficiently helpful to others. These features lead Ms. Hill to adopt a relational stance of passivity and compliance in which she routinely submits to the demands of others while silently harboring anger and resentment at having to cast aside her own wants and needs.

While she is routinely able to think clearly, use logic, and distinguish reality from fantasy, Ms. Hill frequently employs immature and idiosyncratic patterns of thinking and speaking that allow her to appear whimsical and to avoid perceived danger if direct confrontation should arise, but that interferes with her ability to understand aspects of routine social exchanges. This style allows Ms. Hill to create an internal protective space between herself and others as a way of managing her profound anxiety that others will hurt her. Ms. Hill also manages her anxious expectations of frustration, disappointment, and emotional deprivation in relationships through the construction of fantasies. For example, Ms. Hill deliberately fantasizes about suicide as a way to gain relief from her anxiety and depression. She also fantasizes about attaining a modicum of calmness and satisfaction by isolating herself away from others.

Refocusing the Lens on Data Specific to Gender and Sexuality

Ms. Hill appeared to be an individual struggling with a pervasive pattern of interpersonal difficulties coupled with persistent anxiety, depressed mood, and a propensity to distort or misperceive information in social situations. She experienced herself as socially awkward and often disappointed or angry at having to submit to other’s needs. Dr. Diaz contemplated Ms. Hill’s wish to embody more “masculine” attributes, her preference for interacting with men, and her experiences of being marginalized due to her race. Dr. Diaz considered the impact
of Ms. Hill’s experiences on ongoing ambivalence about relationships, including her therapeutic relationship with a Caucasian male. Dr. Smith acknowledged that while Ms. Hill preferred men, she was often shy, disconnected, and withholding of information with him. An additional assessment question emerged: What is the nature of Ms. Hill’s gender identity, and how might understanding this aspect optimize her psychological functioning?

In considering Ms. Hill’s gender and sexuality, Dr. Diaz wondered if standard psychological assessment instruments can fully inform an understanding of an individual’s gender and sexual identities. Dr. Diaz noted that, despite its excellent conceptual foundations, well-documented strengths, and widely recognized utility, the PAI (Morey, 2007) was not designed to assess constructs such as sexuality or gender. Only one item pertains directly to sexuality (the respondent’s current interest in sex as part of the DEP-P subscale). In this regard, the PAI may have been an unfortunate choice of self-report measure, as it offers little in the way of understanding Ms. Hill’s gender and sexual identity dimensions. Similarly, the BORRTI has little to say about these topics but does suggest that Ms. Hill experiences general difficulty with interpersonal intimacy, dissatisfaction with her sex life, feels she lacks adroitness when interacting with men, and is shy in exchanges with men. Ms. Hill’s response to this matrix of questions provides some additional information about the degree to which her sex life is satisfactory and how she relates to opposite-sex individuals. In this respect, it is possible that Ms. Hill’s shyness with men might be inhibiting her progress in therapy with her male therapist. However, the BORRTI has some notable limitations in that it (a) implicitly assumes heterosexuality as the norm, (b) appears to adhere to stereotypic gender roles, (c) provides only a restricted range of response options, and (d) thus yields limited information regarding gender and sexuality.

In contrast to the self-report measures, performance-based measures such as the RISB, Rorschach, and TAT offer slightly more information concerning Ms. Hill’s relationship to her gender and sexuality. Two (12%) of Ms. Hill’s 17 idiographic responses on the RISB provide sexuality and gender-related information. Ms. Hill wrote Men . . . “are powerful and confident” and Most women . . . “are self-conscious.” In tandem, these responses convey Ms. Hill’s experience of discomfort regarding her self-image, her difficulty balancing her positive and negative self-perceptions, and her sense of discouragement regarding the prospect of finding a male intimate.

The R–PAS contains only one variable directly related to the topic of sexuality: Sexual Content (Sx). Sex responses indicate a respondent’s attention to sexual matters and may indicate specific sexual concerns or preoccupations (Meyer, Viglione, Mihura, Erard, & Erdberg, 2011). Ms. Hill’s protocol contained three Sex responses, with one response containing sexuality-related movement. Specifically, Ms. Hill’s response to Card II was remarkable for her association of women, secondary sexual features, aggression, and injury. She relays that these women are frightening and aggressive creatures who, in the course of conflict,
injure one another’s breasts, potentially indicating that her own self-image, relationships with women, and possibly her sexuality and experience of her body are impinged upon by fears of injury from conflict or her aggression toward others. Recall Ms. Hill’s aggressive comment about breasts during her clinical interview with Dr. Diaz. Notably, Ms. Hill’s two other responses containing sexual imagery both occurred in response to Card VII, which has demonstrated a distinct empirical association with femininity and characteristics associated with femininity (Aronow & Reznikoff, 1976; Kamanao, 1960).

Ms. Hill’s responses to Card VII included fictional or distorted people and parts of people, which gave the sense of sexuality being uncontainable. The presence of first sexualized movement and then sexual content in Ms. Hill’s two responses to a card associated with perceptions of femininity, and with strong associations to make-believe or fantasy, gives rise to the hypothesis that Ms. Hill’s sense of her sexuality, and perhaps her sexual identity, may be particularly and strongly related to her perceptions and experiences of femininity in general, her own personal sense of femininity, or both. Integration of the sex response (and its associations) from Card II with those of Card VII raises the possibility that Ms. Hill’s gender identity and sexuality may be influenced by her fear of (psychological) injury due to conflicts regarding femininity. To the extent that an individual’s gender and sexual identities are influenced by caregiver-child relationships, the sexual material produced by Ms. Hill in response to the Rorschach potentially raises questions about the quality of Ms. Hill’s affective relationship with both of her parents and the extent to which overt sexual and aggressive displays were supported, undermined, or treated inconsistently.

Finally, review of Ms. Hill’s TAT protocol yielded three relevant responses to sexual and gender identities. First, Ms. Hill’s narrative response to Card 2 (described previously) was strongly organized around the central character of the girl in the foreground achieving mastery over experiences of deprivation. Second, Ms. Hill’s response to Card 4 relayed the man’s intense facial expression as related to conflicts around intimacy versus independence, while the woman’s posture reflected her desire for romantic fulfillment and her skepticism of the man’s integrity. Ms. Hill noted the man “wins,” and unable to resolve the tension between the two fully, she reverted to her satirical style as she described the two “living happily ever after” married with children. Third, Ms. Hill’s response to Card 13MF incidentally dealt with the female figure’s nakedness, focusing on American middle-class stereotypes, particularly retrospective feminine ideals. She described a “prim and proper” wife and mother who “demurely” does what is expected of her until one day when one of her expected activities kills her. Her husband, stoic and unflappable, finds her dead, naked body and experiences shame about her nakedness. He quickly dresses the body in “appropriate attire.”

When integrated, these responses convey the following: (a) a strong primary interest in attaining a romantic attachment to a man; (b) considerable self-doubt about her value to men; (c) preoccupation with gaining mastery over
experiences of deprivation; and (d) angry feelings and sarcastic attitudes toward traditional feminine ideals and the women who embody them.

**Integrating Subjective and Objective Findings**

Data from traditional self-report and performance-based psychological tests provide a picture of a woman tormented by significant, long-standing anxiety and depression associated with traumas and from relational dyads characterized by emotional dominance and submission. Ms. Hill routinely submits to the demands of others, perhaps with the expectation that her needs will then be met. Unfortunately, her needs rarely are. She remains silently resentful and hypervigilantly awaits the next proverbial shoe to drop to be hurt, dominated, or neglected yet again. Thus, we can glean from the data some answers to the questions posed in this assessment. Specifically, Ms. Hill likely struggles to feel safe in her relationship with Dr. Smith and may eschew her needs and intimacy due to fears of being hurt or burdening Dr. Smith. Ms. Hill likely feels guilty due to her sense of deficiency, her fear of burdening others with her needs, and her feelings of resentment when she does assert her needs. While these findings appear to answer the referral questions well, further reflection on Ms. Hill's gender and ethnic identities allows for a deeper understanding of her relational stance, guilt, and the roadblocks to her progress.

Ms. Hill demonstrates a deep sense of inferiority, which appears related to her subjective experience of her ethnicity and gender. With regards to her subjective gender, assessment data suggest that her experience of gender continues to be built upon and influenced by her experiences with attachment figures, and particularly conflict about separating and individuating from her maternal caregivers (Butler, 1995; Dimen & Goldner, 2005). Chodorow (1999) suggests that gender can be understood within the relational matrix of mothering. In the context of this attachment relationship, the child begins to define her experience of gender via identifications with her mother (Butler, 1995; Chodorow, 1999). Some theorists believe that, for the little girl, femininity is experienced as sameness with mother and masculinity is “defined by the ‘not me’ experience of difference (from mother and mother’s femininity)” (Dimen & Goldner, 2005, p. 94). The strength of the father’s support of traditionally feminine behaviors and each attachment figure’s ability or inability to hold the child’s sexuality and aggression only reinforces the gender binary of me and not me (Maccoby, 1980). Benjamin (1998) suggests that this binary (feminine is what masculinity is not) is influenced by and may ultimately serve as the springboard for other binaries like race (black/white), subject and object, dominance and submission, or passivity and assertiveness.

Within this framework, the sexual material produced by Ms. Hill in response to the Rorschach raises questions about the quality of Ms. Hill’s affective relationship with others and the extent to which overt sexual and aggressive displays were or are supported, undermined, or treated inconsistently. Ms. Hill's
mental representations of mother-daughter relationships are connected to themes of deprivation, fears that conflicts will lead others to injure her emotionally, as well as strong feelings of anger and resentment, particularly in regard to traditional feminine ideals and the women who embody them. Interactions with women likely activate her conflicts surrounding identifications and separation and individuation from her mother. Thus, she aspires to embody those attributes she believes are “masculine” (or what her mother’s femininity is not), in part to separate from her maternal figures. Recall her “No chick flick moments” T-shirt, her hatred of her breasts, and her preference for her father and men, whom she sees as more sarcastic and powerful. Mental images of men, in turn, tend to be polarized into idealized but distant father figures or exploitative, lecherous individuals. Ms. Hill associates femaleness with self-doubt and, conversely, maleness with self-confidence and authority. She aspires to mask her insecurities and portray a facade of self-assuredness around men and compliance with women. Thus, Ms. Hill maintains a facade that “results in a multitude of symptoms and innumerable forms of suffering,” including a chronic sense of neglect, feeling unloved, anxious, fearful, and angry (Dimen & Goldner, 2005, p. 94).

The gender binary extends to and interacts with her experience of her ethnicity wherein she feels further disempowered. Ms. Hill’s experiences as the object of discrimination only increases her vulnerability to mental health issues (Bostwick, Boyd, Hughes, West, & McCabe, 2014). Additionally, we can begin to better understand the power differential between Ms. Hill, an African American woman who believes Caucasian men to be powerful and exploitative, and Dr. Smith, a Caucasian man in a position of authority. It is likely that in this dyad, Ms. Hill feels an even greater pull to portray the aforementioned facade, with a reticence to share information concerning her gender identity, ethnicity, and body image that might make her vulnerable. Note that Dr. Smith described their exchanges as feeling “superficial” and lacking emotional connection. Thus, in considering Ms. Hill’s gender and ethnicity, we come to see a more three-dimensional view of Ms. Hill. In returning to the referral questions, we can now begin to more fully appreciate the complexity of both Ms. Hill’s experience of herself and potential roadblocks in her relationship with Dr. Smith.

**Feedback Sessions**

Feedback with Ms. Hill occurred across two sessions and included both Dr. Diaz and Dr. Smith. It began with each party reviewing his or her understanding of the reason for referral and articulating questions that each had hoped to answer via this assessment. Dr. Diaz then provided an overview of the findings and their implications with regard to each question. Throughout this process, Dr. Diaz inquired about both Ms. Hill and Dr. Smith’s reactions to the findings, whether or not each found the findings plausible, and she solicited examples from Ms. Hill’s everyday life and treatment. Dr. Diaz was able to use her
developmentally informed understanding of the findings to initiate dialogue between Ms. Hill and Dr. Smith regarding Ms. Hill’s past experiences of medical trauma and her current relationship with her body. In response to this information, Dr. Smith stated that he had known of Ms. Hill’s medical issues, but it had not occurred to him to focus their work on these experiences or her bodily self-perceptions. Ms. Hill began to cry as she described to Dr. Smith her hatred of her body for its perceived failings and her large breasts. She lamented about her inability to escape her large breasts—her body making it impossible for her to escape her internal conflict about gender and gender expression. Dr. Diaz facilitated a conversation between Ms. Hill and Dr. Smith regarding Ms. Hill’s experience of her gender, including how it might relate to her attachment relationships and their experience of one another’s gender in the therapeutic relationship. Dr. Diaz also shared the assessment findings regarding Ms. Hill’s fears and expectations in relationships, her relational stance of passivity, her experience of her ethnicity, and her chronic anxiety and depression. Dr. Diaz observed Ms. Hill and Dr. Smith connect on a deeper level in a moving exchange after many months of stagnation in therapy.

Conclusion

Adrienne Harris states, “I like the idea of thinking about gender as something like color saturation. There are people who have high-saturated genders, and for other people it has a milder kind of valence. There’s a lot of variation” (Corbett, Dimen, Goldner, & Harris, 2015, p. 296). The two vignettes detailed above, with perhaps higher-saturated genders and sexualities, demonstrate the importance of clinicians maintaining a stance of curiosity about gender and sexuality throughout the assessment process, even when these issues are not included in the reason for referral. Neither Mr. Castel nor Ms. Hill was referred for psychological assessment to explore issues relating to gender or sexuality. Rather, Mr. Castel was referred to explore his depression and potential ADHD and Ms. Hill was referred to explore roadblocks in her therapy such as a potential personality disorder. Yet in both cases, salient issues relating to the patients’ experiences of their gender and sexuality emerged via the integration of behavioral observations, interactions in the assessment dyad, and testing data. Gender and sexuality constructs also served as a vehicle through which other important issues could be explored. The assessors began to feel the pull of sexuality and gender, and in making space to consider these issues, they were able to more fully understand their clients and more accurately respond to the referral questions.

In the case of Mr. Castel, he and Dr. Rigby came to understand that his worsening depression was strongly related to a resurfacing of conflicts concerning gender and sexuality following the loss of his job. Similarly, in noticing and inquiring about Ms. Hill’s preference for men, experiences in relationships, experience of her female body, and her ethnicity, Dr. Diaz and Ms. Hill
co-constructed a space in which these issues could be brought to the fore. Ms. Hill and Dr. Smith eventually came to understand the important role that gender and ethnicity played in their therapeutic relationship. In both cases, it would have been impossible to fully or accurately respond to the referral questions posed without considering these important experiences. Thus, when seeking to understand an individual’s personality, it is impossible to ignore his or her gendered and sexual selves. These facets will continue to pull anyone in close proximity during the assessment process. We should not underestimate the gravity of gender and sexuality.

Gender and sexuality are important aspects of human functioning that cannot be assumed, intuited, or understood by association, but rather through a relational exploration between assessor and assessee. While formal test data from our best measures play a key role, gender and sexuality are multidimensional, multidetermined, and complicated concepts that our measures are under-equipped to adequately elucidate (Egan & Perry, 2001). Assessments are therefore best conducted with a curious and open approach, in an experience-near fashion, and with a modicum of humility.

**Practical Points**

- Referral questions will likely omit questions concerning gender and sexuality, but understanding the client’s gender and sexual identities can enhance your understanding of the individual and your response to the referral question.
- Issues concerning gender and sexuality may not be evident at the outset of an assessment but may gradually emerge during the assessment process through a combination of behavioral observations, interactions between assessor and assessee, and testing data.
- Use standard assessment measures as a starting point to understand the client. These will likely not be nuanced, specific, or precise enough to fully understand gender and sexuality issues solely and will require the clinical acumen of a thoughtful and knowledgeable clinician (Egan & Perry, 2001). Additional exploration via narrowband measures may be beneficial.
- Consider assessment data as providing hypotheses for further exploration, curiosity, and discussion around gender and sexuality. Important information in these areas cannot be assumed or derived by association. Ask about gender and sexuality explicitly in respectful and articulate ways.
- Given the complexity of gender and sexuality, think about assessment and understanding of these issues as a therapeutic conversation occurring across time. A cross-sectional approach will likely not suffice.
- Psychological assessment tools and tests needs to expand their recognition of sexuality and gender issues, integrating personality theory and research to inform the next generation of assessment instruments. Gender and
Answering Unasked Questions, Case Examples

sexuality are crucial personality dimensions to be considered within the
multivariate matrix of personality variables.

- These cases illustrate the importance of considering intersubjective hypo-
thesis as a component of standard psychological assessment practice; indi-
vidual characteristics of assessor/therapist pull for different themes in
patients.

Annotated Bibliography

Comment: This article explores identifications that shape experiences of gender and
sexuality. Specific discussion of “melancholic identifications,” in which the individual
must let go, to some degree, of the same-gendered parent, is offered in respect to
gender and sexuality issues.

Dimen, M., & Goldner, V. (2005). Gender and sexuality. In E. Person, A. Cooper, & G.
Gabbard (Eds.), Textbook of Psychoanalysis (pp. 93–111). Washington, DC: American
Psychiatric Publishing, Inc.
Comment: This chapter is an excellent overview of historical and current views about
gender and sexuality from psychoanalytic perspectives.

doi: 10.1037/0012-1649.37.4.451
Comment: This study explores the relationship between psychosocial adjustment and
children’s gender identity, including gender identifications, experience of their bio-
logical sex, and felt pressures to conform.

Notes

1 This includes the child’s identifications with caregivers and the child’s experience of
that caregiver’s subjective femininity/masculinity.
2 The case examples included in this chapter have been deidentified and altered to pro-
tect the clients’ confidentiality.
3 The results for the MMPI-2 are provided with T scores (Mean = 50, SD = 10).
4 Relational psychoanalysis and intersubjective theories suggest that the self cannot exist
in isolation, nor can the other exist without the self (Benjamin, 1990; Mitchell, 1988).
Self and other create an intersubjective space, wherein “personal idiosyncratic experi-
ences and meanings” interact and influence each other (Whitehead, 2006, p. 38). This
concept extends to gendered and sexual selves that meet and interact in the assessment
dyad.
5 The BORRTI is a 90-item self-report questionnaire designed by Bell (1995) to mea-
ure the constructs of Object Relations and Reality Testing within Otto Kernberg’s
6 Note: Parent–child relationships are merely one of many experiences that may interact
to construct the individual’s experience of gender and sexuality.
7 The relational matrix can be defined as the interaction between “the self, the other,
and the space between the two” (Mitchell, 1988, p. 33).
References


Gender bias in forensic matters can potentially cause deleterious effects on the disposition of forensic cases. Outcomes in forensic matters can have possible life-threatening consequences, as for example when criminal defendants face the death penalty. In this case study, a defendant committed homicide of his spouse from whom he was separated at the time. She was a physically abusive spouse who threatened his life multiple times in severe physical assaults. This dynamic where the woman was the perpetrator of domestic violence and was subsequently murdered by the male victim violates common assumptions about domestic violence and stereotypical gender roles. Absent an evaluator’s ability to suspend judgment regarding preconceived notions of intimate partner violence and stereotypical gender roles, litigants and defendants in various forensic matters face discrimination that may result in loss of life, loss of children or significant time with children, loss of financial reward, denial of post-separation support following divorce, inability to persuade prosecutors to consider plea agreements, ineffectiveness in communicating to mental health professionals, and inaccurate labeling of individuals as malingering, manipulative, and noncredible.

**Time Frame and Critical Elements of This Case Study**

The subject of the assessment was a middle-age Hispanic man who was a criminal defendant in a murder trial. He was incarcerated two years before this assessment, as requested by his attorneys. He spoke English well, lived and worked in the United States for many years, and applied for citizenship shortly before the crime. While in his country of origin, known for its emphasis on family values and “machismo,” he married an older woman whom he impregnated when he was only in his teens. She divorced him after the birth of their third child. At the
time of the crime, he was married to, though separated from, the decedent, with whom he shared a toddler. The couple was romantically involved for roughly three years before the crime and had been married for approximately one of those three years.

This man had a history of passive-dependent relations with women, wherein both wives and one other woman with whom he had a romantic relationship all dominated and controlled him. The decedent, his second wife, perpetrated several life-threatening physical assaults against him. Her murder occurred during an exchange of the minor child. The assessment took place two years after the murder. The acts of life-threatening violence took place over a three-year period before the murder and five years before the assessment.

**Critical Components to the Assessment: Intimate Partner Violence, Diagnosis, and Gender Stereotypes**

In almost no area of forensic practice is discrimination due to gender bias and stereotyping more apt to occur and more likely to be of essential prominence than in the area of partner violence. In the present case, a number of violent acts occurred in the marriage of this man and woman. Violence in intimate relationships is variously referred to as intimate partner violence (IPV) or partner violence (PV) in the literature (Bartholomew, Cobb, & Dutton, 2015; Cummings, Gonzalez-Guarda, & Sandoval, 2013; Hines & Douglas, 2011; Johnson, 2008; Kelly & Johnson, 2008; Radford, Sugarman, Abbey, Reynolds, & Cuevas, 2014). Other typologies include common couple violence (CCV) or conflict instigated violence (CIV), separation instigated violence (SIV), battering or intimate terrorism, and violent resistance (VR) (Johnson & Campbell, L1993; Kelly & Johnson, 2008). Violence against partners occurs at alarming rates (Bartholomew et al., 2015), regardless of the romantic context (e.g., marital, cohabiting, dating, heterosexual or same-sex). The concept of violence includes behaviors from pushing and shoving that occur during arguments to physically injurious acts of assaulting or attacking a partner with or without a weapon (APA, 1996). Violence incorporates isolated events as well as patterns of control and intimidation that are emotional, physical, and sexual in nature (APA, 1996). For the married couple in this case study, (a) information about the wife’s behaviors and her background of trauma and psychiatric difficulties and (b) the husband’s treatment by the legal and social service systems, with assumptions about gender and domestic violence, were crucial elements to an understanding of this case.

The study by Samuel and Widiger (2009) cited in Chapter 1 of this volume suggests a predicament for evaluators, relevant to this case, with regard to gender stereotypes and diagnoses. These authors found that when practicing clinicians rated a male or female version of a case vignette using the *Diagnostic and Statistical Manual of Mental Disorder, Volume IV-TR* (*DSM-IV-TR*; American Psychiatric Association, 2000), they were less likely to see the female
case as antisocial and the male case as histrionic. In the present case study, the white female in her early thirties had a lengthy history of antisocial acts originating in early adolescence, as well as a history of polysubstance abuse and multiple diagnoses of mental illness. The middle-age Hispanic man exhibited histrionic features on psychological testing. Many data sources (to be described) revealed a behaviorally passive-dependent personality style, a finding at odds with his cultural and ethnic origins. Diagnoses offered in this case and contained in record review were shaped by gender bias and stereotyping and could have had deleterious outcomes for the defendant (Johnson & Ferraro, 2000).

The value of personality classification and diagnoses may be questionable with regard to contribution in forensic matters (Greenberg, Shuman, & Meyer, 2004). Greenberg and others (2004) suggest that the relevant issue for the trier of fact is information about psycholegal question(s). In custody matters, for example, parenting styles and skills are the psycholegal questions that require resolution by the trier of fact. Psychiatric diagnoses lack precision regarding the components of parenting and may divert the trier of fact’s attention from the core issue. On the other hand, a diagnosis may be useful and desirable if it contributes to an enhanced understanding of an individual. Imbued with gender bias and/or stereotyping, diagnoses can be misleading and can contribute to untoward outcomes for the subjects of forensic evaluations. For the present case, the issues of partner violence, gender stereotyping, personality information, and diagnosis were fundamental issues contributing to a robust understanding of the subject of the assessment and the context in which he lived with his wife, the perpetrator of domestic violence.

**Background to the Case**

**Day of the Crime**

On the day of the instant offense, the defendant went to his in-law’s home, where his child and wife lived. His father-in-law had previously insulted him with racial and ethnic slurs and once invaded his home, at which time the subject found his father-in-law going through his personal belongings. The father-in-law and subject exchanged heated words, and the subject retrieved his gun from his car, intending only to scare the man, he said. Compatible with how victims of partner violence, regardless of gender, reach a “breaking point” with regard to pressure from repeated incidents of trauma, he grew irrational and impulsive. His wife got involved in the argument. The subject and his wife wrestled for control of the gun, the subject was shot once by his wife, he wrestled the gun away from her, and he shot her multiple times, killing her. He immediately called 911, told law enforcement he had “killed” his wife, and told them to send someone for him.
Characteristics of the Case Study

This case was marked by domestic violence of a physically assaultive, life-threatening type, referred to with various typologies (Johnston & Campbell, 1993; Kelly & Johnson, 2008). The relationship was coercive, controlling, and frightening for the defendant husband. The routine violence perpetrated on him included public displays of slapping, hitting, pushing, shoving, cursing, humiliation, and derision. The life-threatening acts included an injury that resulted in a prolonged hospital stay due to injury to his vital organs. Additional acts of severe physical assault included a knife cut to the head area that severely severed an organ and a second knife cut to several areas of the neck and head. Law enforcement officials were often called to the couple’s home to contain and terminate domestic disputes, which usually ended in motions from both partners for protective orders. The extensive record review conducted as part of this assessment included review of the multiple protective orders and lengthy law enforcement reports. Without an open mind regarding domestic violence and gender, these records could easily have been misunderstood. Alcohol, drug use, and prostitution were additional factors for the wife, as were diagnoses of mental disorders for her that included bipolar disorder, early childhood trauma, and polysubstance abuse. Without careful examination, these diagnoses and phenomena could have been easily misinterpreted or misused, as they were by prosecutors and social service agency personnel (Dutton & Bodnarchuk, 2005).

This case was unusual for the following facts: (a) the perpetrator of the domestic violence was female while the victim was male, and (b) in a struggle over a gun, the perpetrator died despite the fact that the victim was shot first. Other unusual aspects were that the female was physically larger than the male, more psychologically disturbed with multiple psychiatric diagnoses, American born, and white, whereas the male was foreign born, non-white, passive-dependent, and histrionic. A considerable age difference existed between the two, with the male being older by approximately 15 years.

Notion About Perpetrator–Victim in Domestic Violence

Some authors (e.g., Bartholomew et al., 2015) note that perpetrator–victim distinctions blur partner dynamics, context, and consequences that characterize partner violence. These authors also note that perpetrator–victim concepts emerged from the early literature on domestic violence that was largely feminist-driven (Bartholomew et al., 2015; Kelly & Johnson, 2008). Regardless, an analysis of the present case revealed that the male was a passive recipient of the numerous female-instigated assaults, and he was a victim of her routine acts of control, coercion, and intimidation, both public and private. For ease in discussion, the male is referred to as the victim of the violence between the couple, while the female is referred to as the perpetrator. Context, dynamics,
and consequences were examined during assessment. It is recognized, however, that use of perpetrator–victim labels may result in bias or preconceived notions if left unexamined, blur distinctions of personal responsibility for actions, and represent false dichotomies (Johnson & Leone, 2005).

**Gender Bias as Applied to This Case**

Gender bias or preconceived notions about gender roles permeated routine events and attitudes of public safety and health care professionals involved in this case. Unexamined biases of prior evaluators and attitudes of legal representatives who came in contact with this couple also constituted instances of gender bias. One example of gender bias occurred during hospitalization of the man, early in the relationship of this couple some three years before the crime. He was stabbed from behind by his wife, with sufficient force and invasiveness to damage multiple internal organs. This injury required hospitalization for several weeks. There was limited investigation during his hospital stay into the circumstances surrounding the injury that punctured vital organs. Health care officials, including some mental health care workers, asked routine questions from a checklist yet failed to delve into the precise details of the event. They failed to refer the man for any therapeutic intervention, to an abuse shelter, or for domestic violence education programs. Some authors (Dutton, 2007; Dutton & Corvo, 2006; Graham-Kevan, 2007, in Bartholomew et al., 2015; Kelly & Johnson, 2008) report on statistics in this country and abroad that document the absence of programs for and proper assessment of male victims of domestic violence.

A result for this particular man was the continuation of a cycle of helplessness/hopelessness that is experienced by any victim of violence (Kelly & Johnson, 2008), particularly those for whom no exit from or end to the violence is perceived as possible. His helplessness/hopelessness was especially poignant when he separated from his wife, leaving behind a toddler. As he sought protection for his child from social services, the gender bias of workers there prevented a full understanding of the domestic violence perpetrated toward him. This culminated in a repetition of the cycle of helplessness/hopelessness that characterized his marriage, renewed the extreme trauma he experienced from repeated acts of life-threatening violence, and ended in the tragic murder of his wife (Riggs, Caulfield, & Fair, 2009).

A second circumstance of gender bias involved multiple domestic disputes when law enforcement officials were frequently called to the couple’s home. Extreme alcohol use and illicit drug use characterized the wife’s polysubstance abuse, which routinely precipitated partner violence. The husband, however, was typically also drinking alcohol, creating a potential for law enforcement officials to treat the partners as equally culpable regarding violent acts. Both husband and wife filed motions for protective orders following domestic disputes, contributing to greater confusion for court officials (Moffitt et al., 1997).
Interestingly, law enforcement officials knew the wife well for years, and neither they nor court officials were misled by her claims of assault against her. She was not granted protective orders, whereas the husband was.

A third circumstance where gender bias manifested itself was in the failure of social service systems to foster attitudes in community aide workers that would allow them to be responsive to the needs of the couple’s young child. Through the help of friends and supportive co-workers and employers, the husband left the marriage and sought the help of our social services agency due to growing concerns for his young child. As a result of inexperience, lack of training in or knowledge about partner violence, preconceived notions about partner violence based on gender assumptions, or a combination of these factors, these workers inadvertently or otherwise overlooked various contributing factors to the violence, failed to fully assess the dynamics of the marriage, and consequently arrived at ineffective recommendations.

This combination of factors contributed to the husband’s increasing sense of desperation, hopelessness/helplessness, and sense of isolation and not being understood. This man’s situation of coercive control by his wife was reinforced on a routine, daily basis, resulting in compound psychological results (Kelly & Johnson, 2008). Among these were fear and anxiety, loss of self-esteem, depression, and post-traumatic stress. The original injury from which he nearly died and injuries that followed created a condition of post-traumatic stress that was (a) little affected by the help of friends and supportive co-workers and employers, (b) not addressed by therapeutic interventions or education, and (c) exacerbated over time by bias and lack of knowledge of professionals interacting with this man. His sense of helplessness and hopelessness increased when he was not able to protect his child as anticipated by contacting social services.

In the disposition of the case, gender bias was evident as well. The death penalty was originally sought following explosive media coverage characterizing him as an abusing, violent husband. This media coverage and charges presented to the grand jury reflected a lack of understanding regarding partner violence and gender bias as regards this relationship. Ultimately, the charges were reduced to felony murder and related felonies due to his entry into the home of his wife and her parents. It is noteworthy that his prior criminal history included one conviction for driving while impaired. He immediately complied with the court for resolution within the specified time frame. Elements of self-defense and provocation appeared a part of the instant or present offense of homicide, although for reasons related to the charge of felony murder and the man’s confession to law enforcement immediately following the crime, these were not allowed during trial.

Referral to the Examiner

The referral originated with the man’s defense attorneys, who released the first evaluator based on their perception of this party’s lack of understanding of
partner violence. The attorneys contacted the author and evaluator, reportedly due to experience with assessment psychology and knowledge of partner violence. Questions presented to the evaluator included: (a) What was the man’s state of mind at the time of the crime?; (b) What was his role in the partner violence that characterized his relationship with his wife?; and (c) Did he suffer from diminished capacity at the time of the crime?

Selection of Assessment Instruments and Rationale

After reviewing extensive documentation that included law enforcement reports of frequent calls to the marital home for domestic disturbances, numerous motions for protective orders, law enforcement reports from the day of the crime, and numerous other relevant legal documents, the evaluator interviewed the man. An interpreter was used who spoke Spanish, the defendant’s first language. The defendant had lived and worked in the United States for the greater part of his adult life and had applied for citizenship just prior to the crime. While his English was satisfactory for many situations, a translator was used to ensure that nuances in understanding would be captured.

Due to the change in evaluators and because of the question of trauma and partner violence, the current evaluator decided to interview first, in order to establish rapport, and to test later. The Forensic Client History and Checklist (FCHC), a structured interview form, was first administered. The FCHC was developed by Anthony Sciara (1998) and is included in the references. It allowed for some time in creating a greater understanding of this man’s means of expression and allowed for examiner familiarity with the man and the translator. The DVCC (Domestic Violence in Child Custody) Protocol (Drozd, 2007) was subsequently employed to examine specific types of violent situations and ways in which conflict was managed within the marriage.

Self-report measures, all administered in Spanish versions, included the Mil- lon Clinical Multiaxial Inventory—III (MCMI-III; Millon, 1997), the Minne- sota Multiphasic Personality Inventory, 2 (MMPI-2; Butcher et al., 2001), and the Personality Assessment Inventory (PAI; Morey, 2007). The Detailed Assessment of Post-Traumatic Stress (DAPS; Briere, 2001) was administered in English, with the translator present.

During initial interviewing with the FCHC and probing about his background, the subject was always polite and deferential and was also reserved and guarded. He minimized the partner violence and other problems in his relationship with his wife. Due to this minimizing style and because each self-report measure yields slightly different kinds of information, multiple self-report measures were selected. The specific referral questions also guided the selection of assessment instruments. Peer supervision with another forensic psychologist influenced the choice of instruments, as did the tremendous yield of information from administration of the DVCC.
The Rorschach Inkblot Measure (Rorschach, 1934) was administered to provide a second performance measure to the battery, along with a test of intelligence. The Rorschach was administered using the R-optimized method of the R-PAS (Rorschach Performance Assessment System; Meyer et al., 2011). It was scored using both CS (Comprehensive System; Exner, 2001) and R-PAS norms and scoring criteria.

What prompted selection of specific instruments were results from administration of the DVCC that yielded considerable, specific information, as did the reports from law enforcement, the protective orders, the hospital records, the records of social services, and the mental health and criminal history records of the wife. All of these sources made it abundantly clear to the examiner that trauma was a probable phenomenon at work for this man. It also became evident from results of the DVCC and record review that domestic violence was highly significant in ways that challenged common assumptions.

Findings From the Assessment

The results of this assessment were considered valid and reliable because of the subject's cooperation, although he presented himself defensively and symptom free on self-report measures. Behaviorally, it was noteworthy that this man was never escorted to the examination room in the jail with a correctional officer and was never shackled or handcuffed. Supervisory correctional officers, some of whom were interviewed, gave him special status in the jail. Interviewing correctional officers, particularly for reasons that would illustrate this man's cooperative and compliant nature, is unusual. His status that allowed him freedom of movement about the jail is an atypical situation for most offenders, particularly offenders charged with violent crimes. He was housed with prisoners with special needs; he attended to their needs and reported on their well-being to correctional officers. He was consistently polite, deferential, pleasant, and friendly. He exhibited an average level of intellect on IQ testing and appeared brighter intellectually than the average inmate. He was different from many inmates in terms of education, family history, and socioeconomic status. These differences gave him a sophisticated demeanor and style of interacting, and he appeared to comprehend fully and easily.

The attorneys sought a complete understanding of this man, in part to prepare for his trial and in part because he was a mystery to them. His employers and co-workers admired, liked, and praised him. He was an easygoing man who worked hard and obtained supervisory positions in employment; he was working toward obtaining permanent citizenship, which his employers funded; and he was responsible and dependable, according to multiple sources. How or why he committed the crime to which he confessed was puzzling to correctional officers and his attorneys. These facts combined with previously mentioned findings from the DVCC and record review resulted in administration of a
number of psychological measures in order to obtain a complete picture of his psychological makeup, his personality dynamics and structure, and his mental status on the day of the crime.

He did not evidence feigning on testing, a response style that could lead to questions of malingering and/or credibility. Feigning psychopathology may enable an offender to gain sympathy if the response style is not considered and fully addressed. On the Rorschach, he gave an average to slightly above average number of responses and was as nuanced with regard to description of his percepts as the average person. Thus, he engaged fully, and conclusions about him were descriptive, useful, and interpretable. His responses to the PAI and MMPI eliminated a conclusion of feigning or exaggerating. No findings from other psychological measures that indicated feigning or exaggerating were obtained.

In spite of his usual defensive responding where he minimized symptoms or problems on self-report measures, his DAPS and MCMI-3 protocols produced clinically significant findings. The stress and distress he was experiencing was also evident on the Rorschach. It was remarkable for him to present with this level of defensiveness when one considers the dire consequences he faced if found guilty of the instant offense. A more common expectation is that he would present an overly negative picture or exaggeration of his symptom picture, in order to win sympathy from a jury or to impress others with his suffering. During interview, he remarked that he “felt better” and “more human” since his incarceration than before. In light of the severe and life-threatening partner violence he experienced, these comments are noteworthy and make sense. Incarceration was a known situation, with unambiguous rules, a respected role for him, and relative safety. He continued to profess during interviews that he loved his wife, regretted her death, and accepted his prison time as a fitting punishment or consequence.

Other thoughts and interpretations about his defensive style include cultural ones. He may have interpreted psychological problems as a sign of vulnerability or weakness. Stereotypes abound about “machismo” in some Spanish-speaking countries (Cummings, et al., 2013), which could provide further explanation of test findings, although behaviorally he was not a dominant man. He responded on the MMPI-2 in ways that suggested strong needs for affiliation and attention, which might be interpreted as a tendency toward drama and attention seeking. During interviews, he did not perceive himself as weak and, on the contrary, he believed he could genuinely assist his wife, for example, in overcoming her severe addiction and lifelong sexual promiscuity problems. This suggests a level of grandiosity or a sense of invulnerability, which is congruent with test findings from the Rorschach, MMCI-3, and MMPI-2. It is also compatible with research about traumatized individuals who are mired in relationships characterized by partner violence (Bartholomew et al., 2015; Kelly & Johnson, 2008). It may also be consistent with his own sense of identity, which is that he is a capable, competent individual who is successful at helping others in many
situations. Congruent with his culture, when help is forthcoming, it will likely come from the family and not from a stranger.

This defensive response style on self-report inventories was interesting and contradictory when compared to his responses to the DVCC. This measure allows for probing with considerable specificity and depth into the details and nuances of conflicted and violent interactions of the partners. From his teenage years, when he married for the first time, through the rest of his adult years, this man routinely selected women who dominated him, some of whom perpetrated violent assaults of a severe, life-threatening nature against him.

When asked direct questions about the specifics of his interpersonal relations by use of the DVCC, he gave answers that illustrated his emotional dependency, his excessively easygoing nature, and his easily dominated manner. Of particular interest for diagnosis were his answers to these highly specific and direct questions about interpersonal relations. These illustrated how accustomed he had grown to extreme control by others, especially the decedent, and to her horrific acts of violence perpetrated against him. In initial interviews, where he was asked about the first injury he sustained from her, he minimized the attack and seemed slightly awkward or embarrassed while discussing it. When queried with regard to specificity during administration of the DVCC, however, he was guided by the questions into providing details he could or would not offer during the prior interviews. The format of the DVCC and the attitude of acceptance it creates regarding partner violence yielded greater information about the assaults he experienced, relative to other forms of interviewing.

Findings about his dependent style of interacting emerged from the Rorschach, the MMPI-2, the PAI, and the MCMI-3, as well as descriptions from various individuals who were interviewed and who knew him. The specificity he provided on the DVCC was instructive in creating a vivid picture of him as passive and dependent. When asked specifically if his wife, the decedent, suspected him of “cheating,” he responded yes to this question from the DVCC. He added that she frequently smelled his “private parts” when he returned home to see if he had been with another woman. The degree of passivity and/or dependency that allows this interaction is striking. A co-worker reported an incident of his wife’s jealousy when this co-worker (a female) called the man to ask a work-related question. She reported that the wife screamed at her over the phone, accusing her of “carrying on” with the subject. These and other numerous examples given during interviews illustrate how his interpersonal experiences were dramatic, traumatic, and indicative of control by women that was variable, confusing, and volatile.

His tendency to deny or minimize the impact of these horrific incidents lent additional credibility to his reports, in that he was not engaged in exaggerating these accounts or using them to promote self-interest. His pattern of responding—that is, guarded on self-report measures yet more detailed in face-to-face, direct interviewing—paralleled his responses about the intimate partner violence in his relationship with his wife. In other words, he minimized the
domestic violence perpetrated against him when asked general questions, yet when questioned about specific acts toward him in interaction with his former wife, he provided details that allowed for meaningful conclusions about this partner violence. This illustrates how accustomed he had grown to accepting such acts perpetrated against him as ordinary, normal, and routine and also how he complied with the questions from the DVCC about interpersonal conflicts. Answering directly to an examiner with highly specific questions about conflict appears to have provided him with the context in which he could respond with specific information.

Of note during interviews was his spontaneous report that at no time was he asked the kinds of questions and details during previous interviews as during this evaluation. This was significant when one remembers he interacted (a) with hospital personnel including mental health workers, (b) with agency personnel whose job was to provide family services, and (c) with law enforcement. While lack of knowledge about partner violence may be an explanation for these omissions, it appears that his ethnicity as a Hispanic man and his male gender may also have been powerful factors operating to inhibit full investigation of his substantial, documented, and noticeable injuries for which he received multiple protective orders.

The examiner decided to use the trauma instrument DAPS because of the wealth of information regarding trauma that emerged from record review and administration of the DVCC. On the DAPS, despite his denial and his defensive, guarded, or unrevealing manner, he elevated on three clinical scales. The DAPS requires identification of an “index trauma,” which he indicated was the stabbing injury that resulted in several weeks of hospitalization. He provided specific details that indicated he was fearful of dying and had a likely dissociative experience immediately following the injury, while being transported to a hospital. It is noteworthy regarding gender bias that he was discharged from the hospital with no recommendations (a) for follow-up to a safe shelter, (b) to any form of therapeutic intervention, or (c) for any educational programs. Subsequently, he reported feeling helpless, hopeless, and resigned to his fate, particularly when his wife “courted” him with food, repeated offers of sex, and the opportunity to be her confidante.

He produced clinically significant elevations on three clinical scales from the DAPS as follows:

1. **RTE:** Relative trauma exposure. Review of his responses to the DAPS revealed that most of his traumas, the result of physical assaults by his wife, occurred in the three years prior to the instant offense. This was the time period during which he was romantically involved with or married to his second wife, the decedent in the crime. All traumas were perpetrated by his wife. These included multiple stabbings; a severe knife cut to the head area; repeated incidents of domestic fights sufficient for frequent summons of law enforcement agents; unpredictable physical attacks that included
hitting, pushing, shoving, and punching in public places or in the home; repeated threats of intended violent acts; intimidation by verbal means, including insults and swearing; suspiciousness of his movements that resulted in restriction of activities, friends, and times he could leave home if not working; isolation by means of disabling his cell phone or intimidating his friends to leave their home; destruction of his personal belongings and clothes including throwing a brick through his car window; constant hitting, punching, pushing, and being spat upon; and false accusations in the way of filing inaccurate court claims of partner violence alleging he was the perpetrator of the domestic violence.

2 PDST: Peritraumatic Distress. He experienced greater distress during or after the index trauma than the average trauma victim. Distress is defined as fear, horror, disgust, helplessness, hopelessness, guilt, shame or humiliation, upset, and thoughts of dying. He endorsed fear and helplessness in excess, some horror, some guilt, “a little” shame and humiliation, “quite a bit” of disgust and upset, and “very much” thoughts that he might die. He was significantly traumatized by what he experienced, and thus he was likely to report significant post-traumatic symptomology.

3 PDIS: Peritraumatic Dissociation. Alterations in awareness, especially those involving depersonalization and derealization that occur during a traumatic event. During interview, this man described the immediate sensation he had when stabbed the first time as “not painful—I couldn’t believe I’d been stabbed.” He described the time period after as “like walking in a dream or in a movie—maybe two months or so after the stabbing but not now.” Such responses may arise when a sufficiently destabilizing event temporarily overwhelms the individual’s nervous system (Briere, 2001). He talked about how time seemed suspended, how his body seemed to feel strange or to change in size and shape, and how he was not completely aware of what was going on around him. He said his wife did not want to call an ambulance or law enforcement immediately. To him in his injured state, this delay felt like an inordinately long time. Information from the DAPS manual suggests that high scores on PDIS are a risk factor for experiences of more severe post-traumatic stress (Briere, 2001).

At the time of assessment, two years after the crime and five years after the life-threatening stabbing, he did not respond on the DAPS in a manner to suggest he suffered from a diagnosis of post-traumatic state. His responses on the DAPS, however, allowed for description and understanding of the index trauma, both at the time of the stabbing as well as during assessment. Thus this instrument provided useful information for a diagnosis of post-traumatic stress. He denied in interviews that he suffered from post-traumatic stress at the time of assessment. He said he felt “better” in jail than when he had been living with his wife and added that he “feels more human now,” during his incarceration. Not surprisingly, the structure and routine offered by
incarceration was likely more predictable and secure than the chaotic, traumatic environment with his wife.

On the Rorschach, he appeared to have internalized resources available for adaptive coping, similar to other adults. However, his emotions can overwhelm him and cause him to act impulsively. When in a setting of highly charged emotions, this personality feature impairs his judgment and detrimentally affects his ability to function more adaptively. Another finding here suggests difficulties with regulation of emotion. Such difficulties in regulation could constitute part of the symptom picture for post-traumatic stress disorder and were considered to be so by the examiner.

Other findings from the Rorschach indicated he had a keen sense of loss and/or grieving. This can also be interpreted as interpersonal “neediness” and dependency. This finding was congruent with his life circumstances during assessment, where he had lost his wife, his child, and his freedom. This dependency was a consistent finding across other measures like the MCMI-3 and MMPI-2, during interviews, and from descriptions by others, where his “neediness” was described as habitual. Findings from the Rorschach and other specific psychological tests contributed less to diagnosis and conclusions about this man than did information from record review and specific examples from the DVCC. This historical information and amount of information gathered during assessment was later compelling to the jury.

Legal Proceedings

Impact to Jury

The Attorney’s First Question: What was his state of mind at the time of the crime?

For the court and the jury, the following was relevant. On the day of the instant offense, he suffered from trauma that characterized his state of mind for the duration of his relationship, marriage, estrangement, and separation from the decedent. This trauma was brought about by (1) the initial life-threatening injury three years prior to the crime, (2) the occasions of physical assault where he sustained injuries to his face and neck throughout the three-year relationship with the decedent, and (3) the cutting of his head area that required multiple stitches and severed an organ of the head.

The Attorney’s Second Question: What was his role in the partner violence that characterized his marriage?

In addition to these incidents of domestic violence, there were more occasions of physical, emotional, and psychological abuse perpetrated against him that cemented the presence of trauma and post-trauma stress. His wife’s behaviors
were confusing for him. On the one hand, she “courted” him with food, sex, and entreaties to be her confidante and helper. On the other hand, she physically fought him, mocked and insulted him, controlled his actions, exhibited unreasonable jealousy about him, and filed misleading legal petitions alleging he was the perpetrator of the violence. Living this way is similar to living in a state of perpetual terror and uncertainty, which made it impossible, despite supportive individuals and factors surrounding him, for him to extricate from the abusive relationship.

The Attorney’s Third Question: Was he suffering from diminished capacity on the day of the crime?

On the day of the instant offense, his state of mind made it unlikely that he acted rationally and with intent to harm anyone. His judgment on that day was compromised by the constant state of post-traumatic stress in which he lived and the stimuli that activated his impulsive and emotional response to the unusual circumstances of retrieving his child on the day of the crime.

Disposition of the Case

This case began as a capital one, meaning he faced the death penalty. Ultimately, felony murder as well as other, related felony charges were pursued instead. A blurb about the felony murder rule is provided in the Appendices to this chapter. At the time of trial, this subject faced a number of charges, the primary one being felony murder, to which he confessed. Other charges were felonious, and combined they could have resulted in years of incarceration, likely for the duration of his life.

As a result of the facts of the case and the results from assessment, the attorneys concentrated on education to the jury regarding intimate partner violence. Stereotypes that prevailed and that caused discrimination to the subject were clearly explained to the jury. During the trial, the defense attorneys highlighted features of partner violence and the accompanying trauma. They asked questions that emphasized (1) the unusual facts of the partner violence, specifically that the man was the “victim” of the violence, whereas the woman was the “perpetrator” of the violence, (2) the difficulty for the average person in understanding why an individual would remain in an abusive relationship that was continually traumatizing, and (3) the difficulty for the average person in understanding partner violence. The fit and consistency of this man’s personality features and dynamics with behavioral observations, reports of collateral sources, and personal history converged in a compelling way. An educative presentation to the jury was not only relevant but was factually representative and convincing.

The psychological assessment, including extensive record review, use of the DVCC and DAPS, and numbers of collateral witness interviews, was critical to a complete understanding of this man, more so than traditional psychological
test findings. Specific test findings illustrated his tendency to minimize and deny during self-report measures and provided evidence that he was not feigning, exaggerating, or falsely reporting. This denial was less evident during administration of the DVCC and multiple interviews of him that normalized or contextualized the partner violence he experienced. Based on these shared findings, the jury was open to the view that the defendant had experienced trauma.

He experienced post-traumatic stress that affected his interpretation of situations and others’ behaviors and that affected his judgments in tense or volatile situations. The defense attorneys carefully educated the jury about trauma and its effects through a series of questions to the examiner. They led the examiner through a series of questions that explained to the jury how and why each assessment instrument was chosen and the findings that resulted. Education was provided to the jury about self-report versus performance instruments and the need for a multimodal battery of measures. Assessment was defined as the entire evaluation process, complete with collateral sources of information, use of specific psychological tests, record review, and openness to multiple hypotheses.

The defense attorneys were knowledgeable about psychological matters and psychological experts. Their legal team researched the area of partner violence and searched for information that examined partner violence perpetrated on men and provided it in its entirety to the examiner. They spent considerable time in trial preparation with difficult and challenging questions. They were well prepared on the topics of partner violence, partner violence perpetrated toward men, gender stereotypes in partner violence, trauma and its effects, and psychological assessment.

During cross-examination, the prosecutor attempted through questions to portray the defendant as the perpetrator of the partner violence. This attempt was dismantled by questions from the defense attorneys during redirect, a period of time following cross-examination when attorneys are provided the opportunity to ask additional questions of the expert witness. The prosecutor had a difficult position due to the facts of the case that included, but were not limited to, an unsympathetic victim of the murder, multiple affidavits and statements from law enforcement that spoke positively of the defendant and less so of the wife regarding domestic disputes, and the positive character of the defendant conveyed through multiple employer, co-worker, community, and friend interviews, affidavits, and testimony.

The jury returned not guilty verdicts on all charges except felony murder. Without understanding all the legal parameters of the case, the author was told that instructions to the jury were influenced by the defendant’s confession. The defense attorneys noted that the outcome was highly satisfactory for an appeal. Of note, reported to the author by the attorneys, is that all jurors elected to remain in the courtroom when the defendant apologized to his wife’s family and to the court, during which time several jurors were emotionally affected. The attorneys remarked subsequently that (1) the consistency among assessment findings was critical to the outcome; (2) the parallelism between findings,
behavioral observations, and reports of the defendant's behavior by multiple community and law enforcement individuals was critical; and (3) the education to the jury was compelling and critical.

**Practical Points**

- When particular circumstances easily give rise to gendered interpretations, the assessor must be aware of those gendered interpretations and question them.
- Thorough examination of all available records is critical to elicit a more complete understanding of the subject.
- Examine records carefully and critically analyze one's own assumptions.
- Request records that may seem peripheral yet that may provide a more complete understanding of the total picture.
- Be willing to use psychological measures developed for one setting if they can add information to your grasp of the referral questions. The usefulness of any particular psychological measure may go beyond the parameters for which it was originally developed.
- Certain facts, a subject's initial presentation that may blur a more nuanced understanding of a particular subject, and the opportunity for gender stereotypes to prevail all call for persistence, sensitivity, education, and originality on the part of attorneys and psychological examiners.
- Collaborations that allow a willingness to suspend judgment about culpability for an extended period of time are critical. Honesty about various explanations and hypotheses should be fully vetted and explored by engaging in multiple consultations with peers, leading to a genuine sense of wanting to understand gender-influenced phenomena in their entirety and any specific individual's role in the phenomena.

**Annotated Bibliography**


*Comment:* This book chapter provided a comprehensive overview and history of different perspectives of partner violence (PV), with discussion about the limits and varying contributions of the different perspectives. There was considerable research cited to enable the reader to pursue additional reading on specific points and to demonstrate the range and depth of empirically derived support for various conclusions. The discussion of multifactor models was educative and compelling in the integration of a host of variables related to PV, without becoming mired in potentially distracting details. The cultural context for PV is unusual to find in many studies of PV and was helpful with regard to the present case study. The authors of this chapter clearly found a feminist perspective on PV to be lacking and provided considerable empirical data to support their conclusions.

*Comment:* This article was a literature review of articles published since 2000 regarding risk and protective factors of IPV experienced by Hispanics. The authors selected 29 articles from a literature search of PsychInfo, PubMed, and Google Scholar. The authors used the Centers for Disease Control and Prevention’s four level social-ecological model of prevention to examine risks and protections at the individual, relationship, community, and societal factor levels. Their tables were most helpful in clarifying the individual factors involved in IPV for these Hispanic samples. The authors also included a table that listed the studies reviewed, sample characteristics, methodologies, and results.

The authors concluded that men and women share many similar risk factors for both perpetration and victimization of IPV. However, they noted that there were a number of conflicting results for the various studies and provided attention to thoughtfully detailing these. Their discussion of conflicting results regarding cultural factors was presented sensitively and was informative regarding stereotyping. Additionally, what these authors made clear is that different intraethnic groups were not well represented, making conclusions shaky for a unified picture of individuals from various Hispanic countries. Hence, one area of future research they identified was to accumulate more information about intraethnic variations among Hispanics from differing countries of origin. The authors noted the need for research on preventive factors for IPV, especially as this information would undermine stereotyping and would focus on positive aspects of Hispanic culture that prevent IPV.


*Comment:* This article addressed the effects of domestic violence resulting in post-traumatic stress disorder (PTSD). Findings regarding PTSD for women who have suffered intimate partner violence (IPV) is well documented in prior research, although the authors of this article remark that such findings for men are not well researched. Some differences among types of partner violence are given, and differences between community versus help-seeking samples are described. The primary focus of these authors was in examining the differences between community samples and help-seeking samples of men.

The limitations of this article include the lack of supporting research in the field prior to publication of this study and the fact that this is only one study providing these results. If these results are replicated and supported by other studies, then these findings support notions that trauma from violent relationships crosses gender lines and is central to symptoms of PTSD, regardless of gender.


*Comment:* This article was one requested by journal editor Sherry Hamby, who invited five senior researchers to identify the best violence research articles written in 2013. One of those articles identified was a review article by A. Cummings, R. M. Gonzalez-Guarda, and M. F. Sandoval. This previously cited article was selected for inclusion in the bibliography for this case study because it was a review article, and it examined intimate partner violence (IPV) in a cultural context and from a social-ecological framework. The importance of this article is due to its focus on the fastest growing minority in the United States, Hispanics, and due to the lack of studies with this minority group. Additionally, the authors presented a literature review and
incorporated a social-ecological framework for discussion of their findings. Many findings, detailed in the review, were congruent with findings from other studies of risk and protective factors for IPV and for individual-level factors. Cultural factors, on the other hand, were mixed with regard to firm conclusions.

References


THE INTERSECTION
OF GENDER AND
IMMIGRATION IN THE
PERSONALITY ASSESSMENT
OF WOMEN

Giselle A. Hass

Inevitably, psychologists conducting psychological assessments will evaluate immigrant women in many different contexts and circumstances. In doing so, assessors will encounter two challenges: (1) using assessment tools that are not standardized on this population and (2) incorporating diversity and multicultural constructs into the assessment. First, despite the large volume—20,000 mental, personality, and educational tests are developed each year (American Psychological Association [APA], 2012)—psychological tests continue to suffer from a lack of cultural sensitivity and subsequently contribute to biases and misdiagnoses (Strickland, 2000; Suzuki, Kugler, & Aguiar, 2005). The concerns regarding using standardized psychological procedures with immigrants is that the instruments may overpathologize, underestimate symptom severity, provide a completely mistaken diagnosis, or miss the relevant presenting problem altogether (Paniagua, 2005).

The second challenge to psychological assessment of immigrant women is to incorporate diversity and multicultural constructs into the psychological assessment, as stressed by the American Psychological Association Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003). Although most psychologists receive education and training to conduct culturally sensitive assessments and understand the importance of considering gender factors (APA, 2013), this does not always indicate competency with all diverse populations in all settings. The nuances specific to the immigrant women’s world and experience is probably less well known for those who are not working with them on a regular basis. Assessors may find themselves evaluating immigrant clients whose language and
cultural upbringing are vastly different from their own and from most people they encounter in their daily lives.

This chapter aims to familiarize the reader with the diverse frameworks that contextualize an immigrant client’s functioning in the United States. The dynamics inherent to the experience of immigrant women will be analyzed using two perspectives. The first framework is the ecological model (Bronfenbrenner, 1977), which poses that the reciprocal interaction of individuals and their environment shape the human experience. This model illustrates the dynamic between gender and cultural experiences unique to immigrant women in the context of the U.S. society, which subsequently shape their psychological experience. The second perspective is the model of intersectionality of multiple social identities, such as gender, age, sexuality, socioeconomic status, ability, religious/spiritual orientation, education, vocation, and ethnicity. The intersection of these identities is relevant to this analysis because gender and immigration are not independent, but rather they influence and shape each other in relation to other contextual factors (Reid, Lewis, & Wyche, 2014). The core aspects of a culturally sensitive personality assessment of immigrant women will be discussed using these two models as a foundation.

Assessing the Background

Three factors have been found to be motivators of migration: reunification with family members, search for better employment opportunities, and refuge from persecution, war, violence, or environmental catastrophes (APA, 2012). Segregated data from a study in 2008 revealed there were 18.9 million immigrant women and girls living in the U.S., and they represented a widely diverse demographic (Immigration Policy Center, 2010). Mexico was the single largest country of origin for female immigrants (27%), followed by China and the Philippines as distant second and third (at 5% each). Women who came from Cuba and Canada were the oldest and had lived in the U.S. the longest amount of time. Women from India, China, and Mexico had been in the U.S. for the shortest amount of time, and women from India and Mexico were the youngest. Women from India had the highest educational level, median income, and likelihood of employment in management and professional occupations. Women from the Philippines were the most likely to be in the labor force and the least likely to live in poverty. Women from Mexico had the highest poverty rate (28.5%), followed by women from the Dominican Republic and El Salvador (at 25.2% and 18.1%, respectively). More than half of the immigrant women from Mexico (60.8%) lacked a high school diploma as compared to U.S.-born women (11.2%), but they were more likely than their male counterparts to have higher education. In 2008, immigrant women in the labor force had a median annual income of $21,182 compared with $29,533 for immigrant men.

There are numerous factors particular to immigrant women that are not shared by immigrant men. Women tend to migrate independently rather than
for family reunification or as dependents of male relatives, which was a stronger
Compared to men, women are at a disadvantage regarding opportunities for
legal migration and are less likely to receive health care and other services in
the U.S. Women immigrants are more likely than men to end up in low-status,
low-wage production and service jobs. Further, these women often work in
gender-segregated and unregulated sectors of the economy, and they have a
high risk of exploitation, violence, and abuse.

It has been estimated that approximately 4.1 million female immigrants are
 unauthorized to live and work in the U.S. (Passel & Cohn, 2009). These women
may present for psychological assessment in one of several contexts. They may
require a psychological evaluation to support an immigration relief petition, or
they may be referred for serious mental illness, or involvement with social ser-
vices, family, or criminal court proceedings. In many cases, the assessor may not
know at the time of the referral that the client is an immigrant. Since women
with unstable immigration status often fear deportation as a result of revealing
their situation, they do not like to be questioned about it or disclose this infor-
mation. Deportation is feared because it means her life in the U.S. would disap-
ppear, and she will be forcibly returned to the conditions she escaped, and with
the additional shame of failure (Dutton, Orloff, & Hass, 2000). This fear may be
exploited by abusers and predators because it can be a powerful deterrent to
reporting crimes to the police and seeking services.

As illustrated in the statistics above, the diversity of immigrant women pre-
cludes any stereotyping of them as a whole. Assessors may encounter a woman
who arrived with a legal permit to reside and work in the U.S., came full of
optimism and hope, migrated with relatives or friends, had a support system
already in place that greeted her and served as home base, had education and
skills that transferred easily, was eager to adjust to the new environment, and
shared common customs and values with the American culture. In these cases,
the assessor may feel at ease when forming a working alliance and conducting
a psychological assessment. In other cases, the assessor may encounter a woman
who was smuggled or trafficked against her will, arrived sad and alone, fled
from appalling conditions (e.g., poverty, crime, political oppression, torture, per-
secution, and environmental disasters, among others), incurred many losses by
departing, came without knowing anyone in the host country, without knowl-
edge of the English language, without much education or transferable skills,
from a culture that was drastically different and holds strongly to her cultural
background. In this case, the assessor may feel utterly unfamiliar with the client’s
experience and have a harder time understanding her, establishing an alliance,
and conducting a fair and sensitive psychological assessment. Endless combi-
nations of factors make each immigration experience unique. Assessors may
encounter immigrant women who fall anywhere along this continuum.

However, at the core of their diverse identities and heterogeneous back-
grounds, immigrant women share several commonalities that distinguish them
from other clinical groups. They find connections to each other as victims of
gender and ethnic oppression, as well as by the fact that they are defined by their
collective and contextual identities (Comas-Diaz, 1994). Immigrant women
share the marginalization and inferior designation the host society attributes to
them and the powerlessness and vulnerability inherent in their status.

The Assessment of the Migration Experience

The model developed by Comas-Diaz and Grenier (1998) regarding the assess-
ment of the migration experience lends itself well to gathering the client’s crit-
ic background immigration information. The assessor collects information
regarding premigration experiences, including data about the country of ori-
gin, the type and history of migration, losses, traumatic experiences, relocation,
resources and stressors, occupational and financial history, psychological and
medical history, support systems, and cultural conflicts. It is important for an
assessor to gather information about the circumstances under which the woman
left her country of origin and events during transit to the U.S. Post-migration
aspects of the client’s experience also need to be asked, including acculturation,
language, adjustment, and impact on identity (Comas-Diaz & Grenier, 1998).

Current working conditions need to be carefully assessed in order to detect
victimization through exploitation, involuntary servitude, or peonage. Immi-
grant women are disproportionately found in industries such as commercial
cleaning, restaurants, personal services, domestic work, food and garment pro-
duction, and agriculture (National Immigrant Women’s Advocacy Project, n.d.).
When working in these industries, immigrant women often earn minimum
wage or less, work long hours, receive no sick or vacation days or health insur-
ance, and face grueling working conditions, high levels of occupational hazards,
sexual harassment, and abuse (Bauer & Ramirez, 2010; Bureau of Labor Statis-
tics, 2012; Clark, 2004). The impact of poverty on woman’s health and mental
health, as well as the collateral challenges regarding safety and survival, should
not be underestimated. In this model (Comas-Diaz & Grenier, 1998), these
aspects are asked in terms of the client’s cognitions and emotional perceptions,
not only as an individual but also with regard to how they relate to her family,
acknowledging that immigrant women typically have strong collectivist ori-
entations. That is, women with collectivistic values consider themselves as part of a
larger group, like their family or village, and define their roles and choices based
on what is best for the group instead of what is best for an individual (Leake &
Black, 2005).

It is also important to pay attention to the clinical relationship (Comas-
dynamic of power that may range from overcompliance and friendliness to sus-
piciousness and hostility on the part of the client, and the clinician may range
from denial of differences to guilt, pity, fascination with the cultural differences,
or overidentification. Awareness of this dynamic and the correction of such
Intersection of Gender and Immigration

biases enrich the experience for both examiner and examinee and lead to a true meaningful assessment. Although consultation with a culturally competent colleague is always recommended when doubts arise, it is most urgent in situations of difficult working alliances (Arredondo, Shealy, Neale, & Winfrey, 2004).

Assessing Cultural Socialization, Gender Roles, and Multiple Identities

Clinicians have the ethical and moral obligation to learn about the client’s cultural background and integrate this knowledge when delivering services. Cultural background refers to the numerous factors that build up the sense of self and identity linked to a person’s psychological makeup, which in turn plays a major role in a person’s behaviors, thoughts, and feelings (Hays, 2008). Factors such as race, social class, social status, religion, geographic provenance, cultural history, ancestry, gender experiences, migration, socialization, and family dynamics combine to determine how we relate to others and to ourselves (McGoldrick, Giordano, & Garcia-Preto, 2005). Reviewing articles and books specific to the assessment of certain ethnic groups and cultural backgrounds can be useful to the assessor during the administration, scoring, and interpretation phases of a psychological assessment.

However, assessors have been urged to understand not only immigrant women’s cultural identity and context but also their own and to negotiate those two worldviews (APA, 2003). In particular, it is important for assessors to understand their own reactions and values in relation to the immigrant experience because these factors might color their professional behavior. Unconscious biases and stereotyping affect clinicians just as they do anyone, including assessors who are female, ethnic minorities, and immigrants. Hays (2008) recommends that clinicians explore and question their own personal belief systems and worldviews, remain current regarding the multicultural literature and research, and engage in community events and peer relationships that expose them to diverse experiences and perspectives. This wider mindset is crucial when conducting a psychological assessment, as knowledge regarding how the client sees the world, what matters to her, what coping mechanisms she has learned to use when in crisis, what rules of behavior she follows in certain situations, and how she relates to herself and others are critical to hypotheses regarding the client’s psychological makeup and dynamics. In the process of learning about these issues, the unbiased and nonjudgmental attitude of the assessor is paramount to the immigrant woman’s ability to open up and feel understood and appreciated.

Of particular importance for the assessor is the ability to understand the gender roles and values that women learn in their country of origin and that shape their multiple identities and how the migration experience transforms them. The Socio-Cultural Profile (Fuentes & Adames, 2011) is an effective model to assess the multidimensionality of identities. When completing this profile, clients are asked to identify themselves on the basis of race, ethnicity,
class, sex/gender, religion, sexual orientation, and ability/disability and discuss with the assessor the dominance of each membership. Then, the client is asked to consider the levels of power, privilege, and oppression inherent in each aspect. It could be fruitful to add other gender issues to this profile, such as civil status and appearance, which highly impact immigrant women’s sense of identity. This activity sheds light on the woman’s intersectionality, her psychological stories, and alternative identity narratives (Fuentes & Adames, 2014). This technique is particularly relevant in the assessment of immigrant women whose identities are intertwined and fluid. This technique also provides insights for the assessor regarding the woman’s fantasies and realities of her adaptation and functioning in the new land.

Women who migrate to the U.S. by choice often describe their hopes of finding safety, a more egalitarian society, political democracy, greater economic opportunities, and more personal freedom to make choices for themselves. Many women find that the migration brings about positive changes and even fulfills their dreams and expectations. For others, there is much hardship and new traumas. Either way, immigrant women go through a process of adjustment that is stressful and draining. Regardless of how similar or different they are from the women in the U.S., their lives in the U.S. will always demand a degree of assimilation.

Immigration in and of itself represents a drastic life change that may be transformational in many ways. Together with their hopes and fears, women arrive to this country with backgrounds and identities already formed. Traditional values, roles, and identities are challenged and modified in relation to the psychosocial differences between the culture of origin and the U.S. society. For example, the responsibility of a woman often shifts after the migration from being a hands-on caregiver to becoming a financial provider for the children, spouse, or parents left behind, and the distance from the family amplifies, rather than diminishes, the need to fulfill those social expectations (George, 2005). The new wave of immigrant women is typified by having arrived alone and first in their family with the responsibility to send money to support families in the homeland, which are called remittances, forcing them to transform the traditional gender values and practices from their culture regarding being dependent on a male in financial matters to a new role of financial autonomy.

It has been found that the patterns regarding remittances to the country of origin by immigrants are gendered (United Nations Foundation Research and Training Institute for the Advancement of Women, 2007). While, in the overall picture, women immigrants send approximately the same amount of money as do male immigrants, women send a higher proportion of their income, in spite of their lower salaries, and they send money more regularly and for longer periods of time. In many cultures, women are not socialized to be in charge of their finances and seek out the best economic opportunities for themselves. This value may play a role in the fact that they spend more than men on transfer fees because they send smaller sums and more frequently than men do.
Even when women migrate with or join a partner, their assimilation and need to contribute economically often brings changes and stress to the division of labor and spousal identity (George, 2005), compared with the way that the marital relationship functioned in their home country. Changes in cultural practices, identity, gender roles, and different social, economic, and cultural environments require a reinterpretation of the couple’s relationship, leading at times to conflict (Falicov, 2007). For instance, a study with immigrant women found that 31% reported an increase in battering incidents after migration to the U.S. and, for 9% of these women, the abuse began with their immigration (Hass, Dutton, & Orloff, 2000).

Espin (1999) asserts that gender roles and sexual behavior are profoundly impacted by migration as women face new sex-role patterns, have greater access for employment outside the home, and have new educational opportunities. Some women may come from cultures that disempower women through rigid traditional gender roles, and deviations from these norms are met with disapproval or even punishment by their relatives and community (Bui & Morash, 1999; Huisman, 1996; Kulwicki & Miller, 1999; Morash, Bui, & Santiago, 2000; Perry, Shams, & DeLeon, 1998; Tran & Des Jardins, 2000). Women with these cultural values feel pressured to be subservient to men and self-sacrificing to community and family, and this frame of mind could lead them to have reduced options to fulfill their personal goals (Raj & Silverman, 2002). This is also a tremendous psychological burden to bear. For some immigrant women, observing “alternative meanings of womanhood” generates a sense of “permission” (Espin, 1999, p. 5) to break the learned boundaries and transform their gender role and sexuality. For other women, the vast losses incurred with the migration may incline them to adhere more rigidly to their cultural identity and traditional sex role in order to hold on to the familiar and known.

Another area that is highly impacted by the experience of migration is the identity as a mother (Bornstein & Bohr, 2011). The immigrant family often suffers from instability, as the mother may leave children behind in her home country, has U.S.-born children, sends them to the home country, brings her children to join her in the U.S. sometimes one by one, or may have a combination of U.S.-born and raised and immigrant children. This fluidity of the family structure creates significant challenges to a woman’s cultural mandate to create and maintain the integrity and harmony in the family. When contending with unresolved emotional losses, guilt, painful separations, and surrender of the mothering role for a period of time while balancing new employment and relationships, an immigrant mother may not feel that she has the moral authority or leadership capacity to adequately fulfill her motherly role.

In most cultures, women are considered to be the transmitters of cultural and traditional roots for the family (APA, 2007). As a result of migration, however, lack of direct connection with their native background and exposure to diverse patterns of motherhood and childrearing may lead to conflict, inconsistency, or confusion for immigrant women. In particular, the emphasis on individualism in
the U.S. society, in contrast with the values of interdependence and collectivism in other cultures, may cause a mother to feel conflicted. While her role is to provide cultural roots for her children, she may fear that teaching her cultural values is of little significance to children who need to adapt to the society in which they are going to live and work.

Parenting when there is lack of familiarity with the predominant culture is challenging and stressful. Parenting beliefs and norms are often resistant to change (LaVine, 1988), especially when a mother lacks the societal support to negotiate the transformation of this role. For example, an assessor in a custody case with an immigrant Middle Eastern family had to confront the request of the father that custody be determined on the basis of gender due to the cultural value that boys need a male figure and girls a female figure to properly develop their gender identity. Because the mother was economically dependent on her husband and did not have the proper government permit to work in the U.S., she felt hesitant to voice her opinion for fear of the husband cutting her off financially. The father’s beliefs about gender matching were based on very strong and rigid traditional values that conflicted with the custody evaluator’s opinion. The evaluator wanted to recommend joint custody and keep the children together on the basis that both parents had complementary parenting skills and talents the children needed on a regular basis. The realities of gender values and socialization can exert a strong influence in the way that parents socialize their children, and the custody evaluator’s opinion thus could appear biased or irrelevant to them. A custody evaluator in this position may need to negotiate a culturally sensitive recommendation that would be accepted and implemented by the parents.

**Oppression, Discrimination, Inequality, and Injustice in the Host Society**

Leaving the country of origin, even when forced to do so by appalling circumstances, involves a host of losses, hardships, and challenges. Leaving tangible resources, a familiar environment, the climate, the social milieu, family and social networks, and the contextual background is a significant psychological loss. In addition to this hardship, the presence of an anti-immigrant climate, xenophobia, and discrimination in the receiving community can significantly contribute to an immigrant woman’s adversity. Not only do biases and discrimination produce a hostile environment, but these experiences also have been implicated in lowered access to education, services, employment, and other opportunities (Rumbaut & Komaie, 2010).

For many immigrants, the experience of discrimination and prejudice is completely new. This extremely negative phenomenon involves a very difficult adjustment that challenges a person’s sense of identity and self-worth. For some, such as Asian immigrants, unrealistic stereotypes of success and prosperity also create stress and pressure, further challenging their identity (Lee, 2009). Sexism
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and objectification are also adversities immigrant women may face in the U.S., especially women from cultural groups like Asian and Latin American, whose stereotypes of being overtly sexual and available are reinforced in the popular media.

Immigrant women may face other forms of discrimination as well, such as ageism, which do not exist in some non-Western cultures (APA, 2007). In some cultures, such as Latin American, older women hold a great deal of status, power, and respect (Espin, 1997). For older Asian Indian immigrant women, acculturative stress appears to have long-term consequences and loneliness is prevalent, unless they maintain their sense of connection with their children and hold religious beliefs regarding the aging process that provide meaning to this life transition (Tummala-Narra, Sathasivam-Rueckert, & Sundaram, 2013).

Similarly, discrimination based on gender diversity and sexual orientation is very stressful. Encountering homophobia in the U.S. can be a shocking and disappointing experience for homosexual, bisexual, or transgender women who expected the new environment to be more sensitive and tolerant. Insertion into a new community and creation of a social network for a gender-diverse immigrant woman may seem like an insurmountable chore and lead to a great deal of stress and isolation.

Discrimination and oppression affect not only immigrant women from specific groups such as those with lower economic or educational status but also those with visible characteristics of a foreign-born person (i.e., having an accent). Immigrant women with a professional status and with a great many similarities to the larger community of American women are not exempt from oppression and discrimination. There is documentation that, in spite of being highly educated and skilled, immigrants often face a decrease in their employment opportunities and limits in their upward mobility, especially if they are racial minorities (Catanzarite & Aguilera, 2002). Immigrant women, even in highly skilled jobs or professional occupations, may have hurdles such as social isolation, conflicted cultural values, overwhelming economic demands, and limiting gender roles that decrease their power and status with peers, supervisors, employers, and subordinates. Professional immigrant women also suffer from the stress related to the complex burdens in their lives and the interaction of racism, sexism, tokenism, and stereotyping (Amaro, Russo, & Johnson, 1987).

It is important for the assessor to investigate these issues with open-ended questions that give the client the space to describe her intimate sentiments and conflicts. For example: “What has been the most painful aspect of your migration to the U.S.?” or “How has your work life changed with your migration, and how has it impacted you and your family?” and “Tell me about the changes that you and your family underwent with your immigration to this country.” Without competent knowledge of the immigrant experience and an understanding and curious attitude on the part of the examiner, many immigrant women are hesitant to disclose their worries. In fact, most immigrant women are resistant to describe sad, shameful, or difficult experiences during an
assessment due to mistrust of authority, a fear of appearing even more vulnerable, past experiences with victimization and exploitation, values of pride and privacy, hesitancy to receive help from a stranger, and a fear of being deported (Segal & Mayadas, 2005).

The segment of the interview used to gather the client’s worldviews and psychological experiences assists with the development of a formulation that is sensitive to the intersectionality of race, ethnicity, and gender, and leads the assessor to a better understanding of these identities. In taking these stresses into consideration as contextual frameworks, assessors may increase their ability to empathize with and respect issues that may appear farfetched from their own reality, while still appreciating the differences with an open and unbiased mindset. To understand the source of the client’s problem and prevent the client from assuming the blame, clinicians may want to discern whether the problem is created by institutional, societal, or individual racism, prejudice, or biases (Helms & Cook, 1999).

For example, take the case of Mai, a young immigrant single mother who was charged with child endangerment because she left her five-year-old boy sleeping alone at home while she went to work. When she was still at work, the building caught fire and her child nearly died. When interviewed, Mai explained that her sister, who used to care for her son at night, had been hospitalized earlier that day due to an accident at her job. The question in the investigator’s mind was how was it possible that Mai did not know one person who could care for her son during an emergency. Knowing her plight helps a clinician appreciate that she did not see a different option because her situation was complicated by being an undocumented immigrant afraid of being exposed as such, not knowing English, not knowing night-time babysitters, living in a neighborhood with high crime rates where she felt she could not trust her neighbors, living without family other than her sister and without a social network, living without the father of the child because he was deported, and being unable to miss work because she depended on her salary to survive and missing work could get her fired. Having an understanding of these circumstances makes a whole world of difference in the way an assessor conceptualizes the psychological dynamic of this case of neglect. Awareness of Mai’s predicament helps illustrate the dire circumstances that played out in her decision-making and may trump other pathological assumptions. This does not mean that her actions were excusable, but understanding the context and situational factors behind Mai’s reasoning is helpful when making recommendations for her treatment and to form an opinion about her risk of recidivism.

**Assessing the Vicissitudes of Attachment Processes**

Attachment is critical to a number of important outcomes associated with well-being and psychopathology throughout the life cycle (Dozier, Stovall, & Albus, 1999). Immigration is a critical life experience that challenges a person’s
adaptive functioning and identity to its core, including attachment and caregiving systems. In fact, research has reflected that immigrants have a higher proportion of unresolved attachment statuses (van Ecke, Chope, & Emmelkamp, 2005).

Women immigrants may leave behind parents, children, partners, or relatives with whom they had significant bonds. Women who migrate in search of a better economic situation to help their families often leave behind their own children and may be forced by economic need to send the children born in the U.S. back to their country of origin to be raised by relatives while they continue to work here (Bornstein & Bohr, 2011). Sometimes children who are misbehaving are sent to their family’s country of origin to have them resocialized by grandparents (Smith, 2005). Immigration raids that lead to deportation of parents without legal authorization to live in the U.S. also rip apart families and reenact previously experienced attachment traumas. These significant separations from loved ones may lead to states of perpetual bereavement and may markedly disturb family cohesion and the woman’s caregiving-attachment system.

Disrupted attachments constitute tremendous losses for an immigrant woman and may create a deep sense of grief, guilt, and shame, especially when there is a violation of the cultural expectations of motherhood (Bohr & Tse, 2009). These losses, especially if coupled with interpersonal trauma, are perceived as dangerous to a person’s need for safety and may lead to maladaptive self-protective coping (Crittenden & Landini, 2011). An excessive focus on the self and overuse of self-protective strategies sometimes needs to be understood as part of the process of adapting to perceived dangers and disruptions brought about by the uprooting, losses, attachment disruptions, and living in a foreign and unwelcoming environment.

Similarly, adult attachment needs suffer with the migration. When faced with a foreign and mysterious new social environment, the presence of a trusted relationship can make the difference between a healthy adjustment that leads to growth or maladaptive coping that leads to negative outcomes. Immigrant women, just like everyone else, want to turn to a trusted person when facing personal challenges or stressful life experiences, as sharing and receiving support restores well-being (Mers & Consedine, 2012). For many immigrant women, the geographical change involves losses and shrinking of their social network, as noted in the case of Mai. When this is coupled with social discrimination and a lack of social support in the host country, the immigrant woman is more vulnerable and at risk of feeling alienated and lonely.

Developing new relationships is challenging, especially when the social status is unequal and disadvantageous in the new community. People in search of new attachment figures in a foreign and possibly unwelcoming environment may be forced to make choices they would not have made under different conditions. It is important for the assessor to understand the dynamic that plays out when the immigrant woman’s choice of friends or partner, or the way in which she confronts interpersonal conflict, seems to defy logic. When interpreted through the lens of her attachment needs, guilt from abandonment, and sense of social
alienation, abnormal interpersonal responses such as excessive submission or abusive control may make clinical sense. In the same way, the phenomenon of zealous religious fanaticism that often happens with some women after migration can be understood in light of the desperate search for a “haven of safety and secure base” (Kirkpatrick, 1999, p. 807) in a person who has incurred massive interpersonal losses and feels unattached and interpersonally alienated.

These key issues in the dynamic of attachment processes that help explain motivations, behavior, cognitions, and emotions are also an important part of psychological assessment with immigrant women. Instruments to assess attachment and adult relationships fulfill the need to understand these cognitive models of self and others and add an important phenomenological aspect to the formulation of an immigrant woman’s psychological picture (Bartholomew & Horowitz, 1991; Brennan, Clark, & Shaver, 1998; George, Kaplan, & Main, 1985; George & West, 2001).

**Psychological Assessment of Immigrant Women**

The use of standardized measures of behavior, cognitions, and emotions that compares the examinee’s performance with others and sets it in a cohort perspective is at the foundation of our field. However, the use of psychological tests with immigrant clients presents certain difficulties that may be at times insurmountable. The APA Ethical Principles of Psychologists and Code of Conduct has stated that adjustment in administration or interpretation of particular interventions of techniques because of factors such as an individual’s gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status may be necessary in some cases (APA, 2002).

The literature on the assessment of immigrant and diverse clients applies to immigrant women. Specifically, immigrant women are considered to be not a good fit for conventional assessment instruments that compare them with group members from the dominant culture (Dana, 2000). In particular, gender and cultural differences in personality traits are important to consider (Costa, Terracciano, & McCrae, 2001). Some consider the use of etic instruments (those that measure universal variables) to be less effective than emic instruments (those that measure culture-specific constructs) (Dana, 2000). However, culture-specific measures are also deficient in that they often replicate the errors in the development of the tests they purport to replace by considering the population they serve as being homogenous and establishing norms based on race and ethnicity but not for economic, generational, religious, or gender factors. Still, depending on how well the culture-specific tests fit the client’s demographics, they may have a place in the assessment by helping narrow down and contextualize the issues that are or are not identified in other generic measures. For instance, the Phan Vietnamese Psychiatric Scale utilizes cultural idioms and cultural concepts to assess depression, anxiety, and somatization, in ways that Western measures may fail to identify (Phan, Steel, & Silove, 2004). Appropriate
Integration of both etic and emic approaches may provide a more comprehensive picture of an immigrant woman’s psychological picture (Cheung, van de Vijver, & Leong, 2011).

Geisinger (1998) has offered considerations when selecting an instrument that can be adapted to the use of tests with immigrant women. These include (a) the match of the client’s demographics to the test’s normative population, (b) the extent to which the instrument can be administered without encumbrance, (c) the existence of publisher- or researcher-sanctioned translated, adapted, or accommodated versions, or recommended alternative testing procedures, and (d) whether the planned accommodation has been assessed regarding the meaning of the scores it yields. The answers to these questions aid the assessor in judging the fairness of the instrument to validly and reliably represent an immigrant woman’s functioning.

A multi-method approach to the evaluation and both self-report and performance-based methodologies are recommended. Even when an instrument meeting all of these criteria is identified, the assessor still needs to exercise caution when interpreting the results and place them in the context of the immigrant woman’s life.

Assessing Acculturation

Acculturation is the dynamic process of adaptation to the host country that is part of the immigrant experience (Berry, 1997). Either support for the cultural background or pressure to assimilate may lead to positive or negative outcomes depending on how the individual perceives and interprets her particular circumstances (Phinney, Horenczyk, Liebkind, & Vedder, 2001). Acculturation conflict occurs when the cultural values of the immigrant collide with the cultural values of the host society (Sue & Sue, 1999). Whether or not the woman lives in a multicultural environment will shape her acculturation experience (Acevedo-Polakovich et al., 2007). It is important for assessors to understand and apply these constructs because it helps them to choose the more sensitive and successful assessment instruments and strategies. This understanding also enables the assessor to identify the challenges or strengths that a woman brings in terms of her adaptation to the environment and its relation to specific behaviors and mental processes.

The acculturation level of a client to the U.S. society or her membership in a specific ethnic group cannot be assumed or even trusted as reflecting her self-identification, as it has been noted that people tend to give socially desirable responses (Tsai, Chentsova-Dutton, & Wong, 2002). Many instruments measure acculturation and identification within various ethnic groups (Phinney, 1992; Zea, Asner-Self, Birman, & Buki, 2003). Some interviews assess the level of acculturation through questions regarding the use of language, values and norms, customs, and beliefs in relation to both the native and host culture (Berry, 1997; Weiss & Rosenfeld, 2012).
For the purposes of a psychological evaluation, the assessor should be mostly concerned with three issues: (1) whether the immigrant woman fulfills the demographic characteristics of the normative population for the specific instrument that the assessor intends to use; (2) the impact of these acculturative status, stress, and cultural experiences in her response to the assessment; and (3) the role of acculturation in the woman’s coping and adjustment to her immediate environment. This knowledge is especially important when assessing immigrant women in settings such as employment, school, forensic, and other fields where knowledge of how the woman has integrated social expectations and the values of the society at large in her adaptive functioning is important (Phinney, Horenczyk, Liebkind, & Vedder, 2001).

Once the assessor has determined where the immigrant woman falls in terms of her acculturation, the decision can be made about whether she belongs to the group for which the test was designed. If the woman’s ethnicity and gender are properly represented in the normative sample, the assessor can have confidence that the standardized administration and interpretation of scores will fairly represent her functioning. If she does not approximate the normative sample, then the assessor should find out if adaptations of the test conducted in the country, region, or for the culture where the client comes from are available, as the client possibly resembles more the people from her own country and culture than the American sample. However, if no adaptations are available for the client's demographics, then the assessor should use clinical judgment to balance the need for standardized information with the potential reliability risks of obtaining this information with inadequate instruments. If a less than ideal test is utilized, the assessor should proceed with caution during the interpretive phase and note the caveats in the report.

Immigrant women have been noted for achieving a greater level of acculturation faster than their male counterparts, especially for younger women and those with children (Brock-Utne, 1994; Lopez, Escoto, Monford-Dent, & Prado-Steiman, 2011). Acculturation is involved in the expression of distress and coping. For example, acculturated women may begin to experience psychological symptoms more commonly found in the American population, such as body image problems and disordered eating. Jane, Hunter, and Lozzi (1999) found Cuban American women with close identification with the Cuban culture to have fewer negative attitudes toward eating, while second-generation Mexican American women have highly disordered eating patterns (Chamorro & Flores-Ortiz, 2000). Assessors want to keep in mind these connections between acculturation and psychopathology when assessing immigrant women, because it may explain the root of certain problems and treatment options.

**Assessment of Preferred Language**

The assessor needs to ensure that an immigrant woman has a fair opportunity to express herself in her preferred language during the evaluation, both in the
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Interview and in the psychological tests (American Educational Research Association, APA, & National Council of Measurement in Education, 2014). Even when immigrant women come from English-speaking countries, all aspects relevant to the issue of language choice with language-diverse clients are applicable given that language is highly impacted by cultural values. Both proficiency and literacy need to be determined in relation to the language and reading level of the test. Whether the assessor allows the client to identify her skills, obtains a reliable assessment through the interview, or uses a more standardized mechanism, the assessor should make sure that the client is going to understand the instructions and items, as well as what they mean. In particular, psychologists who are utilizing translated versions of the psychological tests should make sure that the test was not only properly translated, but also that its meaning was preserved and adapted to the nuances of the examinee’s language, and that it maintains the reading level of the original instrument.

It is important that the assessor feels comfortable using an interpreter and understanding broken English or an accented speech when evaluating women whose primary language is not English. Non-English speakers may have difficulty with language nuances, idioms, and humor. In addition, the assessor needs to understand gendered idioms and stylistic forms of speech utilized by women of certain cultural groups. For example, in some cultures, women speak with an excessive use of diminutives, euphemisms, and entreaties (Sadiqi, 2002). Assessors should be patient and speak clearly and with simple terms, and without infantilizing the client or being condescending, which would be a biased stance and place the woman in an inferior position.

Assessment Instruments for Immigrant Women

The literature addressing the intersection of gender and diversity in psychological assessment is limited. While there is a strong body of literature on ethnic and cultural diversity and some literature on gender studies in assessment, the combination of these factors does not seem to have captured as much attention. This gap in knowledge leaves the assessor needing to review each factor separately when interpreting the scores or responses of an immigrant woman. Unfortunately, studying each factor separately does not equate to the knowledge that can be derived from studying them alongside each other. To borrow the words of Bowleg, “once you’ve blended the cake, you can’t take the parts back to the main ingredients” (2013, p. 754).

Performance-based measures of personality have been considered ideal to explore the intersectionality of race, ethnicity, and gender, because they facilitate individualized responses instead of providing preset choices (Miville & Ferguson, 2014). The Comprehensive System developed cutoffs for different indexes on the basis of a normative group that was largely Caucasian middle-class city or suburban residents with high school education and above (Exner, 2003). However, the normative sample was increased over time to simulate the census
demographics. The Rorschach Performance Assessment System (R-PAS; Meyer, Viglioni, Mihura, Erard, & Erdberg, 2011) has the most extensive international normative sample and strong research literature supporting its use with people from different ethnicities and different countries. The R-PAS also has had the standardized administration and scoring software translated into several languages. Further, the R-PAS is suitable for women not born in the U.S. because its vast normative sample most likely includes individuals of a similar age, gender, race, and ethnic demographics to their own.

Assessors may wish to pay attention to the themes of examinee responses, as immigrant women interpret the inkblots from their own experience and framework, and this interpretation would be projected into the thematic and qualitative aspects of their responses. Albeit the fact that projective pictures have a Western context, open-ended formats such as the Thematic Apperception Test allow the examiner to follow up with questions that more directly inquire into the underlying aspects of the woman’s response, and help clients verbalize the conflict between self-concept and imposed identity, including experiences of discrimination, oppression, and sexism (Ruth, 2012).

The recognition of clear gender differences in personality, psychopathology, cognition, and social behavior has been the foundation for the development of separate gender norms in the test design and scoring of some tests, including the MMPI-2 (Mason, Bubany, & Butcher, 2013). In particular, the MMPI-2 has been translated, adapted, and normed for numerous languages and cultures (Butcher, 1996). Numerous studies have demonstrated its applicability with immigrant populations, including sets of codes and elevations that tend to be present in certain contexts (Butcher, Cabiya, Lucio, & Garrido, 2007; Butcher, Hass, Greene, & Nelson, 2015). The intersection of diverse cultural background and gender has not, however, been the focus of systematic inquiry with the MMPI-2 or most other self-report measures. Particularly, insufficient attention has been paid to gender differences among immigrants in spite of findings that specific patterns or unusual symptom constellations have been found to represent gender- and culturally related expressions of distress rather than the serious psychopathology suggested by the more traditional interpretation of the scale (Cervantes, Salgado de Snyder, & Padilla, 1989; Saborio & Hass, 2012). Hopefully, in the future, researchers will conduct more studies in which norms for different ethnic groups, intersected with gender and education level, are segregated in order to improve assessment measures (Fuentes & Adames, 2014).

Other self-report measures have been developed with the focus of evaluating immigrants and refugees in different languages (i.e., the Hopkins Symptom Checklist-25: Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987; and the Harvard Trauma Questionnaire: Mollica et al., 1992). Other instruments have been cross-validated for use with immigrants and refugees (i.e., the Symptom Checklist-90, Derogatis, Lipman, & Covi, 1973; and the Beck Depression Inventory, Beck & Beck, 1972) among others. These self-report scales have a narrow focus and are helpful adjuncts to generic instruments and other sources
of information. Knowledge and familiarity with the instruments is paramount, since assessors need to constantly strive to minimize sources of error.

The Integration of Findings in the Assessment of Immigrant Women

Because no instrument or strategy in the field of personality assessment holds universal truths, throwing a broader net of methods to gather information decreases the possibility of missing relevant issues. However, a psychological assessment consists not only of psychological tests but also the interview and behavioral observations. These additional components of the assessment provide data regarding the social environment, personal history, and collateral information, which together contribute to the generation of hypotheses to answer the referral question (Groth-Marnat, 2003). Additionally, the working relationship between the assessor and the examinee provides a great deal of information and is key to the success of the evaluative process since it has to be a joint endeavor to be meaningful.

Competent assessment and diagnosis does not happen when instruments or techniques are used in a vacuum. Integrating various sources of data with the assessor’s knowledge of the sociocultural context and using a dynamic sizing process are critical to accurate assessment interpretations (Sue, 1998). Dynamic sizing, according to Sue, means that the assessor needs to have sufficient clinical judgment to know “when to generalize and be inclusive and when to individualize and be exclusive” (p. 446) in relation to the characteristics that belong to the group but not to the individual and the other way around (Sue, 1998).

Ultimately, the assessor is responsible for integrating all individual differences in the administration, interpretation, report, and feedback in a psychological assessment that should sensitively portray an accurate and fair picture of the immigrant woman’s contextualized functioning. Cultural and contextual information constitute alternative explanations of behavior that can also enlighten the path to recovery and treatment needs. Hypotheses derived from psychological tests that conflict with the other assessment data need to be carefully examined by narrowing down the level of analysis in the data, adding sources of information, consulting the literature, consulting with colleagues, discussing the discrepancy with the client, or some combination of these behaviors. The goal of reducing error, bias, and stereotyping is paramount in this aspect of the evaluation.

An equally important ethical and moral obligation is to recognize and address the strengths and resiliency that immigrant women possess and give them their proper place, without idealizing or spinning favorably a problem issue, which involves bias, is patronizing, and is ultimately unhelpful. Assessors need to avoid overfocusing on the psychological dysfunctions, depicting the immigrant woman as inadequate, or suggesting she is producing her own social disadvantage. Research indicates that, in spite of their stresses and risks, recently
arrived and second-generation immigrants fare better than their counterparts who remained in the country of origin (Alegria et al., 2007; Corral & Landrine, 2008). Immigrant women have been found to have resilience, flexibility, and effective problem-solving skills (Berger, 2011; Pittaway & Bartolomei, 2001). First-generation immigrants often have a tendency for high aspirations and achievement (APA, 2012; Fuligni, 2001), including hard work, positive attitudes about education, and healthy values regarding family support (Suarez-Orozco & Carhill, 2008). In spite of the emotional cost, immigrant women adapt better and faster than immigrant men to the host society (Brock-Utne, 1994). Immigrant women are incredibly quick to rebuild their lives in the new environment and have a stronger ability to negotiate the multiple and changing situations in their lives (Berger, 2011). Sources of resilience are cited to be their support systems (Friedman-Kasaba, 2000), availability of role models, family support (Berger, 2011), and drive toward self-sufficiency (Balgopal, 2000).

When formulating recommendations, the assessor wants to maintain a broad focus that includes not only individual changes to the client but also changes to the environment and circumstances that contribute to the problems. Particular healing beliefs proper of a woman’s cultural background need to be taken into consideration when making recommendations. It is important to remember that the legality of a woman’s immigration status does not forfeit her human rights, especially her right to safety and medical and psychological services. While psychologists evaluating an undocumented immigrant woman need to understand the fear of deportation and the limitations that her status presents to her quality of life, it is important to avoid making assumptions or statements that may reflect any bias regarding her ability to use the resources that the government has created for her safety and protection.

**Cultural Factors When Diagnosing Immigrant Clients**

The *Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition* has recognized the need to address the cultural context when identifying and managing psychopathology (*DSM-5*; American Psychiatric Association, 2013). In addition to describing the variations that culture and gender exert on many of the diagnoses, the *DSM-5* offers an outline for cultural formulation to obtain information on a person’s mental health in the context of his or her cultural background and history. Psychological disorders called “Cultural Concepts of Distress” (American Psychiatric Association, 2013, p. 833) are separate and distinct from the traditional diagnosis included in the *DSM-5* and for which the *DSM-5* diagnosis may be inappropriate. These culture-bound syndromes present in certain cultures and are recognized by members of the same cultural community as distress (Trujillo, 2008).

Among the cultural idioms of distress noted by the *DSM-5*, the “Ataque de Nervios” has received attention in the psychological literature for individuals with a Latin American background, especially women. As described in the
DSM-5, this disorder includes “uncontrollable attacks of anxiety, anger, crying, shouting, screaming and trembling” (American Psychiatric Association, 2013, p. 833). Sufferers may describe a heat rising from their chest and an experience of feeling out of control. Dissociative symptoms, suicidal gestures, and seizures or fainting episodes happen to some sufferers. A key characteristic of this type of episode is onset; symptoms occur following a distressing event, such as an interpersonal conflict or the death of a loved one (Guarnaccia, DeLaCancela, & Carrillo, 1989), but often resolve without any clinical sequelae. Although “Ataque de Nervios” is comorbid with anxiety disorders, including post-traumatic stress disorder, and panic disorder (Guarnaccia, Lewis-Fernandez, & Marano, 2003), this disorder has a distinct clinical picture.

This diagnosis seemed appropriate in the case of Mayra Mora, a 55-year-old Mexican immigrant, who was referred for a psychological evaluation to rule out a psychotic disorder. Child Protective Services investigated Ms. Mora for using excessive physical abuse with her 12-year-old granddaughter. When the social workers and police arrived at her apartment to remove the child, Ms. Mora threw herself to the floor, pulled her hair, yelled, and screamed. Next, she started to run outside of the building and into traffic. When the police tried to restrain her, Ms. Mora was belligerent, screamed that she was dying, and ended up fainting. She was hospitalized but released within 24 hours because the psychiatrist did not find any reason to keep her. During the interview, Ms. Mora reported that these episodes started at age 16, and the first one happened when her mother died during childbirth. Another episode happened at age 20 when her husband beat her up and kicked her out of the house without the children. Another episode occurred when she found her youngest daughter in the streets prostituting herself to maintain a crack addiction. Ms. Mora did not present any signs of an altered state of mind, and her psychological tests pointed toward anxiety, but there were no scales or indexes (Minnesota Multiphasic Inventory-2, Trauma Symptom Inventory-2, and Rorschach Inkblot) in the clinical range. Ms. Mora did not present in this assessment any clinical difficulties that would warrant a diagnosis of mood disorder or psychotic conditions. It was concluded that the crisis that Ms. Mora underwent was more likely an “Ataque de Nervios” that expressed her distress and resolved without significant sequelae.

In addition to these cultural constructs, particular symptoms appear more consistent with the expressions of distress in certain cultural groups. In particular, somatic concerns and symptoms have been mentioned to be more prevalent as reactions to trauma in groups such as Africans (Peltzer, 1998), Armenians (Armenian & Hovanesian, 1998), and Vietnamese (Conrad et al., 2010), to name a few. It is important to assess these particular symptoms and behaviors when evaluating immigrant women because, in many instances, they are the only way in which deviant psychological functioning present itself.

Knowledge of the trauma literature and particularly the cultural aspects of trauma on women is essential for the assessor working with immigrant women, as they often present with histories of trauma (Cervantes et. al., 1989).
Some refugee women who escaped from war-torn countries may have been directly or indirectly exposed to combat, sexual assault, torture, concentration camps, and political persecution. These various traumas have occurred in Bosnia (Weine et al., 2004), Mozambique (Sideris, 2003), Iraq (Laban, Gernaat, Komproe, van der Tweel, & de Jong, 2005), Ethiopia (Fenta, Hyman, & Noh, 2004), and El Salvador (Zentgraf, 2002). Other immigrant women may have escaped natural disasters such as typhoons, hurricanes, earthquakes, or man-made nuclear disasters. Women from extremely poor countries or rural areas may have been exposed to deprivation, neglect, and childhood abuse (Cervantes et al., 1989; Kaltman, Hurtado de Mendoza, Gonzalez, Serrano, & Guarnaccia, 2011), and women from some cultural groups may have been victimized by cultural traditions such as female genital mutilation or being a child bride.

Luckily, research regarding the presence and management of trauma in refugee and immigration groups is very solid (i.e., Marsella, Friedman, Gerrity, & Scurfield, 1996). It is important to note that clients from non-Western cultural groups may present with diverse signals and symptoms of distress that do not fit the standard criteria set out for PTSD (Kohrt & Hruschka, 2010; Lewis-Fernandez et al., 2010).

Due to the limitations of the medical system of categorical nomenclature, some assessors have moved away from this system in favor of other approaches in the formulation of a woman’s psychological functioning. For instance, the five-factor model of personality provides a hierarchical organization of personality traits (Widiger & Trull, 2007). Some literature supports the use of this model with clients from different cultures. Other clinical formulations (Kinderman & Lobban, 2000) or psychosocial models (McWilliams, 1999; Mundt & Backenstrass, 2005) have also been developed in the hopes of attending more carefully to the intersubjective experience and addressing the etiology and maintenance factors, which are more useful for treatment intervention.

**Practical Points**

- Assessors should achieve and maintain competency in the psychological assessment of immigrant women through diverse and constant efforts to familiarize themselves with ethnic groups, cultures, and issues different than their own. Professional training and consultation are also recommended. Most importantly, a curious self-examination of personal identities, values, and beliefs around diversity set the stage for a culturally competent attitude.
- Assessors need to integrate cultural knowledge and information in all aspects of the assessment process, including preparation, interviews, adaptations to testing, and interpretation and reporting of data, diagnosis, and recommendations.
- Assessors should make efforts to utilize assessment techniques and measures that are adequately validated for use with immigrant women and use a broad method of gathering information. When the methods of evaluation
are less than ideal, efforts should be made to diminish errors, and the tenta-
tiveness of the findings need to be spelled out in the report.

• Assessors should consider protective factors (e.g., cultural values, extended family and community relationships, resilience, etc.) in the assessment pro-
cess in order to present a more balanced picture of the immigrant woman's psychological functioning.

Annotated Bibliography


Comment: This document constitutes the most overarching review of literature regarding immigrants in the United States and the immigrant experience. It includes guidelines for the psychologist regarding any type of psychological services with this population and includes an impressive list of references.


Comment: In this book, Hays provides numerous suggestions and guidelines for the clinical practice to ensure that issues of race, ethnicity, and gender are addressed and integrated.


Comment: Within the framework of intersectionality, this book provides an excellent review of the impact of gender and ethnicity in clinical practice, including assessment.

References


Intersection of Gender and Immigration


Intersection of Gender and Immigration


19

PSYCHOLOGICAL ASSESSMENT OF THE EFFECTS OF SEXUAL HARASSMENT

Nancy Kaser-Boyd

Maria Zhang formed a start-up company that was subsequently sold to Yahoo!. She took the employees of her start-up with her to Yahoo!, including Nan Shi. Nan Shi subsequently complained to Yahoo!’s Human Resource Department that Maria Zhang sexually harassed her. She claimed that Zhang instructed her to move into temporary Yahoo! housing in the Silicon Valley, which is when the alleged harassment began. She claimed that, in shared housing, Maria Zhang crawled under the covers, without clothes, and hugged and kissed her. She claimed also that Zhang coerced Shi to have oral and digital sex with her on multiple occasions and told her she would have a “bright future” at Yahoo! if she had sex with her.

Maria Zhang filed a countersuit, arguing that Nan Shi’s lawsuit is a form of defamation and an attempt to extort Yahoo!. She argues that Nan Shi had negative performance reviews from other Yahoo! staffers, due to low productivity, and filed her claim in anticipation of termination and the loss of hundreds of thousands of dollars in unvested Yahoo! stock. Yahoo! put her on paid leave after she complained to Human Resources. Yahoo! said they found the sexual harassment claims unsubstantiated and were standing behind Maria Zhang. Shi was subsequently fired.¹

Sexual harassment claims are on the rise in the tech industry (Quart, 2013) and in the military (Foote & Goodman-Delahunt, 2005), which are two of the largest workplaces for young Americans. Sexual harassment is reported on college campuses (Dziech, 2003) and in private industry as well (Lundberg-Love & Marmion, 2003). A person who has experienced sexual harassment may present for psychotherapy or may be referred for a psychological evaluation. Some cases may be referred for a forensic psychological evaluation. This chapter is a general introduction to the psychological assessment of the effects of sexual harassment. It is not intended as a guide for forensic evaluations; recommended readings for such evaluations appear at the end of this chapter.

¹
Definitions of Sexual Harassment

The Equal Employment Opportunity Commission Definition

Sexual harassment is more than overt sexual acts or *quid pro quo*. The Equal Employment Opportunity Commission (EEOC), which enforces Title VII of the Civil Rights Act, defines sexual harassment as follows:

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when (1) submission to such conduct is made either explicitly or implicitly as a term or condition of an individual’s employment, (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individuals, or (3) such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive work environment.

(Code of Federal Regulations, 2000, p. 186)

The first two examples are a type of sexual harassment termed *quid pro quo*, while the third is commonly referred to as hostile environment (DeSouza & Solbert, 2003). The courts have further defined sexual harassment, as have social scientists.

The Legal Definition

The legal definition of sexual harassment has evolved from a series of cases brought against employers, which are now codified in Title VII of the EEOC guidelines (Civil Rights Act of 1991). The earliest cases concerned employment benefits, such as advancement, based on acceptance of sexual advances. *Barnes v. Castle, 1977* (562 F. 2nd 983, 990 [D.C. Cir. 1977]) was such a case. The plaintiff filed suit under Title VII of the Civil Rights Act, claiming her employer fired her in retaliation for her refusal to grant sexual favors. The Court defined this as *quid pro quo* harassment. In *Meritor Savings Bank, FSB v. Vinson* (477 U.S. 57, 106 S. Ct. 2399, 1986), the Supreme Court held that Title VII prohibits sexual harassment in employment even if the harassment does not cause a direct financial injury (such as loss of promotion). The Court recognized a cause of action for sexual harassment based on creation of a hostile work environment.

In *Harris v. Forklift Systems* (510 U.S. 17, 114 S. Ct. 367, 1993), the Supreme Court opined that the mere utterance of an epithet that creates bad feelings in an employee does not rise to the level of harassment; the conduct must be severe and pervasive enough to create an *objectively* hostile environment. The conceptive of *objective* was defined as what a *reasonable person* would find hostile or abusive. The court further stated that the conduct did not need to affect an
The Effects of Sexual Harassment

employee's psychological well-being to constitute harassment. Same-sex harassment was addressed in Oncale v. Sundowner Offshore Services (118 S. Ct. 998, 1998). The Supreme Court said that nothing in Title VII necessarily bars a claim of discrimination merely because the plaintiff and the defendant are the same sex. Case law will likely continue to evolve, and states may have further defined or added to federal civil rights laws. Practitioners are well advised to know the laws regarding sexual harassment in their jurisdiction.

Lawsuits for sexual harassment can be filed in Federal Court under Title VII, or they can be filed in state court under Tort Law (Foote & Goodman-Delahunty, 2005). Cases filed in Federal Court under Title VII, but not Tort cases, have an additional component called “welcomeness,” where the plaintiff is required to prove that the harassing conduct is unwelcome. This will be discussed in greater detail below.

The Behavioral Definition

Till (1980) outlined domains of behavior that are sexually harassing. These included (1) generalized sexist remarks and behavior, (2) inappropriate and offensive sexual advances, (3) solicitation of sexual activity or other sex-related behavior by promise of reward, and (4) coercion of sexual activity by threat of punishment. Fitzgerald and Hesson-McInnis (1989) suggested harassing behavior consists of three distinct dimensions: gender harassment, unwanted sexual attention, and sexual coercion. Gender harassment refers to a broad range of behavior that conveys insulting, hostile, and degrading attitudes about people. Unwanted sexual attention is behavior that is unwelcome, offensive, and unre- ciprocated. Sexual coercion is the extortion of sexual cooperation in return for job-related considerations. The first two categories are the “hostile work environment” and the third is quid pro quo.

The Psychological Definition

The psychological definition emphasizes the feelings and effects on the person who experiences sexual harassment. It is defined as unwanted sex-related behavior at work that is appraised by the recipient as offensive, exceeding his/her resources, or threatening his/her well-being (Fitzgerald, Swan, & Magley, 1997).

Prevalence and Patterns

Information collected from a large (N = 3,006) national sample of adult women, excluding educational institutions (Dansky et al., 1992; Dansky & Kilpatrick, 1997; Saunders, 1992), found that 11.5% of the women reported sexual harassment that met the EEOC criteria. An additional 16.7% of the women reported sexually harassing behaviors that were distressing, including repeated
unwanted requests for a date, verbal comments about their body, and being told stories about sexual conquests or told sexual jokes. A study of Federal employees (U.S. Merit Systems Protection Board [USMSPB], 1995) reported that 44% of women and 19% of men reported some type of sexual harassment. About 30% of women attending four-year colleges report some type of sexual harassment (Fitzgerald & Ormerod, 1993; Fitzgerald & Shullman, 1993). A study by the Department of Defense surveyed the frequency and impact of sexual harassment in the military and found that 64% of women and 17% of men had experienced some form of unwanted sex-related behavior on the job in the prior 24 months (Martindale, 1990). Fitzgerald, Magley, Drasgow, and Waldo (1999) surveyed harassment experiences of men and women in the military (N = 28,000) using the Sexual Experiences Questionnaire (Fitzgerald, Gelfand, & Drasgow, 1995). They found that sexual hostility was the most common form of harassment, followed by unwanted sexual attention. Sexual coercion was the least frequent experience. Approximately 78% of female military personnel had experienced at least one instance of unwanted sex-related behavior in the previous year, compared to 38% of men. Forty-two percent of the women reported unwanted sexual attention, and 13% had experienced some form of sexual coercion, compared to 8% and 2% for men, respectively.

It is not any less likely for sexual harassment to occur in the private sector. A large study of the civilian workplace was conducted by Gutek (1985), who used telephone interviews generated through a random dialing procedure to interview 1,232 workers in the Los Angeles area. She found that 53% of the female participants reported at least one sexual harassment experience during their working lives, including insulting comments (19.8%), insulting looks and gestures (15.4%), sexual touching (24.2%), being expected to socialize as part of the job (10.9%), or being expected to participate in sexual activity as part of the job (7.6%).

Sexual harassment occurs to men as well as women and to individuals who are gay or transgender. The Merit System’s 1981 study found that between 14% and 19% of men in the Federal workforce had been sexually harassed (USMSB, 1981, 1988, 1995). The incidence and pattern remained relatively stable over the 14-year span of the studies (Stockdale, Visio, & Batra, 1999). The USMSPB surveys indicated that about 22% of men were harassed by other men, compared with only about 3% of women being harassed by other women (termed same-sex sexual harassment). A number of studies have found that when men are harassed by other men, it is often about not conforming to the male sex role, for example, saying he was not “man enough” or making lewd comments that the recipient found offensive. (Berdahl, Magley, & Waldo, 1996; Stockdale, Visio, & Batra, 1999; Waldo, Berdahl, & Fitzgerald, 1998). When women were the harassers, the behavior took the form of negative remarks about men (such as “men have only one thing on their mind”) or unwanted sexual attention (Stockdale et al., 1999). A study by DuBois, Knapp, Faley, and Kustis (1998) found that men
who experienced sexual harassment by men were more likely to report negative impacts to their professional and personal lives than were men who were harassed by women. Stockdale et al. (1999) suggest that this may be because sexual harassment by men is more threatening to masculine identity.

A recent study (Kabat-Farr & Cortina, 2014) explored the forms of sexual harassment experienced by men and women in three workplace settings—the military ($N = 19,960$), the courts ($N = 1,158$), and academia ($N = 847$)—using the Sexual Experiences Questionnaire (SEQ; Fitzgerald, Gelfand, & Drasgow, 1995), which surveys the types of sexual harassment delineated by Fitzgerald and Hesson-McInnis (1989) and their frequency. They hypothesized that gender harassment (sexist and crude comments) would be greatest in workplace settings where women were in the minority. They found that for women, but not for men, the underrepresentation of the gender in the work site increased the risk of gender harassment.

**Psychological Effects of Sexual Harassment**

This chapter is not intended as a guide to the forensic evaluation of litigants but is focused generally on individuals who present after the experience of sexual harassment. The effects of sexual harassment depend, in large degree, on the type of harassment experienced. As noted elsewhere, all types of sexual harassment cannot be lumped into one basket. Most studies of the effects have found that more serious forms of sexual harassment, such as sexual coercion, cause more serious effects than do the less serious forms, such as name-calling or sexual jokes, although the latter do have psychological consequences for the employee and for the organization itself.

Like research in most areas of psychology, the earliest inquiries about the effects of sexual harassment were clinical and case studies. Most of these were about women who were subjected to sexual harassment by men. Two papers in psychotherapy journals (Hamilton, Alagna, King, & Lloyd, 1987; Salisbury, Ginorio, Remick, & Stringer, 1986) described a sequence of cognitive and affective responses to sexual harassment by these individuals:

1. **Confusion/self-blame/denial.** The individual is caught off-guard by the behavior and assumes it will stop.
2. **Fear/anxiety.** When the harassment doesn’t stop, the individual begins to feel trapped and helpless. He or she goes into conflict over reporting or taking action versus fearing retaliation or destruction of his or her career. These emotions may affect work performance, attendance, concentration, and motivation.
3. **Depression/anger.** Fear and anxiety transform into anger and depression.
4. **Disillusionment.** The sexual harassment and the consequences of reporting such action may result in shattered beliefs about fairness, loyalty, and justice.
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Gold (2004) notes that sexual harassment causes effects on future employment in the form of decline in job performance, decreased motivation, interrupted careers, increased absenteeism, lowered productivity, and impaired relationships with co-workers; there are also health effects in the form of stress-related conditions such as gastrointestinal disturbances, headaches, weight loss, and fatigue and sleep disruption. The stress of sexual harassment can also exacerbate chronic illness such as ulcers.

The first large study of the psychological effects of sexual harassment (Kilpatrick, Dansky, & Saunders, 1994) sampled 3,006 women via a telephone interview procedure. The study found that the lifetime risk of PTSD or major depression was significantly higher among sexual harassment victims than it was among women who never experienced sexual harassment. The increased risk of experiencing PTSD or depression was present even when there was statistical accountability for the effects of other types of victimization.

Cook and colleagues (1996) examined the prevalence and impact of sexual harassment in 186 male and female residents in medical training. Ninety-three percent reported experiencing one or more incidents of sexual impropriety, ranging from sexist jokes to unwanted sexual contact and sexual bribery. Embarrassment, anger, and frustration were the most common responses (20%), followed by anxiety (16%), feeling violated (11%), feeling helpless (7%), feeling threatened (7%), and becoming depressed (6%).

The incidence of drug and alcohol abuse as a coping mechanism was studied by Richman and colleagues (1999, 2002). Both were university studies, one with students and faculty and one with university employees. The authors found that individuals who reported sexual harassment on the SEQ were more likely to abuse alcohol; the more severe the harassment, the more likely they were to abuse alcohol.

An analysis of a portion of the data from the Department of Defense Study (Fitzgerald et al., 1995) examined the effects of the different types of sexual harassment assessed with the SEQ. Of those who experienced at least one form of unwanted sexual attention, 58% experienced emotional distress (such as loss of self-esteem, negative opinion of the opposite sex, deterioration in emotional and physical condition). The more severe forms of harassment had the greatest effect on employees’ emotional well-being (Pryor, 1995).

Palmieri and Fitzgerald (2005) studied the prevalence of symptoms of PTSD in a sample of 1,241 women involved in a sexual harassment class-action lawsuit against a large financial services firm. The majority of the women were sales assistants and had a male supervisor. The subjects completed the PTSD Checklist—Civilian Version (Weathers, Litz, Herman, Huska, & Keane, 1993) and the SEQ. Substantial levels of trauma exposure and post-traumatic stress symptoms were found in the sample. Research has shown an association between sexual harassment and PTSD symptoms in the workplace (Fitzgerald, Drasgow, Hulin, Gelfand, & Magley, 1997), in academia (McDermut, Haaga, & Kirk, 2000), and in the military (Fontana, Litz, & Rosenheck, 2000). The effects of sexual
harassment can differ based on variables such as the rank or position of the harasser or the duration of the harassment (Foote & Goodman-Delahunty, 2005). PTSD symptoms may not be present in less serious forms of sexual harassment, but its absence does not mean that the individual does not have emotional damages (Foote & Goodman-Delahunty, 2005).

A recent study (Leskinen, Cortina, & Kabat, 2011), utilizing the SEQ with women working in two male-dominated contexts—the military (N = 9,725) and the legal profession (N = 1,425)—found that the most common forms of sexual harassment were in the gender-harassment category (sexist and crude remarks). Though experiencing the less severe form of harassment, the women still showed significant decrements in professional and psychological well-being. In the military sample, gender-harassed women reported lower psychological well-being, job performance, job commitment, and satisfaction with their employment and health. Among female attorneys, gender-harassed women reported lower satisfaction with professional relationships and higher job stress.

There is clearly less research on the effects of sexual harassment in men. Men may have a different threshold for defining sexual harassment (Foote & Goodman-Delahunty, 2005; Gutek & O’Connor, 1995). They appear to differ in moving to report sexual harassment; they report one-fifth the number of experiences of unwanted sexual attention and one-sixteenth the number of sexually coercive experiences (Fitzgerald, Drasgow, et al., 1999). There is no research that suggests that the effects of sexual harassment in men are different from those in women, given equal frequency, intensity, and offensiveness (Magley et al., 1999).

While the print and media press seem to regularly report cases of sexual harassment, a minority of women report sexual harassment and take legal action. Only 6% to 18% of individuals reporting harassment bring a formal complaint (Gutek, 1985; Kilpatrick et al., 1994). Women report being reluctant to take formal action, even in the face of serious harassment. They report fear that they will not be believed or that reporting will affect their careers (Gold, 2004). Reporters often face social stigma (Miller & Stiver, 1997). In one memorable case of this author, a woman attorney reporting sexual harassment by a supervising attorney reported feeling devastated when her friends (mostly lawyers) turned away from her. Retaliation is also a significant issue; this usually takes the form of demotion, transfer, or termination. Research indicates that between 40% and 62% of women who reported sexual harassment experienced retaliation (Loy & Stewart, 1984; Parmerlee, Near, & Jensen, 1982). Such a response is actionable under the EEOC and may be easier to show than the sexual harassment itself (Foote & Goodman-Delahunty, 2005).

Case 1: Jane D.

Jane D. was referred by private attorneys for a forensic mental health assessment. On her behalf, they filed a civil suit for sexual harassment under Title VII of the Equal Employment Opportunity Act. Jane had been a cadet at a local law enforcement agency, and
she was just 16 years old when she began her training under a local program to interest minority youngsters in a career in law enforcement. Jane was Anglo American and from a middle-class, two-parent home. She had always wanted to be a police officer and had a strong commitment to helping people. Jane was a good student in school, and she enjoyed a number of friendships. Jane said relationships were important to her, and it seemed like she sought and usually got approval. She presented as a pretty, vivacious girl, aged 18 by the time of her evaluation, but she said that she was nothing like she “used to be” before her experience as a cadet.

Jane recounted her excitement at being selected for the cadet program. It began with a formal training camp, the pre-Academy, with the usual physical training and endurance tests, at which Jane excelled, and with classes about law enforcement. She did well with these, too. She graduated near the top of her cadet class and went on to placement at a local precinct. The supervisor of the cadets at that location was a good-looking Hispanic officer, Officer Garcia, aged 36. He was married and had been a police officer for 12 years. Jane quickly proved to be at the top of her class again. She was a quick learner and very motivated to excel. She devoted all of her spare time to her work as a cadet and felt this was more important than dating or other teen social activities.

Jane thought only that she was being treated well when Officer Garcia offered her a ride home from a cadet celebration. He gave her and two other girls a lift, and he dropped Jane off last. In the car, he told her she was very pretty. She said that in the car, “He started telling me what he liked in women and his sexual preferences.” She felt “really scared” about his intentions.

After this, Officer Garcia began to text Jane. His first text was “Hi, Sweetie. I just wanted to make sure you are OK.” She said he began to text her daily, sometimes several times a day. Then he asked her if she wanted to do a ride-along with him. She knew that cadets have to take a test before they do a ride-along. He told her that it was OK, since he was the supervisor. While in his police car, a call came through regarding “something floating in the river.” He parked a distance away “and he touched my leg.” She said she asked him what he was doing. This stopped any further touching, and he took her home. Before letting her out of the car, he said “You better not get me fired.”

Officer Garcia began to give Jane rides home. He kissed her in the car. At first, she resisted, but “then I started feeling ‘Whatever.’” As a teenager without a boyfriend, she found this a little bit flattering. The other recruits began to notice, and there was gossip that something was going on between the two. Jane began to become alienated from her friends at the station. Officer Garcia’s seduction of Jane soon escalated. In one trip in his police car, he said “I had a dream of you giving me a blow job, and I woke up and my wife wasn’t in bed, and it made me scared that she knew.” Jane said that he had already begun to talk about his wife and their bad sex life. He told her that he loved getting blow jobs, and his wife refused to give those. He also talked to her about some of the things he had done as a police officer. He talked about enjoying scaring people with his authority. On one occasion, he threatened a motorist when she was in his police car. Shortly before the investigation began, Officer Garcia forced Jane into a sexual act.
The Effects of Sexual Harassment

Jane would have kept Officer Garcia’s behavior a secret, but one of the other cadets complained that Jane had become his favorite, and the girl’s mother told several other mothers, who came down to the station to demand to know what was going on. Interviewed by the Captain, Jane at first denied that anything had gone on. When she was confronted with facts accumulated in the investigation, she admitted that Officer Garcia sexualized their relationship. Jane thought that she would be able to stay in the cadet program. She said she “worked extra hard to show that I was worthy.” At first, she was allowed to stay. When a new Captain took over the station, however, he telephoned her and said, “It is not a good fit for you here.” She said he asked her to come in and sign “a paper that said I resigned voluntarily.” While Jane had been struggling with turbulent emotions when the sexualized relationship became public, and had been stunned when on social media she was blamed for Officer Garcia’s behavior and called a “home wrecker,” being asked to resign was, for her, the crowning blow. It was then that she sought legal advice.

Jane was required to have an Independent Medical Examination (IME). A psychiatrist was chosen for this evaluation, and he referred Jane to a psychologist in his office to conduct psychological testing. The psychologist administered the Minnesota Multiphasic Personality Inventory (MMPI-2), the Personality Assessment Inventory (PAI), the Trauma Symptom Inventory, and the Rorschach, which was scored with the Rorschach Performance Assessment System (R-PAS). Jane was referred by her attorneys to the author. She was interviewed across three visits. Since Jane had been so recently tested, instead of conducting a battery again, which would likely have included the same tests, the defense psychologist’s raw data were requested and received.

Case 2: Bruce L.

Bruce L. was a 32-year-old married father of two children, who presented for a forensic examination after he reported that the man for whom he had been working—a well-known movie star, who was also a married man—had been sexually harassing him. Bruce’s job description was Personal Assistant, and this meant that he was required to be around all the time and to meet the star’s requests. These soon began to feel like extraordinary demands. After a short time on the job and on location, the star asked Bruce to lay next to him on the bed and “cuddle.” This turned out to be just as it was described—cuddling or spooning, and not anything more overtly sexual. However, it made Bruce extremely uncomfortable and afraid of what might come next. He was fearful that others would consider him gay. He was fearful that his wife or friends would find out. He did not feel he could say “no,” because he needed the job, and the movie star wasn’t the kind of person people usually said “no” to. After some period of time, however, he felt he couldn’t continue. He finally told his boss that he couldn’t continue to cuddle with him, and the star fired him. Bruce then filed suit under Title VII.

Bruce was referred by his attorneys for a forensic evaluation. He had not sought therapy, and there were few background documents. Bruce was evaluated by the author.
with interviews and, to formally assess the effects of his reported sexual harassment, with the Minnesota Multiphasic Personality Inventory (MMPI-2) and the Millon Clinical Multiaxial Inventory (MCMI-III). The MCMI-III was chosen to rule in/rule out personality disorder, as Bruce’s lawyer indicated that Bruce would be accused of opportunism in accusing a well-loved and famous star.

Retaliation for reporting sexual harassment is addressed by Title VII of the Civil Rights Act. If the individual can show that his termination is related to his report of sexual harassment, this comprises unlawful retaliation, and the employer would need to prove that the termination was for some lawful reason (Foote & Goodman-Delahunty, 2005). Bruce was referred to the author for psychotherapy by an attorney he consulted. He was not ready to file a lawsuit, as he feared that exposing his former employer would reflect on his sexuality as well as his credibility. He was in considerable emotional turmoil. His attorney also wanted to know whether Bruce was, in fact, credible.

Psychological Assessment of Effects of Sexual Harassment With Case Discussion

Examiner Effects

There is a large literature on examiner effects (Anastasi & Urbina, 1997; Rosenthal & Rosnow, 2009). In cases of gender and sexual harassment, the gender of the examiner is particularly important. Female clients may be unable or unwilling to tell all of the behavior and their thoughts and feelings to a male examiner. LGBT clients may be similarly affected if they perceive the clinician/evaluator to be uninformed or perhaps biased against LGBT individuals. Jane commented that the male IME psychiatrist “didn’t seem to get it,” and she did not feel free to tell him all of her feelings or everything that happened. She said, “He just listened and took notes. He didn’t express much empathy. He just seemed like any other guy.”

The Interview

There are many styles of conducting an interview, and the interview may differ depending on the purpose. An intake for psychotherapy will differ substantially from interviews for forensic purposes. Clinical and forensic work with individuals who have experienced sexual or gender harassment may require multiple interviews because of the need to develop trust and adequate time to articulate feelings. Open-ended questions are generally better because they allow individuals to tell their experience without interruption. When it comes to reporting symptoms, the clinician may need to use her knowledge of the effects of sexual and gender harassment to form questions. Structured interviews may follow; for example, if post-traumatic stress disorder is indicated, then a structured PTSD interview may be appropriate.

The interview should cover the following domains: family of origin (parents’ occupations, educations, cultures), developmental history, exposure to physical
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or sexual abuse, childhood health status, education, relationship history, work history, psychiatric history, current health issues, other life stressors, and possible chemical dependency. These areas lay the groundwork for the interview about the sexual harassment and its effects. In forensic cases, or where external records are available, additional areas for the interview or the highlighting of specific issues may be suggested, and it is best practice to read background documents before conducting the interview.

Jane’s Interview

The interview began with the simple question “How are you doing?” Jane was immediately tearful. She said “I don’t like being like this. I used to be a confident person. I’m afraid it will never leave me. I think about it every day. Passing by the place is a reminder.”

In the long interviews, Jane related a childhood and family life that was relatively normal. Her parents were still married. She denied any history of child physical abuse or sexual abuse and had no major health problems. The worst thing she could remember was her father getting in a motorcycle accident and having to retrain for another career and the natural deaths of both of her grandparents. She described herself as having been a good student, with many friends. She said: “When I went to the police pre-Academy, it was my life. I looked so forward to it. All my friends were there. Before that, I knew what my life was going to be. I wanted to be a cop. When I couldn’t go there anymore, it was like I fell off the face of the world. My best friends said hurtful things about me in depositions. I used to be so self-motivated. Now, I’m having a real hard time finding my footing.”

Jane had a lot of trouble understanding how she could be blamed for Officer Garcia’s behavior. She said, “I felt that they didn’t take the time to pick someone who really cared about instilling good character traits in young people or cared about our futures. I felt he should have been held to standards. They should have noticed his demeanor, because he had a manner of joking about sexual things. People who make those kinds of jokes shouldn’t work with kids. They were aware that he was taking recruits home. Why didn’t they put a stop to it? I know it happened to at least one girl before me.” She admitted that initially she protected Officer Garcia. She said “He asked me to, and I think it was affection, too. I felt loyalty to him, like I had to protect him and I couldn’t get him in trouble. Looking back, I just feel used. And it makes me feel that I didn’t deserve the promotions and praise I got. I feel shame. I feel that people are laughing at me, that I was so stupid.”

Jane confessed that she had become deeply cynical, not just as the result of Officer Garcia’s behavior but because of other things she saw officers do and say. She said her father told her that another nearby city was hiring, and she told him she couldn’t even think of becoming a cop now. She said she had become a loner because she no longer felt she could trust friends, since her friends in the academy had either failed to support her or had said hurtful things about her in their depositions.

Jane said, tearfully, “This has made me lose a part of myself. I was raised with good values, and this questioned everything I believed in. Also, I question my judgment. I feel unsure of myself. I think bad about everyone, like everyone is out for themselves. The world just seems corrupt to me.”
Despite these feelings, Jane was doing her best to get on with her life. She had returned to college, to study psychology, and she was working part-time. Officer Garcia was criminally charged with a sexual offense (since Jane was a minor). He pled guilty. He had to register as a sex offender, take classes, and do community service. This outcome did little to change Jane’s symptoms, however. She reported ongoing symptoms of depression, with fatigue and feelings of worthlessness. She had a hard time concentrating on her studies, and she felt she had lost motivation and lost “a part” of herself. She had unwanted recurrent memories of Officer Garcia, the investigation, and everything that had ensued. She seemed to be coping by trying to repress her memories and feelings and avoiding places that reminded her of the whole event. She was hypervigilant when in the area of the police station and the general neighborhood, tensing up when she saw a car like Officer Garcia’s private vehicle or a police car. She had become deeply mistrustful of the motives of others and said she lost the belief in institutions and individuals in authority. She was also having health issues. Just 19 years old at the time of this author’s evaluation, she was reporting shortness of breath and episodes of near-fainting.

Choosing Assessment Tools

To assess sexual harassment experiences, the Sexual Experiences Questionnaire (SEQ; Fitzgerald, Gelfand, & Drasgow, 1995) is widely used. The SEQ is a 28-item scale that presents the individual with behavioral items tapping gender harassment (sexist behavior, crude comments and jokes of a sexual nature, and other comments that disparage a gender), unwanted sexual attention (unwanted touching, repeated unwanted requests for dates, or sexual involvement), and sexual coercion (implicit or explicit demands for sexual favors with the threat of consequences or promise of rewards).

For measurement of the effects of sexual trauma, conventional wisdom is that an assessment battery should consist of both broad-band and narrow-band instruments (Briere & Elliott, 1997). Broad-band instruments are those that survey a variety of mental disorders and symptoms. They can be, and are routinely, used for any psychological evaluation. Examples are the Minnesota Multiphasic Personality Inventory (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) and the Personality Assessment Inventory (PAI; Morey, 1991). Narrow-band instruments are those that specifically focus on a particular symptom or syndrome. Examples are assessing trauma with the Trauma Symptom Inventory (Briere, 1995) or the Detailed Assessment of Posttraumatic Stress (Briere, 2001) or anxiety with the Beck Anxiety Scale (Beck & Steer, 1993). In most cases, an instrument that evaluates personality pathology may be important, particularly if life history variables suggest personality disorder.

A performance-based test, such as a Rorschach or Thematic Apperception Test (TAT; Murray, 1943), is a useful addition because performance-based tests sidestep the self-report aspect of many psychological tests. The Rorschach, in addition, provides important information in the accuracy of perception,
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including the perception of self and others, and clinical symptoms such as anxiety, depression, hypervigilance, and other effects of harassment reported in the literature. A TAT could add important information about the perception of self and others, especially if one employs an object relations scoring system such as Social Cognition and Object Relations Scores (SCORS; Westen, 1991a, 1991b). There is an emerging literature about the effects of trauma as captured by the Rorschach and TAT (Armstrong & Kaser-Boyd, 2003).

If there is any concern about malingering or exaggeration of symptoms, and especially if the case is in litigation, the addition of a malingering assessment is important. The MMPI-2 and the PAI both offer well-researched scales and indexes for assessing malingering (Friedman, Lewak, Nichols, & Webb, 2001; Hopwood, Morey, Rogers, & Sewell, 2007; Rogers, Sewell, Martin, & Vitacco, 2003). A test specifically designed for malingering, such as the Structured Inventory of Reported Symptoms (SIRS-2; Rogers, Sewell, & Gillard, 2010), can also be chosen. While it is possible that the same test battery might be used in both therapy and forensic evaluation, in the latter it is important to consider the potential weaknesses of particular instruments. It is also frequently observed that the treatment provider does no formal psychological testing at all. This is unfortunate because the individual reporting sexual harassments often has his or her first contact with a therapist and doesn’t see the forensic evaluator until months or even a year or more later, when there has usually been some effort to recover or to suppress the distress that such events cause.

The choice of assessment instruments is as important as the way in which the instruments are interpreted. It does no good to give an MMPI-2 if the assessor has inadequate training in the MMPI, or if he or she fails to research databases that are relevant, such as published research on individuals who have experienced gender harassment or who have been in a situation of sexual coercion. Other errors in the use of psychological tests occur as well. The defense psychiatrist’s handling of Jane’s test results is an illustration.

Case 1’s Test Results

The defense psychiatrist abstracted details from his consulting psychologist’s report. Since her report was not turned over, it is not possible to tell if the errors and omissions in his summary are hers or the defense psychiatrist’s; however, the raw test data do point to significant errors. The defense psychiatrist’s summary indicated that test results showed a constant state of anxiety and tension that may lead to disruptions in her concentration as well as to impulsive behavior and outbursts of emotion. Her anxiety manifests in physical symptoms. She appears to worry excessively about relationships. She may be upset by nightmares, flashbacks, or intrusive thoughts. She may use avoidance strategies to eliminate painful thoughts or memories. She exhibits a number of depressive symptoms, such as a damaged sense of self, feelings of sadness, loss of interest in normal activities, and a loss of a sense of pleasure in things
that she once enjoyed. She also appears to be capable of becoming moody and emotionally labile, and she is prone to bouts of anger that break through her significant efforts at self-control.

With his summary and his forensic interview, he decided on a diagnosis of Adjustment Disorder with Anxiety. He wrote that the sexual behaviors of Officer Garcia “temporarily overwhelmed her coping skills” but that she was mostly having difficulty now because of the loss of her plan to be a police officer. He wrote that if she could be helped to “regain her footing and make up for lost time in the development of her adult identity,” which she could do in “one to two years of psychodynamically oriented psychotherapy,” her Adjustment Disorder with Anxiety could be resolved.

It seemed to this author that the defense psychiatrist chose a diagnosis that was the most benign and the most likely to be short-lived. In reality, the psychological test results pointed strongly toward a diagnosis of Post-traumatic Stress Disorder, and there was a clear indication that her symptoms were quite serious. On the MMPI-2 (which was valid, with no evidence of exaggeration), Jane had a prominent elevation on Scale 6 (T = 72), evidencing many “paranoid” thoughts and feelings. Among these were feeling that other people had it “in” for her, mistrusting the motives of others, feeling that others were looking at her critically and probably talking about her and saying insulting things about her, and feeling that others are actually out to harm her. Jane is also elevated on Scale 2, having endorsed a number of items surrounding depression, such as crying easily, brooding, and feeling not as good as other people.

She also endorsed many symptoms of anxiety on the MMPI-2. Importantly, Jane is quite elevated on the scale Repression, indicating that she copes by attempting to avoid, suppress, or repress emotion. This was consistent with her interview materials when she said she felt she should just “suck it up” when she was experiencing sexual pressure from her supervisor and again when the situation became known and investigated. Like others with a strong inclination to suppress emotion, her distress is expressed through physical or somatic channels, thus her symptoms of irregular heartbeat and fainting, and her Scale 1 score (T = 66) is high for her age.

On the PAI, Jane is quite elevated on the subscale Traumatic Stress. This scale elevates in individuals who have experienced a traumatic event and who are having intrusive memories and other symptoms of PTSD. This is her highest scale elevation (T = 94). Jane is also elevated on the subscale Obsessive-Compulsive (T = 73), which may be a defense against the anxiety caused by the harassment and her general anxiety about her well-being. Her high elevation on Paranoia (T = 76) indicates that she is hypervigilant to potential harm and likely is quite mistrustful in interpersonal relationships. She is at the cutting point for clinical significance on Depression (T = 71), which mirrors the finding on the MMPI. Also, she is high on the subscale Irritability, and she readily admits feeling a kind of free-floating anger about Officer Garcia’s behavior and its impact on her life. On the Trauma Symptom Inventory, Jane was elevated on all of the
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component trauma scales, including Anxious Arousal, Anger, Intrusive Experiences, Defensive Avoidance, and Relational Avoidance.

Jane’s Rorschach was particularly revealing. The content itself was instructive. Images of potential threat and damage prevailed. She reported seeing:

- Something angelic but the blackness makes it seem demonic, too, with wings, shedding his dead layers.
- A pumpkin that’s been carved, split in half, and flattened. People make pumpkins to be scary. Pieces fell off.
- A ladybug, a distorted one. A devilish ladybug. Maybe it killed someone. The blackness of it. Ladybugs are usually red, so since this is mostly black, I feel like its soul was taken over.
- A heart upside down, like a heart that blew up and smoke is coming out of it. Smoke is never good, smoke is always something bad happening.
- A monster that is going to take over the world, really demonic, the blackness of it, and it has little things sticking out of it. It’s creepy, or like it got splattered, like it was creepy and someone killed it.
- A scary bug that got killed, splattered, and spread out everywhere.
- Clouds of smoke coming from a building.
- A Devil butterfly, maybe he got killed, too, and splattered out, like he got stepped on or something.
- Ballerina feet, maybe a ballerina from the Swan movie. She was really a devil.
- A bug. Maybe he died, too, and he got squished. Everything is flattened out.
- A person’s self, body in the center, things from the outside coming to attack it, like infection. Things in color are different things coming to attack the immune system, like things trying to eat away at the body.

The sheer number of dead (killed), damaged, or destroyed percepts is alarming and statistically unusual and likely reflects her intense feelings of having been damaged. The threats described seem to come from many avenues (infection, being squished, body parts blowing up). She appears to scan the field for signs of evil or threat. In some cases, she vacillates on whether a percept is “angelic” or “evil,” reflecting the problems with reality testing when interacting with others who could potentially harm her.

Formal R–PAS scores also support a finding of more serious emotional damage than the defense expert describes in his summary. To begin with, her Form Quality (FQ) is poor. Forty percent of her record is FQu (unusual form quality) and 27% is FQ– (distorted form). Only 33% is FQo (ordinary form quality). This supports the contention that she does not now know whom to trust and doesn’t trust her own judgment. The experience of sexual harassment by a supervisor has thrown her worldview upside down, and it has not adjusted. While there is no indication that she is experiencing psychotic symptoms, there is clearly affective disruption. To begin with, she has 9 Blends, which indicates
that a great deal of complexity characterizes her thoughts and feelings. She has 2 Color-Shading Blends, which reflect the experience of painful, conflicting thoughts. She has 3 Y responses, indicating considerable anxiety. Her 9 C’ responses indicate a depressed and very negative worldview. This is paralleled by 8 Morbids, which indicate depression as well as a very damaged sense of self. At the time of testing, she also clearly felt profoundly helpless (with 5 m and m + Y = 8). R-PAS presents scores as percentiles and standard scores, which can make them more understandable than other Rorschach systems. For scores mentioned above, the findings were:

<table>
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<tr>
<th></th>
<th>Percentile</th>
<th>Standard Score</th>
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<tbody>
<tr>
<td>Blends</td>
<td>92</td>
<td>122</td>
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<tr>
<td>MOR</td>
<td>&gt;99</td>
<td>143</td>
</tr>
<tr>
<td>m</td>
<td>95</td>
<td>125</td>
</tr>
<tr>
<td>Y</td>
<td>83</td>
<td>114</td>
</tr>
<tr>
<td>C’</td>
<td>99</td>
<td>138</td>
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Her Critical Content score is 70%, which is at the 99th percentile and indicates that a significant portion of her Rorschach record contained scores seen in traumatized individuals. A fair reading of the psychological testing indicates that there is considerably more symptomatology than one would see in an Adjustment Disorder with Anxiety.

**Case 2’s Psychological Assessment**

While Bruce was a psychotherapy client, there was a clear possibility that he would decide to file suit either in state or federal court. The primary focus of psychotherapy was to address the considerable emotional turmoil he was experiencing over what had transpired between him and his employer and his subsequent termination. However, his attorney also was asking about whether Bruce showed bona fide effects of sexual harassment and whether he appeared to be a credible person. Individuals who make such allegations about famous people are subjected to special scrutiny, accused of seeking fame or fortune. To evaluate symptoms and their severity, and to assess credibility, two assessment instruments were chosen: the MMPI-2 and the MCMI-III. The MMPI-2 has been described in previous sections. The MCMI-III can also evaluate potential effects of sexual harassment (e.g., anxiety, depression, fear of harm) as well as pathological personality dynamics that may affect credibility (e.g., antisocial or borderline personality types). Similar to the MMPI-2, it has validity scales (Disclosure, Social Desirability, Debasement) that permit an evaluation of exaggeration or malingering.

On the MMPI-2, Bruce had clinical scale elevations on Scales 2 (T = 75), 6 (T = 72), and 7 (T = 76). On the Content Scales, he was elevated on Anxiety (T = 76) and Fears (T = 73). On the Supplementary Scales, he was again elevated on Anxiety.
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\(T = 74\), as well as \(PK (T = 76)\). His validity scores were not elevated into the clinical range, and the results therefore did not appear to exaggerate his symptoms.

On the MCMI-III, used in this case to rule out personality pathology, Bruce was not elevated on Antisocial Personality, the Borderline, or the Paranoid Personality Disorder Scale. As with the MMPI-2, he was elevated on Anxiety Disorder and Major Depressive Disorder scales. On the validity scales, there was no indication that he exaggerated his distress, as neither Disclosure or Debasement were above a base rate score of 75.

Presenting Findings of Assessment of Effects of Sexual Harassment and Defending Findings

There are several possible products of an evaluation for sexual harassment. The psychotherapist is well advised to keep careful, legible notes and to make his or her diagnosis clear in the notes. Such treatment records are often very useful should the individual go on to file a lawsuit.

Writing a formal report is not the final product in every case of the evaluation of sexual harassment. In both cases presented in this chapter, a formal report was not requested. In Jane’s case, a deposition was held where findings were sought in preparation for trial. However, the case settled after the deposition, and perhaps because of it. In Bruce’s case, a formal mediation was held. Lawyers for both sides were present, and the author verbally summarized the general effects of sexual harassment and Bruce’s specific symptoms and his credibility. The case settled out of court. When a formal report is requested, it is usually for anticipated litigation, and it should follow guidelines for forensic reports (de Ruiter & Kaser-Boyd, 2015; Foote & Goodman-Delahunt, 2005).

In the legal arena, the issue of the effects of sexual harassment becomes complicated by the advocacy nature of litigation. Advocates for the defense against claims of sexual harassment (Feldman-Schorrig, 1996; Feldman-Schorrig & McDonald, 1992; McDonald & Feldman-Schorrig, 1994) have noted that many sexual abuse claims are made by individuals (usually women) with histories of sexual abuse. They have argued that a person who has suffered child sexual abuse or other sexual victimization will likely be hypervigilant to cues of danger and thus be hypersensitive to sexual innuendo or behavior and perhaps over-report such behavior. They also suggest that child sexual abuse victims may have certain behaviors that elicit sexual responses, to which they then respond with offense. Also, they have argued, with respect to damages, that current measured effects of emotional distress come from child sexual abuse and not from any workplace behavior.

Fitzgerald, Buchanan, Collingsworth, Magley, and Ramos (1999) conducted two studies to address these contentions. In the first study, 307 college women were divided into a group with no history of child sexual abuse and those who had an experience of unwanted touching of breasts or genitals by a person at least five years older. They presented both groups with scenarios of various forms of sexual harassment, increasing in severity to sexual coercion. They were then
asked to rate their affective response to the scenarios with 25 words describing feelings that they rated on a five-point scale. Abused and nonabused women did not differ overall in their affective reactions to the scenarios. In the second study, 56 women involved in sexual harassment litigation were subjected to in-depth psychological evaluations that included, among other instruments, the MMPI-2 and the Trauma Symptom Inventory (TSI), the Clinician-Administered PTSD Scale (CAPS-1), the Crime-Related PTSD Scale, and a measure of personality disorder, The International Personality Disorder Examination (Loranger, Sartious, & Janca, 1996). They divided the group into those with no history of prior victimization, those with childhood sexual abuse, and those with other sexual victimization. They found that the most common diagnoses in this sample of women claiming sexual harassment was Major Depressive Disorder and Post-traumatic Stress Disorder. There was no difference in results between the child sexual abuse survivors and the women with no history of abuse, either in level of severity of clinical symptoms or type of symptoms. Also, a tiny fraction (six) of the women were found to have personality disorders.

**Practical Points**

Sexual harassment has clear effects on workers, whether they are male or female. These range from dissatisfaction with work to more serious psychiatric symptoms. A variety of general and specific psychological assessment methods can be employed to assess the effects and their severity. Such assessments can be useful in planning treatment and may take the form of a more structured forensic evaluation for litigation. There is a large research database with which to compare the individual who is reporting sexual harassment. While there is some concern that assessing and labeling symptoms or effects of sexual harassment puts complainants at risk of being considered mentally impaired (Fitzerald, Buchanan, Collingsworth, Magley, & Ramos, 1999), careful assessment can also debunk accusations of exaggeration and malingering and support the fact that sexual harassment has multiple layers of damage. Sexual harassment has clear psychological effects whether the target of such harassment is female or male.

- All degrees of sexual harassment can have effects on employees’ well-being.
- There is a growing literature on the effects of sexual harassment in women and in men.
- An assessment battery should include broad-band instruments, to survey the presence of a wide variety of possible symptoms, and narrow-band instruments, to focus more specifically on targeted symptoms.
- A good-enough assessment battery would include the MMPI-2 or PAI, the Trauma Symptom Inventory, and the Rorschach.
- As in all assessments of potentially traumatic effects, the examiner should consider preexisting personality, stressors, and the amount of time that has passed since the harassment reported.
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Annotated Bibliography


Comment: This book is a comprehensive guide to the forensic evaluation of sexual harassment. The authors review the legal framework of sexual harassment and describe harassers and harassment contexts. They outline the practical, legal, and ethical contours of the forensic evaluation and discuss assessing liability and damages. The addition of two complete forensic psychological reports is especially useful.


Comment: This book is also focused on evaluation for the forensic context. The author provides a non-test-based methodology for evaluating the idea of “welcomeness” that must be evaluated in Federal Court and also for evaluating credibility. She also discusses the assessment of emotional injury and damages.

Notes


2 Where 100 is the mean.

References


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Nancy Kaser-Boyd


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Trans people are high utilizers of psychological services (Grant et al., 2011), yet the literature addressing their needs and professional training to work with trans people are both severely lacking (Sanganjanavanich, 2014). The literature on psychological assessment with transgender people is even more limited, and our intent in this chapter is to begin a discussion that will assist psychological assessors to better understand and work with the specific needs of the trans population. Here we will discuss a general overview of the transgender phenomenon, look at ways in which trans people have been pathologized and marginalized, explore countertransference and other assessor-assessee relationship factors, present and discuss a case example, and make specific recommendations for the psychological assessor who works with trans people.

The American Psychological Association (APA) defines transgender as “an umbrella term for persons whose gender identity, gender expression, or behavior does not conform to that typically associated with the sex to which they were assigned at birth” (APA, 2014). People whose lived experiences fall within the parameters of this definition self-identify using a wide variety of terms, some of which include trans, trans*, genderqueer, nongendered, gender non-conforming, gender variant, transsexual, bearded lady, and many others (Gender Equity Resource Center, 2014). For the purposes of this discussion, we will use the term trans to refer to anyone who meets this definition, though not all people who meet this definition will identify with this term. We use the term both because it is commonly used and for conciseness. When working with a person of transgender experience, it is imperative that the assessor determines which terms and pronouns (many trans people choose to use pronouns that do not conform to the gender binary; for example, ze rather than he or she) the person uses and use those terms and pronouns throughout the assessment encounter.
Wayne Bullock & Nicholas Wood

In contrast to *trans*, the term *cis* or *cisgender* refers to those individuals whose gender identity, expression, and behavior does conform to that associated with the sex they were assigned at birth (Gender Equity Resource Center, 2014). While the vast majority of people are cisgender, the National Center for Transgender Equality (NCTE) estimates that between 0.25% and 1% of the population is trans (Grant et al., 2011). According to Gates (2011), nearly 700,000 trans people live in the United States. In a comprehensive report compiled by the NCTE and the National Gay and Lesbian Task Force (Grant et al., 2011), it is estimated that up to 75% of all trans people will have some involvement in the mental health system, while 41% report suicide attempts. Given these high rates of psychological services utilization, the psychological assessor may become involved with trans people related to gender-specific concerns, to the requirements of gender reassignment processes, or to all of the other reasons that people find themselves interacting with mental health providers and psychological assessors.

We are able to make rough estimates of the number of transgender people within the population, but we must also caution ourselves against viewing trans only as a categorical one-size-fits-all label for a group of people. Rather, we might better view trans as a spectrum (Harris, 2011), a lived experience (Goldner, 2011a), and as a particular way of being in the world that involves standing in the spaces (Bromberg, 1996) between traditional gender identities. Historically, the profession has viewed trans as pathological, as a diagnostic category, and as something to be corrected, especially in children (Drescher & Byne, 2012). The assessor is cautioned to avoid assuming prejudicial attitudes and to approach interactions with trans people bearing in mind the history of the profession. The assessor will also benefit from an understanding of those factors that lead to high rates of mental health utilization among trans people, specifically related to the way they have been marginalized as a group and as individuals. To address this marginalized and disenfranchised status, in 2008, the American Psychological Association Council of Representatives resolved to direct the APA to be leaders in establishing a more just society for trans people (Anton, 2009).

The Marginalization of Trans People

The lived experience of a trans person is likely to promote the development of high levels of resiliency, flexibility, and creativity (Hendricks & Testa, 2012). As trans people navigate a world that at best knows very little about them and at worst intrudes upon them, is confused by them, is titillated by them, or wants to hurt them, they develop useful skills for survival. There is risk here, though, as navigating this same, often dangerous world simultaneously promotes the development of a wide array of difficulties. Trans people experience high rates of employment and housing discrimination, interpersonal violence, self-directed violence, community-level violence (Anton, 2009; Richmond, Burness, & Carroll, 2012; Stotzer, 2009), harassment, and disappointment in
authority figures who are tasked with ensuring their safety in the environment (McGuire, Anderson, Toomey, & Russell, 2010). These adverse experiences lead to higher rates of mental illness, sexually transmitted infections, incarceration and involvement with the legal system, and difficulties forging intimate relationships (Hendricks & Testa, 2012). After exploring some of these factors, we will examine an explanatory model that connects the experiences of trans people to their heightened risk of mental illness.

Many trans people experience violations of their safety from very early in life (McGuire et al., 2010). As youth, they are likely to experience pervasive harassment at school, not only from peers but also from staff members whose job it is to allow them a safe environment within which to learn. This lack of safety at school contributes to an increased risk for adverse outcomes and is not necessarily mitigated by involvement in gay-straight alliances, the support network of peers whose experiences most closely relate to those of trans youth (McGuire et al., 2010). Since the lived experience of being lesbian, gay, or bisexual (LGB) is qualitatively different from that of being trans, the support felt by LGB students from their participation in gay-straight alliances may not be felt by trans students, as their concerns are likely to be different from those of the other members. Further, cisgender members of these alliances may hold the same transphobic biases as the world at large, which may further illustrate to trans students ways that they are members of an invisible group. Mascis (2011) argues that this lack of safety at school extends to all aspects of a trans youth’s development such that, from a self-psychological perspective, trans youth lack within their families the mirroring, idealizing, and twinship functions that are integral to the creation of a “consistent and resilient self” (Mascis, 2011, p. 202). According to Mascis, without these functions, the youth may have deficits in the ability to emotionally regulate, affectively soothe, and to internalize a sense of safety.

Trans youth, if they are below the age of legal consent, are often left to rely on parents and professionals to make medical, psychological, and legal decisions for them (Drescher & Byne, 2012). This can be highly problematic if the youth’s parents and the professionals they consult are uninformed about the trans experience. Parents and professionals can cause great harm if they attempt to change the youth’s gender presentation, if they reject the youth, or if they replicate patterns of abuse and victimization the youth may already be experiencing in other areas of their lives (Drescher & Byne, 2012). Being left to depend on others who may not value what is best for the youth can lay the foundations for distrust of authority figures and medical/psychological professionals, which can interfere with getting the assistance they need later in life.

Mascis (2011) points out ways in which trans people may lack outlets throughout their development for idealizing role models, being mirrored, and identifying with other figures in the environment. Mass media has largely ignored trans people. During the 2014–2015 television season, for example, there were 170 LGB characters on broadcast and cable television, but only one trans character
was featured in broadcast and cable programming (Gay and Lesbian Alliance Against Defamation [GLAAD], 2014). Jeffrey Tambor’s award-winning role in Amazon’s series *Transparent* and the depictions of Unique Adams and Sheldon Beiste in Fox’s *Glee* represent marked exceptions. But generally, when trans people have been portrayed by the media, they have been presented as objects of derision, people to gaze at as an anthropologist might (Goldner, 2011a), and as people whose form of genitalia is a mystery that must be solved by all who encounter them (dozens of daytime talk show episodes can demonstrate these points). Trans youth might learn that the world around them only cares about their genitals and their sexual functioning, effectively reducing the full identity of a whole person to particular sexual parts.

As members of that world who likely consume media, psychological assessors may have internal representations of trans people that also reduce them to their genitals. Seemingly well-meaning and informed interviewers often, when interviewing a trans person, will find some way to ask him or her about their genitals: “Have you had surgery?” or “What surgeries have you had?” Given all of our social contexts, it is natural to have these curiosities, though it is important that we maintain sufficient empathy to recognize how such invasive questions could create discomfort.

This sort of erasure of a trans person’s full identity is consistent with what Nadal, Skolnik, and Wong (2012) have identified as 12 categories of microaggressions toward trans people (see Chapter 1 in this volume). Microaggressions are “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, negative slights and insults toward members of oppressed groups” (Nadal, 2013, p. 5), and as a person experiences microaggressions, a cumulative detrimental effect occurs (Nadal, 2013). Nadal and colleagues (2012) interviewed nine trans individuals and identified their common microaggressive experiences. Table 20.1 presents these experiences in the first column and examples of ways these are manifested in the second column.

Microaggressions occur daily in the lives of trans persons, including within the mental health system. This population has been pathologized throughout history, and the psychological literature has a reputation for being harsh, even now. Recent authors (Hendricks & Testa, 2012; Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014) have applied the Minority Stress Model (refer to Chapter 1 in this volume) to the transgender population to explain why trans people have higher rates of mental health difficulties and to offer a framework for the pathologization of trans individuals.

The Minority Stress Model was developed by Meyer (1995) to explain why lesbian, gay, and bisexual people experience elevated rates of mental health difficulties. Specifically, Meyer posited that external events in a person’s life related to sexuality status lead to increased stress, that members of minority groups become highly vigilant to these stressful external events, and finally that some of these external processes become internalized such that, in the
case of a trans person, the person develops an internalized transphobia. This combination of stress, vigilance to signs of stressors, and loss of resilience due to self-dislike greatly increase risk for adverse psychological (and physical) outcomes. Hendricks and Testa (2012) expand this model to trans people and argue that it maps very well onto the experiences of trans people such that violence, discrimination, and internalized transphobia increase the risk for mental health troubles and for suicide. Gamarel and colleagues (2014) apply this model to explain ways in which trans women may have difficulties navigating and maintaining healthy romantic relationships with cisgender individuals, as the self-stigma the trans person experiences is likely to lead to enactments of the external threats and vigilance to them within the relationship. The assessor who understands the role of Minority Stress and Multiple Minority Stress will provide a better assessment experience, and if the assessor specifically assesses for the role of Minority Stress, the recommendations from the assessment will be more useful.

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**Table 20.1 Trans Microaggressions as Identified by Nadal, Skolnik, and Wong (2012)**

<table>
<thead>
<tr>
<th>Microaggression</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of transphobic and/or incorrectly gendered terminology</td>
<td><em>He/she, shemale, tranny, etc.</em></td>
</tr>
<tr>
<td>Assumption of a universal transgender experience</td>
<td><em>All of you are the same</em></td>
</tr>
<tr>
<td>Exoticization</td>
<td><em>Objectified, sexualized, dehumanized</em></td>
</tr>
<tr>
<td>Discomfort/disapproval of transgender experience</td>
<td><em>Things will be better if you act like a girl like you’re supposed to</em></td>
</tr>
<tr>
<td>Endorsement of gender-normative and binary culture or behaviors</td>
<td><em>Enforcement of gender stereotypes</em></td>
</tr>
<tr>
<td>Denial of existence of transphobia</td>
<td><em>Minimizing trans person’s hurtful experiences</em></td>
</tr>
<tr>
<td>Assumption of sexual pathology/abnormality</td>
<td><em>You must have HIV/be a sex worker</em></td>
</tr>
<tr>
<td>Physical threat or harassment</td>
<td><em>Fear and hypervigilance</em></td>
</tr>
<tr>
<td>Denial of individual transphobia</td>
<td><em>It’s your fault that person hurt you</em></td>
</tr>
<tr>
<td>Denial of bodily privacy</td>
<td><em>Referring to a trans person by their body parts</em></td>
</tr>
<tr>
<td>Familial microaggressions</td>
<td><em>Hostility, rejection, disapproval, refusal to use chosen name</em></td>
</tr>
<tr>
<td>Systemic and environmental microaggressions</td>
<td><em>Trans-panic in public restrooms, issues within the legal system, barriers to changing name and gender, healthcare disparities</em></td>
</tr>
</tbody>
</table>

_Note:_ Adapted with permission from Nadal, Skolnik, and Wong (2012). See the original text for fuller explanations of each microaggressive category.

Extant Assessment Literature

The assessment literature on trans people is limited. A number of specific, narrowband measures have been developed that may allow the assessor to approach the assessment with a greater level of nuance and context. Balsam, Beadnell, and Molina (2013) developed a research instrument called the Daily Heterosexist Questionnaire, with the intent of measuring minority stress among LGBT adults. This 50-item self-report scale measures minority stress along nine subscales that relate to gender expression, vigilance, parenting issues, discrimination/harassment, vicarious trauma, family of origin issues, HIV/AIDS, victimization, and isolation. The instrument was validated on a population of 852 LGBT individuals and has acceptable or good construct validity, internal consistency, and concurrent validity. Additionally, it closely maps onto important aspects of Minority Stress Theory.

The same group (Balsam, Molina, Beadnell, Simoni, & Walters, 2011) previously developed the LGBT People of Color Microaggressions Scale in an attempt to measure the experience and impact of multiple minority stress. This measure, a 26-item self-report questionnaire, was also designed for use in research, but it may be useful for the assessor to directly assess for components and impacts of minority stress. The instrument contains three subscales, which include (a) experiences of LGBT racism, (b) people of color heterosexism, and (c) LGBT relationship racism. The instrument was validated on 297 LGBT people of color and demonstrates good construct validity and internal reliability. Given its focus on people of color, it will only be useful for work with trans people of color.

Both of these scales group trans people with LGB people. Similarly, the only chapter we identified as addressing assessment with trans individuals does the same (Prince & Potoczniak, 2012). The title of the chapter, “Using Psychological Assessment Tools with Lesbian, Gay, Bisexual, and Transgender Clients,” purports to contain a discussion of assessment with trans people, but the case presented and the discussion of the case are of a young gay man. Assessment with gay men and with trans people are not the same, though the literature has tended to erase the experience of trans people in favor of that of LGB people.

A number of studies looked at the performance of trans people on the Rorschach and found that combinative thinking is elevated on these protocols (Mormont, Michel, & Wauthy, 1995; Peterson, 1992; Tuber & Coates, 1989). Conclusions included that trans people are more likely to engage in disordered thinking and that it was possible that their trans identity arose from this pathological way of engaging with their environment (Peterson, 1992). These studies did not discuss other potential reasons that trans persons performed in this manner.

A recent study from the Netherlands (de Vries, Kreukels, Steensma, Doreleijers, & Cohen-Kettenis, 2011) administered the MMPI to 293 trans adults and 83 trans adolescents. This study presents its findings within a pathologizing
frame, but the authors do argue for earlier gender reassignment treatment for adolescents given that their MMPI scales were less pathological than those for adults, potentially suggesting that the cumulative impacts of minority stress do have an impact on the presentation of psychopathology in trans adults.

A group of researchers (Brewster et al., 2012) has created trans-specific forms of three measures of workplace experiences for LGBT people. Specifically, these authors changed the wording of the Workplace Heterosexist Experiences Questionnaire (WHEQ; Waldo, 1999), the Lesbian, Gay, Bisexual, and Transgendered Climate Inventory (LGBTCI; Liddle et al., 2004), and the Workplace Sexual Identity Management Measure (WSIMM; Anderson et al., 2001) to better include trans people. Although the LGBTCI has the word “transgendered” in its name, none of these instruments was developed with a focus on trans people or validated with a sample that included many trans people. The first round of study of the LGBTCI, for example, aimed to include only LGB people (Liddle et al., 2004). To correct for the lack of trans inclusion, Brewster and colleagues validated their transgender forms on a sample of 263 trans people, and they found support for the factorial structure of the LGBTCI and made slight modifications to the factor structure of the WSIMM and the WHEQ. Given the solid psychometrics, the assessor who aims to understand a trans client’s experience of workplace discrimination (WHEQ-TF), perception of the workplace environment (LGBTCI-TF), or degree of openness in the workplace about being trans (WSIMM-TF) may find these instruments useful.

Finally, a recent presentation at the Annual Convention of the Society for Personality Assessment (DeVinny, 2014) made compelling arguments for improving the approach to assessment with trans people. The presenter argued that an assessor cannot do an assessment with a trans person “without a thorough understanding of trauma,” as even basic screenings at their clinic showed high levels of pathology among the trans population, even for those known not to have psychopathology. Minority Stress trauma, the presenter argued, had resulted in “targeted attacks against the self,” paranoia, revictimization fears, and what looked like psychopathology. DeVinny (2014) suggested that the task for the assessor is to be able to differentiate the impacts of trauma from the elements of character, trauma reactions from delusions and paranoia, and PTSD from psychosis.

The Assessor

We very much value the contributions of contemporary models that clearly situate the psychologist and the client within a co-created, two-person relationship. Given this understanding of the professional encounter, we wish to discuss some of the implications the assessor-assessee relationship may have for the assessment experience. As the assessment literature has not looked at relational and countertransferential factors between an assessor and a trans client, much of this discussion will be drawn from the psychotherapeutic literature.
Trans people may approach an encounter with a new doctor with a great deal of uncertainty, ambivalence, and trepidation about whether this person will actually be able to meet their needs. We professionals, unfortunately, tend to approach new encounters with trans clients in the same way, wondering if we will be able to meet their needs or sufficiently understand them (Poteat, German, & Kerrigan, 2013). The anxiety that abounds within both members of the assessment relationship may contribute to premature foreclosures of possibilities, precipitous conclusions, and may lead the psychologist to begin becoming curious about “why” the client is trans. This “why?” question, we must remember, is irrelevant to the understanding of the individual and may be rooted in unconscious efforts to enforce traditional gender norms (Goldner, 2011a; Kassoff, 2004).

The impulse to ask the question *why* is a person trans rather than *how* is a person trans is rooted in the microaggression of “exoticization” (Nadal et al., 2012), and assessors are cautioned not to trans-fixate, especially if the referral question is not at all related to a client’s trans status. One commentator shared,

> It is never acceptable to bring up a client’s trans status if it is not the presenting issue. . . . It is absolutely unethical and, unfortunately, incredibly common for therapists to fixate on a trans client’s gender. . . . This can be a harrowing and negative experience for a client, and therapists should avoid this fixation.

(Shelton, Winterkorn, Gay, Sabatino, & Brigham, 2011, p. 216)

We should note that trans people may wish to avoid talking about their trans status from concern of how the assessor may react, or may simply defend against some unconscious aspects of their identity by not wishing to talk about their gender; however, trans people’s gender is a salient aspect of their identity (as gender is for everyone), and exploring it is an important area of understanding the patient’s experience. This is distinguished from “fixating,” where the assessor views all of the patient’s experience through the lens of the patient’s trans identity (Shelton et al., 2011). This discussion of a therapist’s fixating on gender is easily transferable to the assessment relationship. Assessors should not allow the person’s gender experience to unduly influence (in any direction) interpretation of testing data and subsequent recommendations.

The “Why is a person trans?” question also leads us to ways in which authors have discussed gender’s being imbued with a “regulatory anxiety,” such that cultural and familial forces act to control and to maintain binary norms to the detriment of all of us (Corbett, 2009; Harris, 2011). These anxiety-driven efforts to enforce gender norms are rooted deeply within our profession’s relationship with trans individuals. We have served as sources of power and as gatekeepers to treatment options, and this power has been used in ways that harm (Poteat et al., 2013). To avoid causing harm around power and enforcement of gender norms, we must remain vigilant for our own use of microaggressive behaviors, for ways we may key into shame, stigma, blaming, and othering of trans people.
Psychological Assessment with Trans People

(Poteat et al., 2013), and we must look closely into our own beliefs and biases about sex and gender (Kassoff, 2004). Regulatory anxiety may manifest in less overt ways, as well. For example, psychologists may find that they are developing thoughts and feelings related to fear for their clients’ safety, and that if only the clients wouldn’t be so ‘X’ (obviously trans, flamboyant, etc.), they would be much better off. This sort of countertransferential desire to protect clients from the vicious world to ensure their safety may be more profound among psychologists working in trans-unfriendly environments (e.g., prisons, certain communities, some religious groups) (Saketopoulou, 2011).

The beliefs that enforce gender norms may develop from our professional training—perhaps those beliefs that suggest any efforts to make changes to one’s body are simply the acting out of psychodynamic conflicts (Suchet, 2011). The assessor who holds this view may find him or herself taking sides against a client’s trans-ness and interacting, writing the report, and giving feedback in a way that manifests this bias (Suchet, 2011). The client may, in fact, be suffering from psychodynamic issues, but it is important to be able to distinguish them from the client’s trans identity and from the sorts of suffering that result from minority stress (Goldner, 2011a).

Trans clients may contribute to a sense of anxiety in the assessor that is not simply a manifestation of regulatory anxiety. As trans people defy “the either/or logic of the gender binary,” they “disturb the peace” that we all rely on from early in life (Goldner, 2011b, p. 153). As children, we distinguish hot/cold, good/bad, boy/girl, and many trans people can share stories of experiencing both micro- and macroaggressions from children, given their less nuanced cognitive processes and lack of filtering processes when their anxieties are aroused (Nadal et al., 2012). Assessors must remain aware of any anxieties they feel toward their client related to gender expression. And they may note that anxieties related to this may manifest when they first learn a client is trans when they did not know this previously. Some assessors may label the client psychotic, but other possibilities exist and should be explored (Mormont et al., 1995; Saketopoulou, 2011; Tuber & Coates, 1989). The effort here, in the assessment, is to understand, and these sorts of anxieties may impair the ability to understand. For the clients, past efforts to understand trans people have all too often collapsed into efforts to pathologize them, and a vigilance directed against being pathologized may emerge. The relationship, then, becomes unsafe, and the assessor may develop a sense of frustration, feel that the client is resistant to the assessment endeavor, and further pathologize the client (Goldner, 2011a).

Efforts to pathologize trans clients may be viewed as large-scale countertransferential enactments of community-level trauma (Borg, 2011). Borg describes the way in which a trans client felt “alien” throughout life, being different from others across nearly all life contexts and domains of functioning. This client, and many other trans clients, lived within a system that created for him a conflictual identity—the alien might finally state, “this is me!,” only to be told by society and by family (with their binary gender norms), “no, it is not.” (p. 83). As the
client navigates the “degradation, dismissal, and apathy” (p. 82) he faced in the world, he sought (unconsciously?) to identify with the maleness of the therapist, and the therapist found himself feeling a sense of “charged esteem” (p. 82) that the client was working to emulate him. This sort of “charged” excitement enacts social gender roles and becomes imbued with a hunger and a longing, a hope and a dread (Mitchell, 1993) for both affection and care. Borg (2011) argues that those working with trans clients must watch out for signs of excitement, as these might key us into efforts to colonize that which is alien, and to, again, enforce our own notions of gender into a client whose gender expression differs. As people experience oppression, terror, and trauma, their sense of self may become fragmented, confused, and dissociated, leading to desperation to be understood and opening themselves to being colonized and indoctrinated in this way. Here, the power of the assessor could do real harm.

Hansbury (2011) highlights a very similar sort of enjoyment that may come from working with a trans client. Specifically, Hansbury discusses experiences of working within trans–trans dyads (as in both the assessor and the client identify as trans). The author explores the theme mentioned previously of a trans person’s lacking opportunities to idealize, mirror, and establish twinship with others as children. Entering into a relationship with a trans professional could lead the trans professional to overinvest in the trans client, while also noting a sense of basking in the client’s looking to the trans assessor as the “just right” (p. 212) model of a future or professional/successful trans self. If the trans assessor overidentifies or experiences a sense of reverie in serving in this role, this could easily cloud judgment and perhaps lead to underpathologizing.

Saketopoulou (2011) contributes to the discussion of the person of the assessor by providing another case example, which highlights the ways in which a client’s trans status does not exist in a vacuum—rather, transness exists in interaction with other aspects of a client’s identity, including poverty and class and race. Saketopoulou argues that preliminary foreclosure of possibilities can occur on both sides of the dyad. Trans advocates may be reluctant to open space to discuss the possibility of pathology, given the history of pathologization, while transphobic assessors may be reluctant to open space to consider nonpathological trans experiences, which may lead to collapses into dissociation and suicide. These sorts of collapses can be all the more problematic when mixed with youth, poverty, and trauma. When all of these factors combine, it may be quite easy to activate a transferential neglect and abandonment, especially if foreclosing a trans person’s identity into a diagnostic category.

Assessors working with trans people, especially those trans people who are cued into the political situation surrounding their basic civil rights, may find themselves pulled to act as advocates (Griffin, 2011). As trans people may lack advocates throughout their lives, they may unconsciously move the assessor into this role, especially if the assessor is working within a system that manifests trans bias. The assessor who feels a strong identification as an advocate for trans people may become reluctant to ask certain questions, follow certain lines of
inquiry, and may work to prevent others from doing the same. This sort of advocating countertransference reaction limits the possibilities for the assessment experience (Griffin, 2011; Shelton et al., 2011).

Case Presentation

Having explored the context of trans people’s lives, the history of their involvement with mental health professionals, and the various ways the assessor may impact or be impacted by the assessment experience with a trans person, we now turn to a case example to highlight and further develop some of the points we have made.

Blair is a 39-year-old Latina transwoman who was referred for assessment by her therapist for evaluation for bariatric surgery. Blair had entered therapy to work on several traumas and had made significant gains over the course of therapy. Blair engaged with the assessment process and revealed a thoughtful and reflective approach to answering questions during the clinical interview. She demonstrated that she had woven a coherent and meaningful life narrative. She made eye contact, asked questions about the assessment process, and demonstrated no overt signs of psychopathology. She presented as a well-dressed and thoughtful woman who was able to discuss past traumas and present-day real-life concerns, such as the ongoing fear of romantically meeting a man who might physically harm her when he discovers she is trans. This vigilance regarding the realistic possibility that she, like some people she knows, could be severely harmed simply because she is trans, is an aspect of trans minority stress (Hendricks & Testa, 2012).

Blair completed several self-report measures, including the Personality Assessment Inventory (PAI; Morey, 2007), Beck Anxiety Inventory (Beck & Steer, 1993), Beck Depression Inventory—Second Edition (Beck, Steer, & Brown, 1996), and the PTSD Checklist–Civilian Version (Weathers et al., 2013). Blair also completed performance-assessment measures, including a Thematic Apperception Test (TAT; Murray, 1943), the Rorschach Performance Assessment System (R–PAS; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011), and the Wechsler Adult Intelligence Scale–Fourth Edition (WAIS-IV; Wechsler, 2008).

Blair’s performance on the R–PAS was deeply problematic, as she demonstrated nine instances of combinative thinking out of 24 responses. This placed her at greater than the 99th percentile on the WSumCog variable. Blair did not demonstrate other significant cognitive scores except for two DV1s. The nature of these findings suggests the possibility of a thought disorder, though none had been apparent in either her therapy or in the clinical interview.

We must examine Blair’s performance on the other assessment materials to begin to make sense of this highly elevated variable. The PAI illustrated some of Blair’s trauma and elevated scores on hypervigilance and negative relationships. Additionally, there was an elevation on the Thought Disorder Subscale, which measures the same type of phenomenon as the combinative thinking variables on the R–PAS. Blair scored in the Average range of intellectual functioning on
the WAIS-IV and did not demonstrate any scores or behaviors, such as clanging, circumstantial, or tangential thinking, that would be consistent with thought disorder. For example, her definitions were concise and easy to follow. Blair’s TAT stories, while long and imaginative, showed coherence and organization. She demonstrated themes of relational abandonment, mistrust, and secrets, but she also shared stories that contained characters who were supportive of one another and demonstrated conflict resolution. Given this context, we turn to the R-PAS data and some examples of Blair’s combinative thinking. Among Blair’s combinative thinking responses, on Card III she saw two female monkeys with human bodies and monkey breasts. Her verbatim response was:

**Response:** “Hmmm, this looks like two female monkeys with human bodies facing each other beating on a drum. They have those African neck things that extend their necks. And both of their eyes, you can only see one of their eyes looking at you.”

**Clarification:** “Ok, [laughs], monkey face right here, this here are those neck extenders, here are the monkey breasts. This is the drum. Hands are on top of the drum, like that if I could stand up and do it, hands and feet sticking out [demonstrates].”

Another of Blair’s responses, this on Card I:

**Response:** “I see a small person with wings. These are the hands and the head is like a two headed person.”

**Clarification:** “Here are the legs, the two-headed person, the dark part here are the legs, this is its body, this is the two heads, this here. [What makes this part look like legs?] The shading makes it look like they are standing like this [demonstrates]. And this are the two hands. And of course the wings.”

On Card V Blair gave this response:

**Response:** “It’s some kind of insect with wings that have alligator faces attached at the end of the wings. Not an insect, looks like a rabbit, a bunny rabbit with wings and at the end of the wings have alligator faces.”

**Clarification:** “Bunny is here, these are the ears, right here are the cheeks where the whiskers are at and on the sides, and these are his two bunny feet. [What makes it look like whiskers?] Because these look like ears you can see and the white and black that looks like bunny fur and this here looks to me that the bunny face is facing more to the right you can see more of his right like he is facing to the right shaped like a bunny. [And the alligator faces?] Right here. They are both shaped like alligator heads coming out of the wings.”
In these responses, the assessor can see evidence of combinative thinking. In addition, two of these responses relate to shading, suggesting dysphoria. Blair sees different percepts in the blot and fuses them together, in a style that demonstrates that during moments of heightened stress (such as an assessment session), her cognitive flexibility is reduced. She is currently experiencing multiple aspects of duality in her life. She is a transwoman and she is preparing for bariatric surgery, which will cause significant changes to her body in terms of weight and appearance. In the first response presented above, Blair fuses monkey breasts on a human woman’s body. Could this be an internalization of society’s view of her own breasts as being added to her body but not naturally a part of it? Blair’s next response cites a two-headed person. Does this illustrate her unconscious sense of her own multiple layers of duality or that she is in the process of changing not just her physical body in terms of sex but also with the pending bariatric surgery?

**Case Discussion**

Blair’s results on the assessment measures demonstrate that she is capable of complex and sophisticated cognitive processing until she becomes stressed, which leads her to become rigid in her thinking and to fuse boundaries between discrete entities. This stress tends to be of an emotional nature and difficult for Blair to verbalize. Blair also demonstrated an intensely sad loneliness in her testing, as well as a strong desire to connect with others. This loneliness does not seem to arise from any type of social inability, as she demonstrated an awareness of social needs and responsibilities in her TAT stories, as well as scoring in the Average range on the Comprehension subtest of the WAIS-IV. In sum, Blair’s typically flexible and incorporative thinking becomes rigid and difficult for others to follow when she is under stress, and this presents the possibility that she is experiencing a severe mental illness.

We present three hypotheses to explain these findings, though we acknowledge that other explanations could make sense. As all human behavior can have multiple meanings and be viewed through multiple explanatory models, we believe it is important to consider the broadest set of hypotheses possible in all assessment situations (Bram & Peebles, 2014), and here we present possibilities rooted in psychopathology, in the experience of being trans, and in trauma and minority stress. The first hypothesis is that Blair is living with a thought disorder and ongoing psychotic experiences. The second hypothesis is that something unique about Blair’s trans status has led her to develop a highly creative and combinative thought process. Third, Blair’s multiple minority status (she
is Latina, obese, and trans) may have resulted in lifelong minority stress, which contributed to what may appear to be psychopathology.

Hypothesis One

Evidence that Blair is living with a thought disorder comes from the significantly elevated WSumCog score on the R-PAS and from the elevation on the PAI subscale Thought Disorder, which measures a similar process as the combinative thinking variables on the R-PAS. While these variables support a hypothesis of a thought disorder, other convergent evidence from the assessment is lacking.

Some authors (Piedmont, Satolove, & Fleming, 1989) suggest that the Wechsler intelligence tests provide useful information for assessing psychosis. For example, Weiner discusses the usefulness of examining the verbal content. Blair’s verbal content on the Wechsler test demonstrated a clear and easy-to-follow thought process while she engaged with the task. Piedmont and colleagues (1989) suggest that comparing particular subtest scores is useful in establishing this diagnosis. In their study, the authors used the Wechsler intelligence test to discriminate between affective disorders and psychosis in a population of 141 psychiatric hospital patients. They found that the presence of a higher Information scaled score compared to the Comprehension scaled score is a potential sign of psychosis. Additionally, if Comprehension is at least five points lower than Vocabulary, there is the potential that a psychotic process is occurring. The rationale for this finding is that the Comprehension subtest targets a part of experience that is difficult for persons experiencing psychotic processes to engage.

More recently, literature (Michel, Goldberg, Heinrichs, Miles, Ammari, & McDermidVaz, 2013) shows that psychosis leads to significant deficits in Working Memory and Processing Speed scores on the WAIS-IV, as well as significant deficits on Comprehension, Cancellation, Picture Completion, Coding, and Symbol Search subtest scores. In Blair’s case, WAIS results do not suggest a psychotic process, as her Comprehension score is equal to her Vocabulary score, and her Information score was a point less than her Comprehension. Blair also does not have significant impairment in her Working Memory or Processing Speed Indices. Her scores on Comprehension, Coding, and Symbol Search were in the average range. Blair did have a deficit on Cancellation and Picture Completion, though this is more a function of her anxiety. Additionally, Blair never demonstrated any evidence or behaviors consistent with psychosis during the clinical interview of the assessment or in therapy with her therapist. Her TAT stories also lacked any content or behaviors that would suggest thought disorder. This lack of convergent evidence is meaningful when reviewing the results of other measures used during the psychological assessment. It suggests that another explanation may be needed to account for Blair’s performance on the R-PAS and PAI.
Hypothesis Two

Blair demonstrated that her thinking is complex and flexible; however, during times of stress, she becomes more rigid and loses her ability to approach herself and her environment with this sophistication. It should be noted that Blair only demonstrated two instances of poor perceptual quality on her R−PAS; consequently, her elevated scores are reflective of combinative thinking as opposed to actual distorted perceptions. The majority of Blair’s cognitive scores were associated with human content or human movement scores and occurred with a shading determinant, a color response, and an inanimate object movement, suggesting that the R−PAS was detecting that Blair’s human representations and relationships are an area of emotional pain for her. We wonder if Blair’s use of combinative thinking with human responses could indicate an increased flexibility around what humans look like in terms of how they are embodied. That is, among trans people, people are not always one sex or the other, but instead, gender and anatomical sex can be fluid, and one person may possess body parts that to others may seem to be incongruous combinations.

Blair’s demonstrated perceptual inaccuracy on the R−PAS indicates that she does not see her environment in a conventional manner because she is predisposed to fuse concepts into one, seemingly illogical percept. Given our proposition above, one could argue that for a trans woman, this might not be evidence of disordered thinking, but rather an aspect of her experience that has been a strength and enabled her to construct an identity that feels right and allows for psychological growth and stability. If Blair had not been able to see her environment in an unconventional manner—that is, to experience her body in a way that society does not—she would not have been able to begin to formulate her identity as a woman who has some physical aspects of a man. Blair’s ability to tolerate this ambiguity and conflict between her body and gendered selves enables her to live her life in a manner that feels authentic to her (we must caution that this ambiguity and conflict about the body would cause many trans people great distress as they had much greater difficulty tolerating the splits in the sense of self).

In Blair’s case, while this type of thinking could be viewed as a strength as it has greatly contributed to her adjustment as she has transitioned from seeing herself as a man to seeing herself as a woman, it is also a source of psychological pain in that it causes her great loneliness because she feels that others do not understand her. In addition, Blair might find it harder to understand others’ more categorical approach to their environments, contributing to more feelings of loneliness.

Hypothesis Three

Blair demonstrated increased vigilance on her testing, as well as intense feelings of loneliness despite strongly wanting to connect with other people. This
could be an aspect of living while identifying with the intersection (see Chapter 2, this volume) of several minority statuses. Considering her experiences with rape, feeling misunderstood by others in her life, discrimination relating to her weight, and feeling socially isolated, Blair’s style of thinking and processing information may be more indicative of relational trauma and mistrust arising from microaggressions as opposed to a thought disorder or her lived experience as trans per se.

Our reading of the test data and the literature suggests a combination of hypotheses two and three are most convincing for understanding Blair’s experience.

**Practical Points**

- Adopt trans-affirming policies and practices.
- Use a robust assessment battery that can generate the data needed to support or disconfirm the multiplicity of hypotheses in complex cases.
- Work to understand your own trans biases.
- Work to better understand the lived experiences of trans people.

A brief discussion of each of these recommendations follows:

**Affirmative Approaches**

There are many ways to be thoughtful when conducting an assessment with a trans person. The use of language is a powerful way of reassuring the person with whom we are working, and it can also be a way of causing harm. Beginning with the clinical interview, be mindful of names, pronouns, and gender identity labels. We recommend being open with the client to elicit what name (if different from the person’s government/legal name), what gendered pronouns (or gender-neutral pronouns) that the person wishes to be called by, as well as what, if any, label the person has given to themselves (genderqueer, trans, woman, man, gender nonconforming, etc).

Gender-appropriate identification forms during the assessment process can also be helpful in reassuring a trans person of an inclusive experience (Sanganjanavanich, 2014). Boxes for only man and woman/male and female reinforce the binary and cause a trans person to feel different and isolated. A trans person will feel more welcomed if there is a blank space for one’s gender identity to be written as opposed to selecting from a list. Similarly, the assessor should not ask “Do you identify as a man or a woman?” as the assesse may identity as neither. Another way that the gender binary can be reinforced is the use of language when referring to “the other gender,” such as when giving instructions for House, Tree, Person or other performance drawing tasks. To phrase this as “draw someone of another gender” allows for the diversity and co-construction of gender as opposed to the more societally held view of gender as hard-wired and static.
Assessment Issues Related to Transgender

When working with trans persons, an assessor must be thoughtful about several areas of assessment in a way that one does not need to be when working with cisgender individuals. As elaborated above, trans people are more likely than others to engage in combinative thinking. Being understanding of the underlying psychic processes resulting in this increase in combinative thoughts, an assessor has an obligation to be reflective about the differences between a trans person’s elevated combinative thinking scores as opposed to a cisgender person’s similar elevation.

Trans persons may elevate on measures assessing paranoia, mistrust, and hypervigilance for very real reasons that may not relate to a paranoid personality style or significant physical trauma. Relational traumas and vicarious traumatization from second-hand (and more) stories of friends and other trans people who have been victimized may reflect on assessment protocols, and exploring with trans people how this impacts not only their worldview but also their construction of their gender is important. Being thoughtful about these differences can aid in preventing overpathologizing a population that is already overly pathologized and marginalized. We recommend not only that assessors consider the context of the whole person during the assessment process as they always would, but also that they consider the impact of minority stress on the manifestation of symptoms. We suggest the use of robust, multi-method assessment batteries to account for these possibilities.

Looking in: Understanding One’s Own Trans Biases

We all have biases, which are simply cognitive shortcuts that allow us to process the constant incoming information from our surroundings (Aronson, 2011). However, when we are working clinically, we need to slow down and be attentive to the stereotypes and biases that may influence our behavior, including our administration, interpretation, and providing feedback of assessment instruments and data. Being aware of our own reactions and beliefs about gender will help us to better understand our role in interpretation of data and ensure that the patient receives feedback that will be most beneficial. In assessment, ensuring that trans people are treated as partners in creating the assessment experience may aid in increasing self-efficacy in their own assessment process and result in reduced distress at being perceived negatively by the assessor.

Learning about one’s biases can be a difficult endeavor. Taking a variety of Implicit Association Tests (https://implicit.harvard.edu/implicit/) can help you to better identify some areas where you may hold biases without realizing that you do. Exploring how you view a trans person can also be helpful. For example, do you view a trans woman as a man pretending to be a woman or as a man dressing as a woman as opposed to actually a woman? Do you place a greater emphasis on the biological composition of the person (penis = man, vagina = woman),
or do you allow the person’s gender to be a constructed aspect of identity? It is important to explore whether you have different views or attitudes toward trans people who “pass” as their identified gender versus those who do not pass nearly as well. Are you more willing to see a transwoman who looks like a woman as a woman as opposed to a transwoman who does not appear traditionally womanly? Considering the high costs associated with sex reassignment surgeries, do any of these views reflect a bias regarding class or social privileges? What does this activate within you? Knowing these reactions before you meet with your client can be important to not causing distress in the client and to promote an assessment experience that is most helpful to the client. To give yourself a concrete way to think through these issues, you may consider looking at Drewlo’s (2011) adaptation of The Riddle Scale (Riddle, 1994) for transphobia, which helps the user to assess his or her own attitudes toward transgender people on a continuum ranging from Repulsion to Nurturance.

Looking out: Understanding Trans People

To gain a better understanding of the transgender experience, we recommend that the assessor immerse him or herself in the vast materials about transgender people that are readily available. Our annotated bibliography presents some important articles that might serve as a starting point. GLAAD has compiled a list of transgender resources for those who may be interested in seeking out agencies, advocates, or conferences, and this resource list can be found at http://www.glaad.org/transgender/resources. Additionally, we believe it is often helpful and humanizing to become exposed to the transgender experience through films and documentaries, and an extensive list of such resources can be found at http://www.allthingsqueer.co.za/archives/entertainment-and-celebrity/233-listtransgenderthemedfilms.html.

Annotated Bibliography


Comment: This is the text of the American Psychological Association’s resolutions regarding the need for psychologists to work effectively with trans people. It details the systemic biases against trans people and proposes ways psychologists can address them.


Comment: This article provides a comprehensive overview of the Minority Stress Model as applied to trans people. This will help the assessor to approach the assessment experience with greater empathy, to better select assessment instruments, to interpret findings within the social, cultural, and familial context of the trans person,
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and to make recommendations that consider the intersectionality of multiple minority status.


Comment: This article provides concrete examples of microaggressions and biases experienced by trans people, offering the assessor clear guidance on how not to enact these in the assessment experience.

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Although the American Psychological Association has called upon all psychologists to educate themselves about the needs and concerns of transgender individuals (APA, 2008b), some psychologists will pursue advanced training and expertise in working with transgender clients. One area of specialized competence is the evaluation and referral of individuals seeking medical (i.e., hormonal or surgical) interventions for gender dysphoria. Most medical professionals rely on the Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People published by The World Professional Organization for Transgendered Health (WPATH, 2012). These Standards recommend independent evaluations of transgender individuals from qualified mental health professionals before medical interventions (i.e., hormones or surgery) are begun. I have conducted such assessments numerous times in my career and have developed a protocol based on the principles of Therapeutic Assessment that I believe adheres to the Standards of Care and is respectful of the rights and concerns of transgender clients. My goal in writing this chapter is to describe and illustrate my approach.

My Personal and Professional Context

I am a gay man who “came out” in the mid-1970s in the United States, and I was often targeted as a “sissy” in the small rural village in which I grew up.

I would like to thank Monrovia Van Hoose and Sarvenaz Sepehri for their helpful comments on an earlier draft.
As a result of these and other experiences, I am sensitized to the experience of gender-nonconforming individuals and to members of other “despised groups.” During my graduate training in clinical psychology at the University of Minnesota, I was a research assistant on a study of individuals who had undergone Sex Reassignment Surgery (SRS) at the University of Minnesota Hospitals. I was deeply touched by the lives of the transsexual men and women I interviewed for this project, and this experience broadened my perspective on gender and gender identity forever. Also, during this time, I assessed and treated a number of gender-nonconforming boys and their families—both during my psychology internship and fellowship and after I became a licensed psychologist and opened my private practice in Austin, Texas. In 1984 I accepted a faculty position in clinical psychology at the University of Texas, and my early research was focused on the assessment and measurement of gender identity. I am the co-author of a book that touches upon these topics (Martin & Finn, 2010).

In 1986 I also began consulting to other medical and mental health professionals by providing assessments of transgender adults and teens seeking hormonal and surgical interventions. At first, I leaned heavily on other experts who did this kind of work, but as I gained confidence and experience, I worked more independently. At the time I write this chapter, I have conducted between 20–25 independent evaluations of transgender adults, adolescents, and (recently) children seeking medical interventions for gender dysphoria. I have also worked in individual, couples, and family therapy with many transgender clients, including clients pursuing psychotherapy prior to scheduling SRS. (The current Standards of Care do not require psychotherapy prior to surgical interventions, but many physicians feel more comfortable if a client has had psychotherapy.)

Cultural and Political Context

Although there is increasing public awareness of transgender issues and increasing activism on the part of the transgender community, transgender and gender-variant people continue to face discrimination and stigmatization on a routine basis (APA, 2008a). Any psychologist serving transgender clients needs to be acutely aware of the cultural and political context in which these clients live and to think through a number of questions that arise in this line of work. One question is whether the psychologist is unwittingly buying into a limited, either-or view of gender and gender roles by participating in a process where people medically alter their bodies in order to fit into society and be happy. Some “radical feminists” (as they refer to themselves) have argued that medical interventions for gender dysphoria would not be necessary except for our sexist culture, and that such medical interventions demean “womyn-born-as womyn” (Jeffreys, 2014; Raymond, 1979). I agree that our society is still very limited in its view of what is appropriate gendered behavior, and I always explore a range of options with the transgender individuals who seek support and encouragement from me as a psychologist. Increasingly, many of my clients have opted not to
undergo what once would have been considered “complete” Sex Reassignment Surgery, and some do not have a goal of presenting themselves as gendered. For those who are seeking medical interventions, I am sympathetic to their desire to make their bodies congruent with their gender identities, and I am bolstered by the many research studies that show highly positive outcomes for such medical interventions with well-screened applicants. (See Lev, 2004, for a review of this research.) I consider myself a feminist and am extremely sympathetic to the disadvantages of being a woman in society, but I reject the claim that the choices my transgender clients make further injure women.

A second question, which I take very seriously, is that raised by some transgender activists: Am I placing myself in a disrespectful, “one-up” power position by serving as a “gatekeeper” to those transgender individuals seeking medical interventions? I struggled with this question a great deal initially, for several reasons. First, in recommending clients for medical interventions, for years I was typically required to certify that they had an official Gender Identity Disorder according to the then-current Diagnostic and Statistical Manual of Mental Disorders. I worried that this label contributed to my clients’ sense of alienation and shame, and I always carefully discussed my use of this term with them. The current DSM-5 (APA, 2013) has helped remove stigma from the official diagnostic system by utilizing the term Gender Dysphoria instead of Gender Identity Disorder. Second, I was acutely aware of my gatekeeper position with those individuals who wanted me to endorse medical interventions that I felt I could not recommend. Clearly, I was prioritizing my professional judgment over their wishes, and I never made such decisions lightly. But I was also aware that there are documented cases of individuals who have greatly regretted having undertaken medical interventions to change their primary and secondary sexual characteristics, and that most of these “errors” result from poor screening procedures (e.g., Olson & Möller, 2006). Also, several of the clients whom I declined to recommend for medical interventions told me later that I had made the right decision, and that they were grateful. So I have continued to feel good in the role of screening transgender individuals for medical intervention, but I have worked hard to develop a procedure that empowers such clients, helps them feel respected, and creates an environment in which they can explore what is best for them. In a subsequent section, I will describe this procedure, but first, since my approach is based on Therapeutic Assessment, let me give a brief summary of that paradigm.

A Brief Review of Therapeutic Assessment
Therapeutic Assessment (Finn, 2003, 2007; Finn & Martin, 2013; Finn & Tonsager, 1997) is a semi-structured form of collaborative psychological assessment in which psychological testing is used at the core of a time-limited therapeutic intervention. Therapeutic Assessment builds upon the pioneering work of assessment psychologists like Constance Fischer (1970, 1978, 1985/1994) and
Leonard Handler (1999, 2006, 2012), who began—in the 1970s—transforming the traditional procedures of psychological assessment to make the experience of being tested less traumatizing, more respectful, and more helpful to clients. Fischer and Handler reduced the power imbalance that had historically existed between assessor and client as much as is feasible, and they included clients as active participants in setting assessment goals, interpreting tests, reviewing written reports, and formulating next steps after an assessment. Early in my career, I noticed that when collaborative assessment procedures were used, clients showed measurable benefits as a result of an assessment (Finn, 1996a; Finn & Tonsager, 1992). This eventually led to the development of Therapeutic Assessment (TA), a semi-structured form of Fischer’s and Handler’s models, which has been widely researched in a number of settings. As summarized by Finn & Martin (2013), TA has been shown to benefit clients in a number of ways, including (a) aiding in symptom reduction; (b) increasing self-esteem, hope, and treatment compliance; and (c) facilitating concurrent or subsequent psychotherapy.

Collaborative and Therapeutic Assessment (CTA) have largely been used in clinical settings with voluntarily referred clients, but Fischer has written extensively about using collaborative assessment in potentially adversarial assessment situations, such as the selection of nuclear plant operators (Fischer, 1985/1994) or child-custody situations (Fischer, 2004). Also, others have written about using CTA or TA with involuntarily referred foster parents and children (Purves, 2002), as part of an executive advancement evaluation (Fischer & Finn, 2014), and in parenting plan evaluations (Evans, 2012). The basic CTA approach to such assessments is to acknowledge the potential conflicts of interest inherent to such situations, make it clear what information will and will not be given to sources outside of the assessment (e.g., judges, bosses, social workers), and then see if the assessment can be useful to the client within this context. When clients demonstrate reservations about being fully disclosing, assessors acknowledge that the clients are showing good judgment, rather than accusing them of being “resistant” or “defensive.” Many of the published case examples show that CTA can be helpful to involuntarily assessed clients as well as to the professionals called to make decisions about their lives (judges, bosses, etc.). Hence, there is independent evidence to support the idea that TA is applicable to the assessment of transgender clients who are interested in receiving medical interventions.

As I have written about elsewhere (Finn, 2009), the core values of TA are collaboration, respect, humility, compassion, openness, and curiosity. As I will now explain, I try to integrate these values into my assessments of transgender clients seeking my assistance in obtaining medical interventions for gender dysphoria.

Therapeutic Assessment of Individuals for Sex Reassignment Surgery

So what is the role of a psychologist conducting psychological assessments of transgender individuals seeking medical interventions? The WPATH Standards
Assessments for Sex Reassignment Surgery

of Care (2012) spell out five tasks as follows: (1) “to assess clients’ gender dysphoria in the context of an evaluation of their psychosocial adjustment” (p. 23); (2) to provide information regarding options for gender identity and expression and possible medical interventions; (3) to assess, diagnose, and discuss treatment for coexisting mental health concerns should they be present; (4) if applicable, to assess eligibility, prepare, and refer for hormone therapy; and (5) if applicable, to assess eligibility, prepare, and refer for surgery. For these last two objectives, the Standards spell out a list of specific criteria to be used in determining eligibility. For example, for vaginoplasty in male-to-female transgender clients, one of the criteria is “12 months of continuous living in a gender role that is congruent with their gender identity” (p. 106).

The Standards explicitly state that these criteria are based on expert consensus opinion about what has been found to be most beneficial to clients. The Standards also emphasize that decisions about medical interventions are “first and foremost a client’s decisions” and that the responsibility of mental health professionals is “to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared” (p. 25). I believe this stance is appropriate and well-balanced and congruent with the core values of TA. It also helps address a problem noted by Lev (2004) and others—that is, that the gatekeeper function of the assessor can make it difficult for clients to fully explore all sides of the decision to undertake medical interventions. I try to address this concern through frank discussion with my clients in the initial session of our work together, and I make it clear that I consider it normal and healthy for clients to have mixed feelings at various stages of their decision to undertake SRS. I will now turn to my case illustration.

Therapeutic Assessment of Lana

“Lana” was a 44-year-old transgender woman referred to me by Dr. K, a psychotherapist in Austin, Texas, who frequently works with transgender clients. Lana was applying for SRS with Dr. X and his team in Canada, and the program she had chosen required two letters of recommendation from “clinical behavioral specialists.” As was appropriate, Dr. K was writing the first letter, and she asked me to evaluate Lana to see if I felt comfortable writing the second recommendation. I agreed, and Lana called and scheduled an initial session.

Initial Session

When I met Lana in the waiting room, she was dressed in a light blue, long-sleeved, knee-length dress and high heels. She had long blonde hair, and I noticed her height (6’2”) and the scarf around her neck, both of which reminded me of other transgender women I know. Lana greeted me in a strong, slightly raspy, mid-range voice with a Texas accent, and she thanked me for agreeing to see her. In my office she complimented me on the homey feel of my waiting room,
made herself comfortable on the edge of a sofa, and looked at me directly and expectantly. I said that I understood from Dr. K that Lana was seeking a second letter recommending her for SRS, and she said that was true. I asked what she understood already about such letters and if she had any questions about my approach. Lana was clearly familiar with the WPATH Standards of Care, and she confidently recited the criteria she knew I would be considering. She then asked how many times we would need to meet in order for me to form my opinion. I said that was an excellent question and that it would depend on several things. I then took the opportunity to explain how I approach these types of assessments:

In the end, I strongly believe that whether you go ahead with this surgery is mainly your decision, although Dr. X’s team requires you to have this second assessment. If you decide to work with me, I see my job as follows. First I want to give you any information you need and answer any questions I can about SRS so you can be sure this is a step you want to take. Second, there are a few conditions besides gender dysphoria that sometimes lead people to seek SRS. So, by talking and using psychological tests, I want to make sure that you don’t have one of these conditions. Third, because the surgery is difficult and you’ll need support, the Standards of Care ask me to evaluate whether you have the supports you need to recover well afterwards and live in your new life. Last, because this is such a big step, and there are rare instances in which people have regretted having SRS afterwards, I may raise certain issues for you to think about further and support you while you do that. If I don’t find any mental health or practical blocks to your having the surgery and if at the end of our discussions you still want to go ahead, then I will happily write a letter of recommendation to Dr. X.

Lana appreciated that I saw the SRS as ultimately her decision and said that she was willing to talk about any aspect of her life and her reasons for wanting the surgery. We agreed on an estimated price for the assessment—which might change if we spent more time together than I anticipated—and Lana asked a few other appropriate questions, such as how many people I had previously evaluated for SRS. After this it was clear we had decided to work together, and I asked Lana to tell me about her process of deciding to live as a woman.

Lana’s Story

Lana had approached Dr. K 20 months earlier after becoming clear that she “wanted to become a woman.” At that point in time, Lana was living as a man (named “George”), and she and Dr. K spent five to six months sorting through Lana’s feelings and background. Lana told me that she had felt confused about her sexuality and gender since she was a teenager. As a young man, George had hung around with gay men and had many same-gender sexual experiences. But
these were not very satisfying as he wasn’t erotically attracted to men. At the age of 22, “George” had married a woman and had two children—a daughter who was now 17 and a son who was 15. In contrast to usual gender roles, George’s wife had worked, while he took care of the house and the children. He greatly enjoyed this arrangement and kept thinking, “I should have been born a lesbian. I love women, but I also want to be a woman.” Also, when other couples would visit, George would end up sitting with the women rather than the men. Around the age of 33, George began to cross-dress whenever his wife and children were out of town visiting her parents, and he began to feel, “I will die if I can’t become a woman.” During one of his weekends alone, a gay friend arranged a date for George with a man, and he discovered that he “loved being treated like a woman.” He told his wife about his feelings, and they pursued couples therapy. The therapist told George he had to “embrace his masculinity” and, in the end, the marriage broke up and George moved to Austin, leaving his children with his wife.

In Austin, George went back to school and trained as a medical technician. He became romantically involved with and eventually moved in with a woman, Sara, and began cross-dressing when she was not at home. One day Sara came home early from work and found “Lana” dressed in women’s clothes. Sara accepted this and bought dresses for Lana and accompanied her to bars. Eventually the relationship ended because Sara wanted to have children, and George stopped cross-dressing after a roommate told him, “George, you make an ugly woman.” He married again, became a fundamentalist Christian, and “purged” his wardrobe. After three years of marriage, he became acutely suicidal and entered psychotherapy. The therapist helped him leave his marriage, and he had several “flings” with men that were unsatisfying. Finally, one day he saw the movie My Life in Pink (about a transgender boy who courageously holds onto his desire to be a girl in spite of family pressure and public discrimination). The next day George researched psychotherapists who worked with transgender clients and called Dr. K for an appointment.

Within the previous year, with Dr. K’s help, Lana had begun living full time as a woman, had legally changed her name, and had successfully changed her gender on her driver’s license from “M” to “F.” She had begun hormone therapy under the supervision of an endocrinologist in Austin and was pleased with the ways her body had changed. She said she felt “calmer” and “happier” than ever before. She had begun attending a transgender support group at a local community counseling center, and she had worked with a speech pathologist on “feminizing” her voice. This was important to Lana because she was an amateur singer/songwriter who performed occasionally and sold her songs on the Internet. To help her appearance, Lana also had a number of electrolysis treatments and was saving money to do more. With Dr. K’s help, she had written to and come out to her two children. They had been upset at first, but after several conversations and one visit, they were now supportive. During this whole period, Lana had continued to work at her job and had saved enough money for
a complete vaginoplasty. After research and consultation with peers, she chose Dr. X and his team in Canada to do her surgery, and Lana was ready to submit all of her paperwork if I agreed to write the second letter of recommendation.

I felt touched hearing Lana’s story, and I told her I was impressed with the courage she had shown in facing her transgender feelings and deciding to act on them. She looked me in the eye and said that she would have had to kill herself if she had not. I replied, “That may be true, but it still takes a lot of guts to do what you’re doing.” Lana smiled and said, “I have always been stubborn!” I smiled back and I remember thinking, “I like her spunk.”

**Lana’s Assessment Question**

As is typical in TA, I then asked Lana if she had any particular questions, doubts, worries, or concerns that she wanted to explore in our work together—besides whether she wanted to go ahead with the SRS. She paused and said she had been thinking about this ever since she had read about TA. She said the only question she had come up with was, “Is there anything else I need to do to be happy as a complete woman? I tend to think the vaginoplasty is the final piece, but I’d like to know if there is something else.” I said this was an excellent question and that I would be happy to help her think it through, and I was sure Dr. K would help also. Lana and I agreed that we would try to address this question in our work together in addition to my evaluating her on the usual criteria for SRS.

**Early Assessment Sessions**

Although psychological testing is not required by the Standards of Care in evaluations for SRS, I typically do at least two tests in my assessments of this type: the MMPI-2 (Butcher et al., 2001) or MMPI-2-RF (Ben-Porath & Tellegen, 2008) and the Rorschach (1921). As I have written about previously (Finn, 1996b, 2007), I find that the MMPI and Rorschach are extremely useful to me and my clients in understanding a variety of issues. Early in our work together, Lana completed the MMPI-2, and since she was living as a woman, I scored it using female norms. Lana’s MMPI-2 profile was unguarded—but not overly so—and this finding is relatively common when I assess transgender clients for medical interventions. I believe this result shows the trust clients have once I make it clear that they are free to talk about any emotion or thought without having to worry about my judging them unfit for SRS. Of note, there were no significant elevations on any of the Clinical or Content Scales of Lana’s MMPI-2 profile. In brief, the MMPI-2 suggested that Lana was a sturdy survivor who functioned well in structured, nonemotional situations, and that she was free of any serious mental or personality disorder. The test also suggested that she was a somewhat extroverted person (Scale 0 = 42T) and that her gender identity resembled that of most biological women (Mf6 = 57T; Martin & Finn, 2010). I discussed these
results with Lana and she confirmed them and said she was relieved that the MMPI-2 reflected how she saw herself.

Rorschach

I scored Lana’s Rorschach protocol with the Exner Comprehensive System (Exner, 2003)—the predominant system at the time I did her assessment. As with the MMPI-2, there were no signs of guardedness or any hesitations on Lana’s part about doing the Rorschach ($R = 28$, Lambda $= .52$). There also were no signs of serious psychopathology, just as with the MMPI-2. In fact, Lana appeared to be a woman with excellent psychological resources ($EA = 13.0$, $M = 9$, $D = +2$, $DQ+ = 12$) who had the capacity to work well with others ($H = 6$, COP $= 3$, GHR/PHR $= 5/3$) and excellent reality testing ($XA% = .86$). There were a few indications of underlying shame ($FD = 3$, $V = 1$, Color-shading $Bl = 3$)—not surprising given the prejudice experienced by transgender individuals in our society—and suggestions that this underlying self-doubt might be covered by a confident presentation ($Fr + rF = 2$). There were also signs that Lana was “stubborn,” as she had described to me earlier ($a/p = 13/1$).

The most significant event concerning the Rorschach came when Lana and I were discussing her actual responses immediately after the standardized administration of the test; this is a procedure from TA called the “extended inquiry” (Finn, 2007). On Card X of the Rorschach, Lana’s first response had been,

A beautiful woman performer, singing in a nightclub in Paris. She is wearing a grey headdress, a pink feather boa, and a blue bustier. These are her green stockings and her pointed shoes. These other things on the sides are the colorful clothes of the audience. Everyone in the club is entranced with her and is secretly fantasizing about having a love affair with her—both the men and the women.

In the extended inquiry I asked Lana for any associations to this response, and she immediately said, “Oh, that is me, how I plan to be after my surgery. I also sing and I want to get back to performing. I guess this picture is my hope of how I will be. I think I’ve held myself back when I’ve performed before and that after my surgery I’ll be freer and more confident.” I then asked Lana to say more about everyone wanting to have a love affair with the singer. Lana said, “That is how I’d like to be too, so beautiful that everyone desires me. Just like with the performing, I think I don’t feel attractive right now because I don’t like my lower body. After I have my surgery, I’m sure I will feel more beautiful because I will be a complete woman.”

I found myself reacting in two ways to Lana’s disclosure. A part of me appreciated her exuberance and her hopeful anticipation, and I believed she might indeed feel happier and freer after her surgery because I had witnessed such outcomes before with other male-to-female transsexuals. On the other hand, a
part of me worried that Lana was being unrealistic about the likely outcome of her vaginoplasty. This surgery would not make her a “complete woman”—if by that phrase she meant a biological woman—and it didn’t seem likely that many men and women would start desiring her because she felt more “complete” and “free.” Of course, she hadn’t said that she actually believed this would happen, but her elaboration of her Rorschach response suggested to me that it might be an unconscious fantasy. Finally, although I did not agree with Lana’s previous roommate that she was an “ugly woman,” I thought it unlikely she would easily pass for a biological woman or that her vaginoplasty would increase the likelihood she could do so. I worried that Lana would be very disappointed in her surgery if she didn’t realize all this beforehand. So after a pause, I gently said, “Lana, I hope this doesn’t seem insulting, because I understand how much you’ve always wanted to be a woman. But you know, don’t you, that even after your surgery it won’t be the same as if you were born a biological woman? And even if you feel better and freer and more beautiful—which I think could definitely happen—some people may recognize you as a transsexual woman and not think of you as a biological woman. And given societal hang-ups, that also means fewer people will be interested in being romantically or sexually involved with you.”

When I finished speaking, I saw shock and pain on Lana’s face, and she was silent for five to ten seconds. Then she began to weep, saying,

I’m sorry. I know what you’re saying is completely true, but it’s hard to think about. Dr. K said something like this to me six months ago, but I guess I didn’t let it sink in then. I didn’t realize, but I think I’ve been engaging in some magical thinking. I know a lot of people read me as trans now, and of course, that will probably be true after the surgery too.

I sympathized with how much Lana wanted to be a biological woman and how difficult it was to have a body that didn’t match her gender identity. She grew calmer and looked at me intently as I spoke. I said I did believe the surgery could help Lana feel better about herself and be happier, but that it was important to realize that it also had limits. She was taller than most biological women, had a squarer jaw, bigger wrists, and a lower voice. She could continue to work on feminizing her voice and appearance, but with increased societal awareness of transgender people, there might be more and more people now who would think, “I wonder if that person is a transsexual.” Lana winced a bit when I said that, but then sighed and said, “Of course, you’re right. That’s the way it is now, and that’s the way it’s going to be after the surgery. I wish it were different, but it’s not. Some trans kids now are getting hormones when they’re really young, and they pass better as adults because of that. But that didn’t happen with me. Still, I do think the surgery is worth doing, because it will change how I feel about myself. I’ll be happier with me and that’s what’s most important.” I agreed that how Lana felt about herself was the most important outcome.
I then asked Lana if she had a sense of how often she “passed” as a woman now. She said it was hard to know, but that sometimes she was aware of people looking at her intently when she was in public, and she was pretty sure they were attempting to make sense of her gender. I asked how she felt about such stares, and she said, “It’s hard, but I can live with them. And I understand why people are curious.” I then shared the following thoughts:

Lana, of course people are curious about you. But I also wonder if another part of what you see is that they are struggling with their own ideas about gender. The contribution that you and other transgender people make to the world is that you help us think about gender in a new way. I know that my work with transgender people has completely changed the way I see the world and how I think about what it means to be a man and a woman, and I’m grateful for that. In a way, your courage in living as a transgender woman is a kind of ‘ministry’ to the world, and if you completely passed you wouldn’t have the same kind of impact. People wouldn’t be challenged to stop and think. I know people have all kinds of reactions to transgender people, and I think that’s partly because you defy our usual ways of thinking about gender. I understand why you might not always want to have this job, and you’ll need places to take breaks from it. But I think some piece of it will always be there for you—even if you don’t want it to be—and you’ll need support from other transgender and supportive cisgender people to keep dealing with this and thrive.

Lana thanked me and said she was deeply touched by what I had said and wanted time to think about it. She also expressed her surprise that we had gotten to this important discussion through one of her Rorschach responses. I told her this is why I used psychological testing in my SRS assessments, and that tests often open up things that might not otherwise come out through talking. We agreed to meet a week later to continue our assessment.

Assessment Intervention Session

Of course, I was eager to see how Lana was doing when she arrived for our next session, and I was pleased to see her looking content and poised. She thanked me for my honesty in the previous session and said that our discussion had provoked a lot of thoughts that she had talked over with Dr. K. I asked if she would share some of those thoughts, and Lana summarized,

As I said last week, I think a part of me has been engaging in magical thinking about what the surgery will do for me. I know it will make me feel more like a woman and give me more of the body I feel I should have, but as you said, it’s not going to change how other
people view me very much. I do stand out from biological women, and while I hope to improve that more, you were right that a lot of people realize I am a transsexual woman. So that means I want to claim that identity and accept it and not try to be something I’m not. Otherwise, I’m always going to be worrying about passing and I’ll be scared and miserable when I don’t. Our talk has helped me change my ideas of how I will live after my surgery, and I’m really grateful for that.

I asked Lana to say more about her new ideas, and she said,

I was starting to think that I might move to another city where no one knew me as a man, cut off all my old friends, and just start over as woman. But now I see that was part of the magical thinking—that I could go somewhere and be seen as a biological woman and not have to think about being transgender. Instead, when I think about living as a transsexual woman, I want to stay right here, and keep my friends, and get more involved in fighting for transgender rights. And I still want to perform in public, but I’ll do so as an open, proud transgender woman.

I was really impressed with the thinking Lana had done in the prior week, and I said so. Also, the reservations I had about whether she was unrealistic about her likely surgical outcomes were gone. After we talked further, I told Lana that I had one more thing I wanted us to do for the assessment, and that I thought it would be relevant to her question of what would make her happier after the SRS. She said she was very curious and wanted to know more. And so I moved on to a step in TA called an “assessment intervention.” I had tentatively prepared what I would do if Lana and I got to this step, so let me first explain my thinking.

As I held Lana’s assessment question in mind (about how to be happy after her surgery) along with her test results, I thought about the indications that she possibly covered up underlying shame and self-doubt with overconfidence. If these test results were accurate, they were relevant to Lana’s happiness, as shame might keep her from being satisfied with her surgery, and any overcompensation for shame could interfere with her social relationships. In an attempt to explore these findings and open a discussion about possible shame, I asked Lana to do a test called the Thurston Cradock Test of Shame (TOS; Thurston & Cradock, 2009). This choice was part of an assessment intervention in that I had a previous idea based on the standardized testing of what Lana might do with the TOS, and I hoped it might lead to a discussion of test findings that otherwise might be difficult for Lana to hear. The TOS consists of 10 cards with drawings on them of scenes relevant to shame. For example, one drawing shows a baseball player who has just struck out at bat and lost the game for his team; another shows a man who comes upon his co-workers gossiping at the water cooler (possibly
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about him); and yet another shows an adolescent girl examining a series of pimples on her face in a bathroom mirror. I selected these three and a few other cards and asked Lana to tell me a story to each that fit with the drawing. I quickly noticed aspects of her stories that were consistent with the hypotheses I had developed from the MMPI-2 and Rorschach results. For example, this is Lana’s story to the picture of the girl looking in the mirror, with my prompts interspersed:

*This is a girl who is upset because she has a date with a boy she has been wanting to go out with, and the day before the date she suddenly develops six really bad pimples. She’s looking in the mirror thinking about whether she should cancel the date. [SF: What is she thinking and feeling?] She’s a little upset, because she really likes this boy and thinks he is attractive. And at first she thinks about making up some excuse and calling him to cancel the date. But then, she realizes that this is a chance to find out what kind of person he really is. If he still likes her with the pimples, then it’s because he appreciates her intelligence and her personality. If he never calls her back, then he must be a shallow person. And so she decides not to let the pimples bother her and doesn’t even make a big effort to cover them up and goes on the date. [SF: What happens after?] They have a really good time and he kisses her at the door. And she goes to bed thinking, “He didn’t care about the pimples! He passed the test!”*

Her other stories were equally positive, and I thought that several of them verged on being unrealistic. For example, in Lana’s story, the man who comes upon his co-workers gossiping at the water cooler hears them talking about how much they like and admire him. To my eye, the co-workers’ faces look somewhat arrogant in the drawing.

After several cards, I stopped, and we had the following discussion:

*SF: Let’s stop here and talk. Anything you notice about your stories?
L: Not really. How about you?
SF: Well, I was struck by these cards showing three situations where people might feel insecure or bad about themselves, and in your stories all the characters are—*

*L: Self-assured!
SF: That’s a good word. Do you relate to that?
L: Well, I can have my moments of insecurity, but most of the time I’m pretty confident. Some of my friends even say that I’m pushy.
SF: That’s interesting. What do you think?
L: I think that I spent a lot of my life not knowing what I wanted and now that I’m clear I don’t want to waste time. My motto is, “If you want something, you have to go for it. No one is going to do it for you.” I think that’s the key to happiness. Don’t you agree?

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SF: I do think being your own advocate is really important. And I’m impressed by your ability to do that. I’m also interested in the moments of insecurity you mentioned. Would you tell me more about those?

L: Well, I try not to focus on them, but they’re probably there all the time, and they used to stop me more. Working with Dr. K has helped a lot.

SF: And can you think of a situation where they come up?

L: Well, like I said last week, when I’m singing in public. If I let myself, I can start worrying about how people see me, or about my appearance, or about whether my songs are any good. So I just try not to go there.

SF: That makes sense, especially when you’re performing! But I wonder if there would be anything to gain by exploring those insecurities at another, more convenient time.

L: (smiling) Well, they might make for some good song lyrics! But do you see anything else?

SF: Well, as a psychologist, I know that when people push feelings to the side, they sometimes pile up and come back and bite them in the butt later. I wouldn’t want that to happen to you after your surgery. Also it sounds like if you aren’t aware of those feelings, it could lead to others seeing you as pushy.

L: Hmmmm . . . I see that.

SF: And maybe this is just me, but I think feelings of insecurity are pretty human and normal, as long as they don’t take over. The road to happiness is not necessarily to be some kind of “superwoman” who never feels insecure.

Lana agreed again, and I suggested an experiment with the TOS cards. I asked Lana to retell stories to several of the cards we had previously used, and this time to let the characters feel and stay with any insecurity that came up. This led to a very interesting shift, visible in the end of her story to the card depicting the girl looking at the pimples:

L: . . . the girl isn’t sure whether to cancel the date or not, because she’s not sure that she’ll be relaxed enough to be at her best. [SF: And how does it end?] She calls a friend and talks it over with her, and after discussing it she decides to go on the date. She still feels a little unsure, but she thinks she’ll be able to manage it okay.

SF: How was that?

L: Good. I get what you meant about it being more human.

SF: Good, I’m glad. And did you notice anything else?

L: I’m not sure . . .

SF: In this story the girl gets help from a friend. In the other ones, people handle everything by themselves, or everything is so good they don’t need help.

L: I didn’t see that. That’s like when I was thinking of cutting off all my friends and moving away. I don’t want to do that! I need my friends.
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SF: I’m glad you know that, because I think so too. Everyone needs support to be happy. Do you see how this relates to your question of what else you need to be happy after your surgery?

L: I do, and I’m really glad we talked about this. And I just realized—I am definitely going to keep seeing Dr. K after my surgery. I think that will really help me.

SF: I completely agree.

Summary/Discussion Session

A week after the assessment intervention session, Lana and I met to discuss the assessment results in more detail and to address her assessment question. Typically in TA, I brief referring therapists and get their input prior to such summary/discussion sessions (Finn, 2007). And very often, referring therapists are invited to attend such sessions to support their clients. In my SRS assessments, because my evaluation is supposed to be an independent review, I don’t involve referring therapists in that same fashion, and Lana and I met alone. When I checked in with Lana at the beginning of the session, I was once again impressed with how much inner work she had done since the last session. She had talked to Dr. K about what we had discussed, and especially about her needing others to be happy, and she had asked Dr. K to keep working with her after her surgery. As I expected, Dr. K agreed. Lana thanked me again for the previous session and for all the work we had done together.

Because I suspected it would be on Lana’s mind, I began the session addressing whether I felt comfortable writing the second referral letter for her SRS application. I told Lana that if she felt clear to go ahead with the surgery, that I would wholeheartedly support it. She sighed and smiled, and I paused for a moment and smiled back. I then explained my thinking: (1) her desire for SRS was based on gender dysphoria and not some mental disorder; (2) she had good knowledge of the surgery and a realistic appraisal of its outcome; (3) she had taken the necessary steps recommended by the Standards of Care to prepare for the surgery (such as living as a woman for over a year); and (4) she had sufficient psychosocial support for after the surgery. I also told Lana that I could write Dr. X that she had honestly and deeply explored her desire for gender reassignment and that because of this I had no reservations about recommending her.

Lana told me that she did indeed feel clear about going ahead, and she was very happy to have my support. She said, “I learned things about myself that I never imagined, and now I feel even more certain that I want to have my surgery.” We talked a bit about what would be contained in my referral letter to Dr. X, and I said that I would like Lana to review it before I sent it. We agreed that I would also send a copy to Dr. K. I asked Lana how she felt knowing that I could recommend her, and she said, “Thrilled and excited, and like I am nearing the end of a long road.”
I next turned to Lana’s assessment question, “Is there anything else I need to do to be happy as a complete woman?” As I read it aloud, we both smiled at the phrase “complete woman,” remembering our discussions of what the vaginoplasty could and could not do for Lana. She immediately spoke up and said, “Can I reword that? How about ‘Is there anything else I need to do to be happy as a transsexual woman?’” I nodded and suggested we answer this question together based on what we had learned during the assessment; I then gestured for Lana to go first. She gave a lovely summary about needing to be realistic that she might “pass” in public on some occasions, but that she didn’t want to be crushed if this didn’t happen. Lana said she was embracing a new identity of being a “third gender,” and that she looked forward to becoming more politically involved in the trans community. She also talked about wanting to be aware of fear and insecurity and to lean on others instead of pushing such feelings aside and plunging ahead. She said, “I love how strong I am, but I also want to embrace my softness. After all, isn’t that also a part of being a woman?”

I added to Lana’s summary by showing her the results of her MMPI-2 and briefly going over the Rorschach results. I emphasized that she was a well-functioning “sturdy survivor” with no major psychological difficulties, and that there were some indications of underlying shame and insecurity. As soon as I said this, Lana said, “Ever since we talked about that, I’ve been more aware of how I run past such thoughts and feelings.” I asked for an example, and she told of having seen several beautiful women shopping over the weekend and having caught herself “putting down” her own appearance afterward. I asked Lana what she felt when she did this, and she said, “I noticed it because I started to feel a bit depressed. But then when I caught it, I was able to stop it.” I congratulated her and asked, “And if you don’t put yourself down, but leave room for other feelings when you think of those beautiful women?” Lana paused and thought, then teared up and said, “I feel sad.” I gestured for her to go on, and she continued, “However much I want, I’ll never be one of those women, because I was born in a male body.” “Yes,” I replied gently, “and that is a loss. One you can cope with, but nevertheless a loss.” Lana thanked me for acknowledging that, and then laughed and said, “I just did it again, didn’t I? I was all ready to push those sad feelings away on my own. But with your support, I got to another level that is important.” I agreed and said, “And this loss is one you’ll continue to need support about.” Lana agreed and reaffirmed her plan to keep working with Dr. K after her surgery.

Shortly after this, as our session moved to a close, I asked Lana for feedback about her experience of the assessment. She said,

To be honest, although I understood why I had to get a second letter, at the beginning there was a part of me that resented having to spend the time and money seeing you. I thought I was all ready for my surgery, and that this was just a hurdle slowing me down. Now, I can’t thank you enough. As I said, I learned really important things about myself and those are going to help me after my surgery. In fact, they’re
already helping me. When I talk to other people, I’m going to tell them how worthwhile this process is.

I told Lana I was very happy to hear this and that I had really enjoyed working with her and had been inspired watching her courage during the assessment process. I told her I would write my referral letter within the next week and seek her approval before sending it. Lana also asked me to communicate the assessment findings to Dr. K. We then said good-bye, with Lana promising to keep in touch as she went ahead with her next steps. After she left, I sat for 10–15 minutes pondering my work with Lana and admiring her mix of “stubbornness” and openness.

**Referral Letter**

Figure 21.1 presents excerpts of the referral letter I wrote to Dr. X recommending Lana for SRS. Lana reviewed this letter and made a few small factual corrections to the background information. A month after I sent the letter to Dr. X, Lana sent me an email telling me that she had been accepted for SRS and was scheduled to go to Canada six weeks later. She was bringing a friend with her for support, and she said she would contact me after she was back in town for a follow-up appointment.

Figure 21.1 Excerpts From Letter Referring Lana for SRS

Dear Dr. X,

I am writing to recommend Ms. Lana Sterling for Sex Reassignment Surgery at your clinic. Lana first consulted me in January 20XX, at the recommendation of Dr. K, with whom she has been working in psychotherapy for 16 months. Dr. K recommended me because of my extensive experience evaluating and preparing transgender clients for medical intervention. I conducted an independent evaluation of Lana in keeping with the WPATH Standards of Care, and I can strongly recommend Lana to your program. Let me summarize the basis for my recommendation.

**Gender Dysphoria**

Lana described a lifelong desire to be a woman, which she had repeatedly denied in an attempt to fit into the world around her. Finally, due to her intense gender dysphoria and a growing sense that “time was running out,” Lana began working with Dr. K in psychotherapy 20 months ago. This began a slow and gentle process of Lana’s coming to terms with her female gender identity. With Dr. K’s assistance, Lana has changed her legal status from “M” to “F” and has been living full time as a woman for 13 months. She has come out to her children from a former marriage, and they are now accepting of her current gender. Over the last year, Lana has received feminizing hormone therapy from Dr. N, and is happy with the way her body has changed. She has researched SRS extensively, and now feels she is ready to undertake vaginoplasty.

(Continued)
Absence of Serious Mental Disturbance

As part of my assessment of Lana, we collaborated on several standardized psychological tests, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Rorschach inkblots (Comprehensive System scoring). I also spent over eight hours talking to Lana about her life and her current functioning. On the basis of all these sources of information, I have concluded that Lana has no serious mental disorder, including psychosis, personality disorder, depression, or body dysmorphic disorder, and that her desire to change her gender is due to gender dysphoria and a desire to make her body more congruent with her gender identity. Although Lana has had some periods of depression in the past (not at all uncommon, as you know for transgender individuals), she reports that she currently feels calmer and more content than ever in her life, and the test results bear this out.

Psychological Strengths

The testing also revealed that Lana is a sturdy, determined woman with many psychological strengths. She is intelligent, thoughtful, and insightful and has a great deal of creative talent as a musician/songwriter. As you surely know, some individuals seeking SRS are reluctant to explore their multifaceted feelings about such a change for fear that they will be judged unsuitable for surgery. Of all the people I have assessed for gender reassignment, Lana stands out as having looked honestly at her motivations and feelings about SRS and as having confronted a number of deeper issues. Whenever we met, I often found that I had learned a great deal from Lana and her self-exploration.

Stable, Responsible Life

Lana currently works as a medical technician at Smith Healthcare, a position she has held for eight years. She earned and saved the money for her vaginoplasty herself and has also paid for her hormone therapy, for electrolysis, and for speech therapy. Her medical insurance covers her psychotherapy with Dr. K, and Lana plans to continue working with her after her SRS. Lana was very responsible during our sessions, coming to scheduled appointments, paying her bill on time, and “working” psychologically in between our meetings. Lana does not use drugs and drinks only occasionally. I have no doubt that Lana will be able to reliably engage in the post-surgical self-care required.

Social Support

Lana attends a transgender support group regularly and plans to do so after SRS. She has good friends she spends time with regularly, and often plays together in public with other musicians. As mentioned earlier, she plans to continuing working with Dr. K. During our work together, I saw Lana take steps to consolidate her identity as a transgender woman, and I will not be surprised if she turns out to be a leader in the transgender community.

In summary, I recommend Lana Sterling to you for SRS without any reservations. She is well prepared for and has a realistic understanding of what the vaginoplasty can do for her. In my judgment she has an excellent prognosis for a successful post-surgical adjustment.

Please feel free to contact me if you have any questions.

Sincerely,

Stephen E. Finn, Ph.D.
Licensed Psychologist (TX #23064)
Follow-up

As it turned out, Lana and I didn’t meet again until seven months after her successful vaginoplasty. We did communicate briefly when she went to Canada for her surgery. (I sent a card wishing her well, and she sent an appreciative email in return.) When she scheduled the follow-up appointment, she explained that she had thought of contacting me many times, but that “time, money, and life” had gotten in the way. When she arrived, I was struck by how “centered” and happy she seemed, and she spent the first part of the session filling me in on the surgery, her recovery (which had gone well but was challenging), and her current life. The biggest news was that she had a new romantic relationship with another post-surgical M-F transsexual! “Kendra” was a successful pilot for one of the major airlines, and she and Lana had taken several wonderful trips over the last several months. The two of them were discussing living together, and Lana was very excited about having found a partner. She was continuing to see Dr. K regularly, and told me that she was very pleased with her surgery. She said she was “passing” at times and embracing “third gender” status when possible/necessary.

Towards the end of the session, I asked Lana for feedback about the assessment we had done, and she said she considered it “one of the most important things” she could have done prior to her surgery. She said she especially appreciated my confronting her unrealistic fantasy of being a “complete woman” after the surgery, as well as how kind and respectful I had been. I told her how much of a privilege it had been to assist in her personal growth, and we parted with a spontaneous hug and my wishing her much happiness.

Conclusion

Is it possible to conduct screening evaluations for Sex Reassignment Surgery in a way that is professionally responsible, yet also respectful of the dignity and humanity of the client applicant? I believe it is, and I have tried to demonstrate in this chapter how the principles and techniques of Therapeutic Assessment lend themselves to this enterprise. Interestingly, I developed Therapeutic Assessment during a period of my life when I was working regularly with transgender clients and assessing some of them for medical interventions. Writing this chapter has given me a chance to reflect on how this work impacted the ways I do assessment. I now see that my assessments of transgender clients helped me develop my ideas about Therapeutic Assessment and were foundational in my articulating the core values of this new assessment paradigm. Because I had empathy for gender-variant clients, in part from my own experiences as a gay man, I felt compassion for those clients who sought my help, and I found I had to develop my own way of doing screenings for medical interventions that differed in important ways from the way other colleagues I consulted with approached this work. Happily, this was also an era in which political awareness was growing about the rights and struggles of transgender clients (APA, 2008a),
Stephen E. Finn

and this awareness has led to major changes in the WPATH Standards of Care and in the diagnostic nomenclature used with these clients (APA, 2013). The current Standards are more collaborative than previous editions, and the DSM-5 terminology is less pathologizing. Also, other experts in assessing transgender clients now articulate principles and procedures that are very much in line with those I developed. For example, I highly recommend the book I referenced earlier by Lev (2004) for those of you wanting to read more in this area.

As I told Lana, working with her and other transgender clients has greatly changed the way I view and think about the world. For example, I have an acute awareness of how unnecessarily gendered much of the world is, and I have used that awareness to good result. To give a simple illustration, in my office building there are two “one-seater” restrooms in the lobby that for years were labeled as being for “Men” and “Women.” This created an all-too-common problem that clients would be waiting for the “appropriate” restroom, while the other remained unoccupied. One day, in one of our business meetings for the building, several colleagues and I lobbied to remove the gender signage from the bathrooms. Since only one person at a time could occupy each restroom, why did we need to restrict them according to gender? I was surprised by the resistance shown by several professionals in the building, who carefully explained to me that it would be offensive to women clients to see a urinal next to the toilet in the “male” bathroom! I was also told that women needed their own restroom because “they take longer than men,” and when I gently pointed out that women’s being able to use the second bathroom would mean they had to wait for less time, I was met with blank stares. When we renovated the bathrooms a year later, the consensus was to try nongendered restrooms, and one of the colleagues who was against the change has since told me that it has made her life better.

Writing this chapter has also given me a chance to reflect on how the assessment I did with Lana particularly impacted me. I believe the part that touched me the most was the work Lana and I did about “shame covered by confidence.” Seeing this dynamic in Lana helped me identify it in myself and has aided me in working on my own counter-dependence. As a gay man who grew up in a small rural town in the 1960s and 1970s, I developed a great deal of shame about my sexuality. I came out in college in the 1970s and gradually developed a proud, confident, gay “sturdy survivor” persona. This served me well, but it also impacted my personal relationships. After Lana and I worked together, I was more aware of my tendency to hide my self-doubt and insecurities, or as she described, to “just not go there” when such feelings came up. Like Lana, I have needed reminding that I can turn to others for support, and her articulating that lesson drove it home again and has helped make my life richer and happier.

In closing, I hope that this chapter will inspire other assessment psychologists to get training in working with transgender clients and to incorporate Therapeutic Assessment into screening assessments required for medical interventions.
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Practical Points

• Read the resources in the annotated bibliography at the end of this chapter. They give an excellent overview of research on transgenderism and summarize the political, social, and professional issues involved in working with transgender clients.

• Consider attending the yearly summit sponsored by the Center of Excellence for Transgender Health (www.transhealth.ucsf.edu), where you can take part in continuing education workshops, hear summaries of the latest research, and meet a wide variety of transgender individuals and the professionals who work with them. The Center for Excellence also publishes treatment protocols for professionals working with transgender clients.

• Look for and participate in continuing education programs on working with gender-variant clients. The American Psychological Association and some state and local psychological associations sponsor these workshops from time to time.

• Watch movies that feature transgender characters to get a better sense of what it is like to be transgender. Some that I recommend are Ma Vie en Rose [My Life in Pink] (1997), Southern Comfort (2001), and Transgeneration (2005).

• If you live in or are close to a large city, visit a support group for transgender individuals or for their friends and families, and let them know that you are wanting to learn more about what it is like to be transgender. Local chapters of PFLAG (http://community.pflag.org/page.aspx?pid=212) often organize support groups for families and friends of transgender people. If there are no support groups in your area, visit one of the online forums/groups; many are listed at http://iamtransgendered.com/SupportGroups.aspx.

• Get consultation and supervision from other mental health professionals who have experience working with and assessing transgender clients. If there are none in your area, you can locate experts through the website of the World Professional Association for Transgender Health (www.wpath.org).

• As you take any of the steps above, do explore your own reactions, feelings, beliefs, and thoughts, no matter what they are. Because of the way gender is conceptualized and treated in traditional Western cultures, it is very likely that you will experience a variety of reactions.

Annotated Bibliography


Comment: This slightly dated but excellent report commissioned by the APA gives an excellent summary of how psychologists can support transgender individuals.

Comment: This comprehensive book gives an excellent summary of the research and issues relevant to working with gender-variant people and spells out a strengths-based approach for mental health professionals treating such clients.


Comment: Although this document is criticized as paternalistic by some transgender rights groups, it lays out the standards of care that many medical professionals adhere to in conducting medical interventions with transgender individuals. Every mental health professional working with transgender clients needs to be familiar with these guidelines.

References


Assessments for Sex Reassignment Surgery


PART V

Gender, Sexual Orientation, and Development Status
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Pretend play is increasingly recognized as being important in child development. There is a consensus that pretend play is associated with a number of areas of adaptive functioning in children, such as creativity, emotion regulation, coping, and ego resilience (Russ, 2014; Yates & Marcelo, 2014). Theoretically, cognitive and affective processes that occur in pretend play are also involved in these adaptive correlates of play. There is less consensus in the literature as to whether engaging in pretend play actually facilitates the development of these processes (Lillard et al., 2013; Russ & Wallace, 2013). Nevertheless, because there are adaptive behavior correlates of pretend play processes, assessment of pretend play can be useful both in understanding strengths and problem areas of the child and in treatment planning.

Play, especially pretend play, is important in a child’s development because it reflects many social, emotional, and cognitive processes. Socially, play allows a child to interact with peers in a group setting or to play out difficult interpersonal situations in isolation. Emotionally, play allows a child to experiment with expressing different levels of an emotion and different types of affect, which relates to better emotional understanding and competence. Cognitively, play is associated with language development and adaptive functions in the areas of coping, divergent thinking, and creativity. Given the importance of play, it is important to know how gender may mediate the development of this skill set. A small but growing body of literature has investigated how pretend play either differs or is similar in male versus female children. This knowledge could be used in designing more appropriate and individually tailored play intervention options. Gender differences between girls and boys have emerged in the correlates of pretend play. Aggression in pretend play, in particular, may have a different meaning for boys than for girls in terms of general functioning.
This chapter reviews the processes in pretend play and the Affect in Play Scale (Russ, 2004; 2014) as a measure of play processes. The value of pretend play assessment is also discussed. We review gender differences that have emerged in the research literature and possible meanings of those gender differences. A brief case vignette that demonstrates how play assessment can be useful in targeting intervention strategies is presented. Finally, practical implications for assessment and treatment planning are discussed.

**Processes in Pretend Play**

Pretend play is an activity in which all children engage at some point in their development. One of the best definitions of pretend play is Fein’s, which states that pretend play is a symbolic behavior in which “one thing is playfully treated as if it were something else” (1987, p. 282). Fein also stressed the importance of affect in pretend play. A variety of emotions are expressed in pretend play and are intertwined with fantasy expression. Because pretend play is so natural to the child, and because so many developing cognitive and affective processes are expressed in play, assessment of play can be a useful addition to an assessment battery.

Russ (2004, pp. 2–5) categorized different play processes that can be observed and measured in play (see Table 22.1).

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Assessment of Pretend Play

Affect in Play Scale

The Affect in Play Scale (APS; Russ, 1993, 2004, 2014) is particularly well-suited for inclusion in an assessment battery. It is one of the few play measures that assesses both cognitive and affective components of pretend play. It is short (5-minute task) and can be scored in vivo or from a video. If scored from a video, scoring usually takes about 20 minutes.

The Affect in Play Scale is a measure of pretend play that assesses both cognitive and affective play processes with a standardized play task, instructions, and coding system. The APS is appropriate for children from 6 to 10 years of age. The task consists of puppets and blocks, and the child is asked to play with them anyway they want for 5 minutes. The play is videotaped and then coded on variables of organization of play narrative, imagination, comfort, amount of affect in the play narrative, and variety of affect content categories. Organization, imagination, and comfort are rated on a five-point Likert scale. Affect content is scored with a frequency count of both verbal and nonverbal affect expressions. There are six negative affect categories (e.g., aggression, sadness) and five positive affect categories (e.g., happiness, nurturance). Each unit of affect expression in the play narrative is scored. A detailed coding manual has been developed (Russ, 2004, 2014). There is also a version of the APS for preschool children (APS-P; Kaugars & Russ, 2009), which includes a variety of toys and more structured instructions. There is a brief coding system for both versions of the scale for in vivo scoring, when videotaping is not appropriate.

Factor analyses of the APS have found two factors—one cognitive and one affective (Russ, 2004, for review; Chessa, Riso, Delvecchio, Salcuni, & Lis, 2011). In the Chessa et al. study, a confirmatory factor analysis (CFA) with a large sample of 519 Italian children, there were no gender differences in the factor structure. This suggests that the underlying processes in pretend play are similar for boys and girls. The two factors are correlated but also account for unique

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<td>The ability to express concern for others and to understand others’ emotions</td>
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### Affective Processes

#### Comfort and enjoyment in the play
- The ability to be involved in play

#### Emotion regulation and modulation of affect in play
- The ability to contain the emotion within a narrative

### Interpersonal Processes

#### Empathy
- The ability to express concern for others and to understand others’ emotions

#### Perspective taking
- Taking the view of the other, especially during role playing

#### Communication
- The ability to express ideas and emotions to others

#### Interpersonal Schema
- Capacity for self-other differentiation and trust in others

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variance in the play. The cognitive factor includes organization of the narrative and amount of imagination in the play. The affective factor includes amount of positive and negative affect, intensity of affect, and range of affect expression. Both of these factor constructs are important in treatment planning (Russ, 2004).

What are the constructs that underly these two factors? The cognitive factor is reflecting the child’s ability to use imagination, make up a story with a coherent narrative, generate ideas and object transformations, and function in an “as if” space. The affective factor reflects the child’s access to emotion in imagery, thoughts, and memories. Can they think about and express affective fantasy? It also reflects the ability to express emotion in a pretend situation. In three studies with the APS, expression of affect (content and emotion) in the play narrative related to expression of affect in storytelling (Hoffmann & Russ, 2012), affect content in memories, (Russ & Schafer, 2006), and affect (primary process content) on the Rorschach Inkbot Test (Rorschach, 1921; Russ & Grossman-McKee, 1990). These findings suggest that the ability to express affect is a cross-situational ability that can be assessed in a play task. This affect expression ability has important implications for treatment planning. From a psychodynamic perspective, it reflects the child’s tendency to repress uncomfortable ideas, feelings, and memories. Play can be used in therapy as a safe way for the child to gain access to uncomfortable emotions and ideas and learn to integrate feelings into a coherent narrative.

Different play profiles can emerge in the play assessment. If the child is low on both cognitive and affective skills in pretend play, it is not optimal to use a play approach in therapy. If the child has constricted affect expression and cannot pretend easily, then using a play-based approach in short-term therapy does not make sense. Alternative intervention approaches would be more effective. If, on the other hand, a child is high on imagination and affective expression, a therapy that uses play should be beneficial. The child would be able to play out worries, make up stories, put on different endings, and express affect. Negative emotions should be reduced, positive emotions increased, and affect better integrated and regulated. If a child has good imagination and fantasy ability in play but is emotionally constricted, then a play intervention could help the child feel more comfortable with emotion. For the child who expresses much affect but in a disorganized fashion in a pretend scenario, using play to help with integrating the emotion could be beneficial. The child discussed later in this chapter is such a case.

Value of Pretend Play

One way to learn about the value of pretend play in child development is to review validity studies of measures of pretend play. What are the correlates of pretend play that indicate adaptive functioning in children? A large body of research from different research programs has found associations between
pretend play and adaptive functioning, such as creativity, emotion regulation, ego resilience, and coping. Pretend play also is associated with emotional understanding, empathy, and perspective-taking. These abilities are aspects of theory of mind. These pretend play findings are consistent with recent findings with adults who read fiction. Role-playing in pretend play and imagining characters is similar to imagining characters in fiction. Kid and Castano (2013) reviewed five studies that explored the relationship between literary fiction, affective theory of mind (ToM), and cognitive ToM. Affective ToM relates to an individual’s ability to detect and understand others’ emotions, where cognitive ToM shows an individual’s ability to understand that others have varying differences in beliefs and intentions. Literacy preference was measured through an Author Recognition Test, along with other measures. Results from all studies supported the notion that reading literary fiction led to better performance on affective ToM tests compared with nonfiction, popular fiction, or nothing at all.

A large number of validity studies have been carried out with the APS (see Russ, Niec, & Kaugers, 2000, and Russ, 2014, for reviews). The APS and APS-P have been related to theoretically relevant criteria such as creativity, coping, emotional understanding, emotion regulation, prosocial behavior, and positive mood in daily life. An important point is that measures of intelligence have not related to pretend play processes in most of these studies. Cognitive and affective processes in play are different from the cognitive processes measured by intelligence tests. Pretend play relates to aspects of functioning that are independent of IQ in both boys and girls.

There is some research evidence that engaging in pretend play facilitates creativity and other areas of adaptive functioning (Wallace & Russ, 2013). However, there is no consensus in the field that play brings about change in cognitive functioning (Lillard et al., 2013). Therapists have used play since the 1930s to help children resolve conflicts and fears, and a large clinical literature supports the use of play in therapy. There is growing evidence that engaging in pretend play helps reduce anxiety and fears in children (see Russ & Niec, 2011, for a review). However, there is a need for more randomized controlled trials that demonstrate the effectiveness of play interventions.

**Gender Differences in Pretend Play**

Only a few studies have investigated gender differences in children’s pretend play, both in mean differences in play between girls and boys and in correlates of pretend play. Looking first at differences in play, the incidence of imaginary companions and impersonated characters was compared in 152 three- and four-year-old children (75 males, 77 females) through the use of role-play interviews, questionnaires on toy preference, and observation of pretend and free play actions (Carlson & Taylor, 2005). Results showed a significant difference in the form of a child’s imaginary character, in that boys were more likely than girls to actively impersonate their characters. Results also showed that girls were
more likely overall to have an imaginary companion. Lastly, girls’ imaginary companions were more often invisible and boys’ were more often based on toys.

Gleason (2005) investigated the beliefs of mothers and fathers in regard to pretend play and imaginary companions of their children based on gender. Surveys were completed by parents (73 mothers, 40 fathers) that asked about their children’s pretend play, their attitudes toward pretense, and the environment the parents provide for their children to engage in pretend play. Results from this study showed that girls were rated as engaging in more pretend play than are boys, and mothers perceived pretend play more positively than did fathers.

In a study by Lindsey and Mize (2001), parent-child play behaviors of 33 preschool children were videotaped in both pretend play and physical play sessions. The analysis of the study focused on contextual differences in the parent-child play behavior as well as how parent-child play associated with child-peer play. Results showed that during pretend play sessions, parent-daughter dyads (especially mother-daughter dyads) engaged in more pretend play than did parent-son dyads. Further, during the physical play sessions, the father-son dyads engaged in more physical play than did father-daughter dyads. In terms of peer play, girls were more likely to engage peers in pretend play, whereas boys were more likely to engage peers in physical play.

The social representation of gender and young children’s play was investigated by Lloyd & Smith (1988): In this study, toy choice and play with toys were observed in 60 pairs of children (ages 19–42 months). Children played with gender-stereotyped toys, first with their mothers and then with a familiar same- or opposite-gender peer. Results showed that choice of opposite-gender toys was greater in the action play of mixed-gender peers. In pretend play, only girls in the oldest age group chose gender-stereotyped toys more frequently and used opposite-gender toys less in mixed pairs. Boys engaged in significantly more physical play with toys.

Wall, Pickert, and Gibson (1990) looked at fantasy play in five- and six-year-old children. The verbal pretend play of 16 children were studied in order to delineate age and sex differences during the later preoperational period. Children were paired by age and sex and were videotaped for three 15-minute intervals of play. Verbal interactions were transcribed and the pretend play was classified as object fantasy, imaginative action plans/themes, or fantasy roles. Results showed that girls’ conversations were scored as having significantly more verbal pretending than did boys’ conversations, and a higher proportion of the verbal pretending referred to play roles. The study also found more sex-typed behaviors (in regards to toy choice and theme of play) as children aged. Another study observed pretend play behaviors in 11 females and 11 males (average age 4.5 years) when they were presented with a wide selection of toys (Jones & Glenn, 1991). Results showed that girls engaged in slightly more pretend play actions and showed more personal fantasy play than did boys, who engaged in more object fantasy play. Interestingly, cooperative and same-sex play were most commonly observed in both genders.
Assessment of Pretend Play Scale Studies

In most of the studies that we have carried out with the APS and APS-P, gender differences have not emerged in pretend play. Boys and girls are equally imaginative, tell stories that are equal in story organization, and express similar amounts of affect in play. This is an interesting difference from the other studies that were just reviewed, where girls were often perceived as being engaged in more pretense. In most of our studies, where we look at the amount of imagination and quality of the pretense, boys and girls are equal. One reason that the APS study findings are different from other studies could be because most of the APS studies are with older children, from six to ten years of age. Play studies with younger children may be reflecting gender differences in language and verbal development between boys and girls at that age. Another possible reason for the different findings is that the APS assesses both verbal and nonverbal expressions and is a standardized task administered to individual children. Therefore, the APS could be a more sensitive measure of play abilities than less standardized tasks or group observations of play.

One difference has consistently emerged in most (but not all) of the studies with the APS. Boys express more aggressive affective content in the story narrative than do girls (Russ, 2004, 2014). For example, in a five-minute play period, boys expressed 4.86 aggressive responses and girls expressed 0.63 responses (Russ & Schafer, 2006). Typical aggressive content responses are wrestling or hitting between the puppets, verbal arguing, insults, and bickering. Russ (2002) has speculated that girls are less comfortable than boys thinking about and expressing aggression in this culture. Our results are consistent with those of von Klitzing, Kelsey, Emde, Robinson, and Schmitz (2002), who found more aggressive themes in the MacArthur Story Stem Battery for boys than for girls.

Our play results are also consistent with Rorschach findings that boys give more primary process responses than do girls (Russ, 1982). Primary process thinking is drive-laden (affect-laden) cognition that is not logical and is associative in nature. Dream content is an example of primary process thinking. Specific analyses of the content revealed that boys had significantly more aggressive content. Using Holt’s Scoring System for Primary Process on the Rorschach, examples of aggressive content in children are fighting animals, monsters, exploding volcanoes, and scary insects. Other studies with children found similar gender differences (see Russ, 2002, for a review).

What about gender differences in the correlates of pretend play? For both boys and girls on the APS, imagination and organization of the narrative in play relates to creativity and to coping ability. Total affect in play relates to creativity in both genders. However, when we look at positive affect versus negative affect, gender differences emerge. Negative affect has a large component of aggressive themes. Positive affect has more consistently related to creativity in girls. In a study of school-aged girls, Hoffmann and Russ (2012) found that positive affect
related to creativity in storytelling \( (r = .31) \) and to emotion regulation \( (r = .36) \), whereas negative affect did not. In a longitudinal study of girls, Wallace and Russ (2015) found that positive affect in play predicted divergent thinking \( (r = .32) \) and math ability \( (r = .47) \) over a four-year period. Negative affect in play was not predictive. In a preschool sample with the APS, Fehr (2013) found that for boys, total affect was related to creativity, both positive and negative affect. For girls, affect did not relate. For boys, negative affect has consistently related to creativity. Girls may not be learning to use play to deal with and integrate negative affect as well as boys.

Again, the play findings are consistent with the Rorschach findings. Primary process content was related to creativity measures in boys and men but usually not in girls or women (Russ, 2002; Suler, 1980). In all of the studies in Russ’s research program with primary process in children, there were gender differences in the relationship between primary process and creativity. At times, the differences in the correlations for boys and girls were significant, and at other times the gender differences approached significance. The pattern was consistent.

To summarize the play findings with the APS, girls express less negative affect, especially aggression, in pretend play than do boys. There usually are no differences in total affect expression, which includes both positive and negative affect. For girls, positive affect is more consistently related to criteria of adaptive functioning than negative affect. For boys, both negative and positive affect relate to criteria of adaptive functioning. One might speculate that girls do not get as much practice as boys in expressing negative emotions and thoughts in pretend play; they do not get the experience manipulating this affect content associated with memories and relationships; and they do not learn to use it in areas such as creativity. Parental and cultural expectations about appropriate behavior for girls could be one of the reasons for these gender differences. Another reason could be underlying innate biological differences. In animal play, play fighting in mammals is more frequent in males than females (Smith & Pelligrini, 2005). Innate predisposition to aggressive play could be one factor in sex differences in children’s play as well.

An important finding about aggression in play was found in a study by von Klitzing, Kelsey, Emde, Robinson, and Schmitz (2000). In a study of 652 children, they found that aggressive themes in the play narratives of girls was related to externalizing and internalizing problems for girls. Aggressive themes in play did not predict behavior problems for boys. They concluded that aggressiveness in girls’ narratives might imply more deviance than aggressiveness in boys’ narratives. Boys had more aggressive themes in their play than did girls. They also found that, for both boys and girls, when aggressive themes were expressed in an incoherent narrative, it was associated with more behavior problems. The following is an example of a boy with aggressive themes in play in a disorganized narrative.
Case Vignette: Using Pretend Play With a Child Exposed to Trauma

Pretend play can be used in a variety of settings and situations with children, both with a goal of improving well-being and also in the context of therapy and intervention. Some interventions are highly structured and focus on the growth of specific skill sets, while others are more tailored to the individual child and work on a more global improvement of play abilities that can hopefully extend to other areas of functioning. In this case study, the purpose of play was to assess pretend play abilities and guide play behavior development in a five-year-old boy (who will be referred to as Luke throughout the chapter) who had been exposed to traumatic events. The authors were able to meet with and work with Luke over a six-week period, for about an hour and a half every week in a mental health setting. This was part of an exploratory pilot project to refine a play intervention. The sessions were structured so that guided pretend play occurred for about 20–25 minutes of the total time together. The rest of the session was dedicated to Luke’s preferred activities, such as games and coloring.

Luke presented as very lively, curious, and intelligent. He had slight difficulty leaving his mother’s side during the first session and became moderately distressed. However, he was able to successfully engage in the play session without his mother. During the first session, the authors administered the Affect in Play Scale—Preschool Version (APS-P) to assess Luke’s baseline pretend play abilities. This preschool measure involves presenting the child with a set of toys and a standardized story stem. Then the child is asked to play for five minutes with the toys and to talk out loud. Luke was able to engage in the play task, but it became evident that he had difficulty in organizing his storylines, had low levels of imaginative acts, and showed high levels of aggression in his play. He did also score as being very comfortable and engaged in the play.

On a possible 1–5 scale with defined criteria, his APS-P scores were:

- Organization of play 2
- Imagination 2
- Comfort 4

Number of affect units 10 (all aggressive themes)

Luke did not have sequences of cause and effect, had no plot, quickly shifted from one story to the next, could not pretend well or use toys to represent other things, and only expressed aggressive affect. He smashed toys together, hit things, and could not integrate the affect into the story narrative. He did, however, engage easily in the play and seemed to enjoy the activity.

Based on the findings of the APS-P, the authors decided to focus on integrating more positive emotions into Luke’s storylines and also on helping him better organize his stories, so they would include a beginning, middle, and end, with transitions in between. We used a play intervention manual developed by
Russ, Moore, and Pearson (in Moore & Russ, 2008). In addition to suggesting story stems, we modeled pretending and expression of feelings. We also prompted with what would happen next or how would it end, suggested story endings, and reflected feelings.

During the subsequent visits, the authors began each session with asking Luke which toys he wanted to play with and what type of story could be created with those toys. We suggested different story stems as well. The aim was to play for 20 minutes, while scaffolding and leading the play as needed. During the first few sessions, Luke would be extremely excited to play, and his stories would begin as being well-organized and varied in content and emotional valence. However, it became apparent that Luke would almost get lost or wrapped up in the play too quickly and would not be able to regulate himself within the storyline. For example, he would begin with playing house, but then a storm would come and a tornado ripped through the house and sent the people flying all over the place. As the story intensified in a negative manner, Luke would become excited and would get more and more physically involved in the play. He would be spinning around the room as if he were the tornado and throwing toys around because the wind was “too strong.” It was as if the affect in his play started to dictate Luke’s actions instead of Luke being in control of the situation.

When this would start to occur, the authors would become active in his play and work on (1) calming Luke down to an appropriate level, (2) interjecting more positive affect into the storyline, and (3) organizing the story back into a sequence of events. Once Luke was calm, the authors would model how to show nurturance/affection (e.g., one doll helps another after the storm) and happiness (e.g., the dolls being happy that the storm was over and they were safe). The authors also made sure to scaffold the play by asking questions relating to organization such as “What happens next?” or “What is a good ending for this story?” Every effort was taken to ensure that each pretend play session ended on both a positive note and with an ending to the story that Luke was telling.

Over the course of the six weeks, it became apparent that Luke enjoyed coming to the sessions. His mother commented on how he looked forward to playing and how his actions and growth in play were extended to other areas outside of the sessions. We observed changes in Luke’s play as well that related to more organized storylines and an increased ability to emotionally regulate himself within a play situation. Luke would rarely “lose control” of the play situation like he did at the beginning of the sessions. Further, if this started to occur, he was more receptive to our redirections and pulled many more positive emotions into his play. By the end of the six-week period, Luke was playing out full storylines that still had high levels of aggression, but they were also organized and showed some positive emotions. A particular highlight was one of the final sessions, where Luke was able to calmly sit for the 20-minute period and played out a wonderful “birthday party” with the provided toys and molding clay. He constructed a cake, showed nurturance/affection and happiness in presenting
Assessment of Pretend Play

the cake to the “birthday boy,” and was able to put a positive end on the story (blew out the candles, ate cake, and opened presents) without prompting.

During the last session, the authors once again administered the APS-P to Luke to see if gains had been made in play abilities. Overall, there were fewer aggressive acts in Luke’s play, and he was able to express positive emotions (most notably happiness and affection). Further, his organization was improved (from 2 to 4), and he showed more instances of imaginative and symbolic acts.

His APS-P scores were:

- Organization 4
- Imagination 3
- Comfort 5

Number of Affect Units 15 (aggression, happiness, nurturance, affection)

His story was well-organized, he could make transitions, and there was a storyline. He was able to pretend better and to use objects to be other things (a cup is a house); he showed a range of emotions, some of which were positive. It is possible that the proportion of positive to negative affect is an important variable in general.

This case example demonstrates how a play assessment can be used to guide a play intervention and to assess the effectiveness of the intervention. If this had been a therapy case, then one would try to connect the play themes to his life experiences as well. This case study also suggests that the use of play may be helpful to children who need help organizing their thoughts and integrating emotions. The authors were able to target key areas within Luke’s play that may have been causing him distress (e.g., emotional negativity and his inability to regulate emotion) and give him tools as to how to modulate these intense reactions within a play setting. Gaensbauer and Siegel (1995) have described the use of structured play therapy with very young traumatized children. They think that helping the child to build a coherent narrative around fragmented experiences is an important mechanism of change.

Value of Pretend Play Assessment in a Gender Context

Formal assessment of play or informal observations of play can provide useful information for treatment planning. Can the child pretend, use blocks to represent other objects, make up stories with some sequence of cause and effect, and express affect in the play? How is the child processing emotions? Is the affect integrated into a coherent narrative? Can the child regulate the emotions that are aroused? Play assessment is easy to add to a test battery because children play naturally. If used at the beginning of an assessment session, it can serve as an ice-breaker. If it occurs at the end of a session, it can be a way for the child to relax and end the testing session on a positive note.

Kaugars (2011), in a review of the play assessment literature, outlined a number of advantages of play assessment. She pointed out that play is a good way to
reveal a child’s emotional concerns. Kaugars also cited Pellegrini (1998), who thought that play shows the child’s maximum competence. Kaugars called for more empirically supported play-based measures.

Short, Noeder, Gorovoy, Manos, and Lewis (2011) stressed that one value of play assessment is that it is appropriate for young children who have language difficulties. The nonverbal nature of play lends itself to providing a fuller picture of the child. Play assessment is also very user-friendly. The APS and APS-P give much information in five minutes. Short et al. also stressed that play assessment can be especially useful with children who have special needs. They described assessment needs of children with language disabilities, ADHD, and autism spectrum disorder. The majority of these children are boys. These children can be engaged in a play task, which has the potential for differential diagnosis for developmental disabilities.

Pretend play can be viewed as a reflection of the developmental level of a child, which means that play observation may be used as a diagnostic tool to test for a multitude of developmental disabilities or delays. Various studies have shown that children with different developmental disorders or deficits play differently from their typically developing peers. This knowledge and use of play as an assessment tool can aid in the diagnostic process. For example, play assessment provides the potential to learn about similarities and differences in children with Prader-Willi Syndrome and autistic spectrum disorders (Zyga, Russ, Levers-Landis, & Dimitropoulos, 2015).

Play is particularly well-suited to the assessment of children’s strengths. Because play processes relate to so many areas of adaptive functioning, play can be viewed as a resource for children that is independent of intelligence. This is important when identifying creative potential in children.

**Practical Points**

- Observe children’s play as part of an assessment battery. Although a standardized play task is best, with some normative data available like the APS, informal observation can also be informative. It is important that the toys be largely unstructured with room for imagination.

- Important features of play include the capacity to pretend, to transform objects to represent other things, to make up an organized story, and to express a variety of content themes and affect. Engagement and enjoyment of play is also important. Toy choice itself is not an important variable. What the child does with the toy is more important. A play-based intervention is appropriate if the child has the capacity to pretend and has some ability to express emotion in the play narrative.

- Gender differences in all of these different processes/abilities have not emerged in studies with the APS or APS-P. Girls and boys are similar in their ability to pretend, use imagination, make up an organized story, engage in play, and express affect in the narrative.
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- The one gender difference that emerges in a number of different research programs with different play measures is that boys express more aggressive themes and emotion in pretend play than do girls. Expression of aggressive content is normal for boys. If it is within a well-organized story and if there is also positive affect in the play, then it can be viewed as a resource for the boy.
- For girls, because aggressive content in play is more unusual, it should be evaluated carefully in the play context. It is especially important that the play stories be well-organized and the aggressive content be integrated and modulated. The presence of positive affect is also important.
- For both boys and girls, intense affect expression in disorganized stories, with little capacity to pretend, could be indicative of emotional problems. As with any assessment information, the play data should be combined with the rest of the assessment battery.

Annotated Bibliography

Comment: This book overviews the foundations of play therapy and presents evidence on how this technique has empirical support and validation. Sandra Russ applies the field’s understanding of the role of play in child development to the mental health field, which aims to design intervention and prevention programs that can be empirically evaluated. Overall, the book overviews clinical and developmental research and theory and provides an updated review of approaches to using play in both therapeutic work and assessment.

Comment: This book reviews the theory and research on pretend play and creativity. Sandra Russ provides evidence that pretend play in childhood creates a foundation for the continued development of adult creativity. She describes cognitive and affective processes involved in play and creativity, as measured by the Affect in Play Scale. Theories as to how play development may stem from evolutionary processes are also reviewed. The importance of pretend play in emotional development is discussed, along with how these processes can be targeted in intervention.

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Assessment of Pretend Play


Gender emerges as a salient issue in adolescence. Not only do physical differences become more salient with the onset of puberty, but boys and girls also vary with respect to the preferred and most prevalent activities they engage in with their friends. Boys generally prefer to engage in more action-oriented pursuits, and girls spend more time interacting through verbal communication (Smith, 1997). This is consistent with the plethora of research that indicates that girls highly value intimacy and self-disclosure in their relationships (Bakken & Romig, 1992; Clark & Ayers, 1993). What emerges from the separation of socialization (and a myriad other reasons, as well) is more salient differences in the social, emotional, and even cognitive world of adolescent girls and boys. What this means for psychologists is that in order to understand test data that emerge from standardized tests with adolescents, one must place them within the context of sex, sexuality, and gender.

Sex Differences in Adolescent Psychopathology

There is a long-standing and well-noted literature on the emergence of sex differences in different psychiatric disorders during adolescence. Rutter, Caspi, and Moffitt (2003) have noted that some early-onset neuropsychiatric disorders, such as autism and ADHD, have higher prevalence for males. However, some adolescent-onset emotional disorders, such as mood disorders, anxiety disorders, and eating disorders, show much higher rates for females from adolescence onward. For example, while rates of depression between boys and girls are relatively equivalent in childhood, sex differences in rates of depression emerge dramatically during adolescence, with girls having both subclinical levels of depressive symptoms and diagnosable depression at a rate of 2:1 compared to their male counterparts (Nolen-Hoeksema, 2001; Nolen-Hoeksema &
Puberty

While the term is used frequently, scholars have struggled with defining exactly what puberty is. Puberty is not a single event but a series of complex physiological and psychological changes whose definition depends, in part, on how it is being measured and for what purpose the definition is being used (Hayward, 2003). Hayward asserts that “a full understanding of most psychological aspects of puberty requires measuring both the individual pubertal changes and the environmental factors that give these changes meaning” (p. 2). Yet social context is often not considered in any definition of puberty. In this chapter, puberty will be conceptualized as the two- to four-year period of rapid and dramatic developmental change in physical, social, and psychological domains, which tends to begin between the ages of 8 and 14. Most of the physical changes occur within four years following the onset of initial signs of puberty. This process is initiated by the maturation of the adrenal glands, which results in the secretion of specific androgens (andrenarche). For females, increases in the production of estradiol by maturing ovaries (gonadarche) stimulates growth of breast tissue and the darkening and expansion of the areola (thelarche) and brings about and regulates menstruation (menarche). Small amounts of testosterone in pubescent females encourage muscle and bone growth. In males, testosterone in larger amounts accounts for growth in testicles and penis size, changes (deepening) in vocal tone, and an increase in muscle tone and bone lengthening. For both males and females alike, changes in hormones may also mark an increase in pubic hair (pubarche), acne, mood swings, and changes in biorhythms that control sleep patterns. In both girls and boys, thelarche and pubarche occur during the early stages of pubertal development, while menarche in girls is a late-stage event.

Pubertal Timing

Remarkable variation exists in the progression and onset of puberty across individuals with a wide variety of influential factors, including genetic and biological influences, exposure to stress events, socioeconomic status, nutrition, exercise, and certain chronic illnesses. Timing of puberty varies for girls and boys, with girls showing signs of physical maturation about six months earlier than boys on average. Historically speaking, contemporary girls enter menarche, on average, a few months earlier than girls did 40 years ago (Herman-Giddens, 2007). Improved health and nutrition are thought to be the underlying causes of this century-long trend, with some evidence pointing also to increased prenatal
and childhood exposure to endocrine-disrupting chemicals. Precocious puberty, defined as the appearance of secondary sexual characteristics in an age that is greater than about two standard deviations below the mean age of puberty for the general population (Rosenfield, 2008), has a number of physiological and psychosocial correlates and implications for both boys and girls, although it occurs five times more frequently in girls than in boys (Grumbach & Styne, 2003). Also, the etiology of precocious puberty is less likely to be identified in girls, whereas early maturation in boys can often be associated with some sort of known illness (Muir, 2006).

Pubertal timing has self-perception and interpersonal effects, with different implications for boys and girls. Some have speculated that differences in vulnerability to environmental stress, with girls experiencing more stress than boys on average during adolescence, may play a role in why girls enter puberty at an earlier age than boys (Meschke, Johnson, Barber, & Eccles, 2003). Stress has been shown to modulate the timing of puberty, and early maturation can be particularly stressful for girls (Ruble & Brooks-Gunn, 1982; Conley & Rudolph, 2009). Early-maturing girls may possess visible signs of maturation, such as breasts and weight gain, as early as age 10. These girls tend to have lower self-esteem (Sisk & Zehr, 2005), more depressive symptoms, poorer body image (Compian, Gowen, & Hayward, 2009), and earlier drug abuse, cigarette smoking, and alcohol use than girls who mature later (Graber, Seeley, Brooks-Gunn, & Lewinsohn, 2004). Early maturers (menstrual starting before age 11) have also been found to demonstrate social problems, such as relational and physical aggression and delinquency (Mrug et al., 2014) and elevated social anxiety compared to on-time and late-maturing girls (Blumenthal et al., 2011). Some recent studies have indicated an increased vulnerability to depressive symptoms for early-maturing and late-maturing boys as well, suggesting a curvilinear relationship between timing and psychological well-being, with on-time maturers faring best on these measures (Conley & Rudolph, 2009; for reviews, see Huddleston & Ge, 2003).

Adolescent males who physically mature early are often expected to behave in a more emotionally and psychosocially mature manner than their chronological age would anticipate, and they have been found to have more orgasms and to react to puberty in a more positive way (Savin-Williams, 1995). They are commonly treated as leaders and are more likely to be admired by their peers (Grumbach & Styne, 2003). A recent study of the impact of age, grade, and physical development on male identity development demonstrated that advanced physical maturity in males corresponds with a loosening of commitments and identification with parental expectations and values and the emergence of more sophisticated ideologies specific to dating, politics, and religion (Jones, Dick, Coyl-Shepherd, & Ogletree, 2014). It should be noted that early maturers do not significantly differ in the number of reported lifetime sexual engagements with male or female sex partners, onset of heterosexual encounters, sexual orientation rating, frequency of senior high school orgasms, or levels of self-esteem (Savin-Williams, 1995).
Gender, Sexuality, and Adolescence

Gender effects are further complicated by racial differences in both the timing and the outcome of puberty. Early sexual maturation is more prevalent in the African American population (Herman-Giddens et al., 1997; 2012), and African American girls tend to have more advanced breast development and muscle and bone mass by age six than do Caucasian or Hispanic girls, a trend that persists through puberty (Gilsanz, Roe, Mora, Costing, & Goodman, 1991). Early pubertal timing likely interacts with stressful life events to explain high rates of depression among White early-developing girls but not Black early-developing girls (Hamlat, Stange, Abramson, & Alloy, 2014). Further, differences found in the effect of early puberty across racial groups may involve differing social meanings attached to puberty, the intervening effects of body-image concepts, and culturally constructed differences in the meaning of sexuality, girlhood, and womanhood (Cavanagh, 2004).

In a study of early puberty and mental health problems in adolescence, Mensah and colleagues (2013) noted that many of the identified psychosocial issues associated with early puberty were evident in and persisted through early and middle childhood, suggesting that children with early puberty have different patterns of behavior and social adjustment from the preschool years through early adolescence as a result of biopsychosocial processes that began well before the onset of puberty. Early maturation can also have lifelong implications. Early puberty, particularly early menarche, has been shown to increase the risk for breast cancer and polycystic ovary syndrome, a leading cause of pelvic pain and infertility, in later life; as age of menarche decreases, overall risk of breast cancer increases (Anderson et al., 2007; Neville & Walker, 2005). Behavioral effects have been shown to persist in some women into young adulthood (Grabber, 2004) and middle age (Celio, 2006). Johansson and Ritzén (2005) found that at ages 27 and 43, women who initiated puberty early had lower academic attainment, whereas late-maturing girls were significantly more successful in school and more likely to finish college (Grabber, Seeley, Brooks-Gunn, & Lewinsohn, 2004).

Recent studies have also identified percentage of body fat as a factor in predicting early (precocious) puberty. Girls who are obese enter puberty significantly sooner than those who are not obese and have a higher risk for developing features of metabolic syndrome, including obesity (Gordon, 2008), type 2 diabetes (Svec et al., 1992), and cardiovascular disease (Remsberg et al., 2005). The neuroendocrine apparatus that triggers the onset of puberty consists of a multitude of signaling pathways that are vulnerable to interference or interruption. Obesity has been recognized as a significant endocrine disruptor by dramatically altering insulin, leptin, and aromatase levels. Some studies have shown an opposite relationship for boys, such that overweight boys reach puberty later, not sooner, than their slimmer counterparts (Lee et al., 2010). Boys who enter puberty early also have an increased risk for developing testicular cancer (Golub et al., 2008). Racial differences have also been noted, with African American adolescents entering puberty 7–15 months on average earlier than European
or Hispanic teens, and Asian American teens 7 months later than European and Hispanic adolescents (Brown et al., 1998; Susman et al., 2010). This difference is often attributed to greater body mass and body fat (Daniels, Khoury, & Morrison, 1997), genetic/hormonal factors (Wong et al., 1998), and environmental factors (Bacha et al., 2010).

**Delayed Puberty**

Puberty is considered delayed if there is no initial sign of breast growth (in girls) by age 12 or increase in testicle size (in boys) by age 14 among youth in the United States, or the absence or incomplete development of secondary sexual characteristics by an age at which 95% of children of that sex and culture have initiated sexual maturation (Sedlmeyer & Palmert, 2002). Boys and girls do not experience the effects of delayed puberty in the same way, but both may experience the physiological and social consequence typically associated with off-timed maturation. Later-maturing girls may experience psychological and social difficulties (Natsuaki, Biehl, et al., 2009). Off-timed development for girls is associated with problematic social processes, such as a lack of close friendships (Brooks-Gunn, Warren, Samelson, & Fox, 1986), deviant peer associations, early involvement in romantic and sexual relationships (Cavanagh, 2004), and, for late-developing girls, low social support, acceptance, and popularity (Michael & Eccles, 2003). Late-maturating boys also show more depressive symptoms than do on-time maturing boys (Huddleston & Ge, 2003), and late-maturing male adolescents tend to be more psychosocially immature, experience more negative feelings about sexuality, and demonstrate evidence of lower ego development than do their on-time peers (Lindfors et al., 2007).

**Gender Identity in Adolescence**

Gender identity refers to subjective identification and expression of concepts ranging from feminine to masculine. Gender role socialization is acute during adolescence. Powerful external forces (e.g., family, peers, media) are actively involved in reinforcing gender role conformity, dictating expectations concerning appropriate manifestations of masculinity and femininity among males and females (Steinberg & Morris, 2001). A number of theories have been applied to gender identity development during adolescence and deserve some attention here. Social role theory (Eagly, 1987) contends that people behave in predictable ways based on the roles, rights, duties, responsibilities, and norms associated with a particular social identity. Reproductive activities and the physical size and strength of women and men are often used to account for gender differences, although this line of thinking is typically rooted in dispositional stereotypes, conventions of division of labor, and hierarchies of power and status (Eagly & Wood, 1999). Thus, cultural expectations concerning appropriate gender behavior are rationalized as stemming from physiological differences, and they are
enacted and reinforced by gender stereotypes and tradition (Hoffman & Hurst, 1990; Williams & Best, 1982).

At the center of the cognitive-developmental approach to gender (Kohlberg, 1966, 1969) is a complex interaction among multiple gender-related constructs, such as gender identity, stereotypes, scripts, self-perceptions of masculinity and femininity, and expectations about others’ gender-appropriate behaviors. Gender schema theory, first developed by Sandra Bem (1981) and later expanded by Carol Martin and Charles Halverson (1981), refers to representations of what it means to be male and female that children learn from the cultural norm and expectations relevant to societal classifications of masculinity and femininity, including human anatomy, social roles, and personality characteristics. A gender schema is an organized set of gender-related beliefs that influence behavior that are reinforced by societal expectation of appropriate gendered conceptions of what it means to be male and female. Thus, children learn to cognitively process and categorize new information in their environment based on its maleness or femaleness. Information that does not fit the gender schemas tends to be either forgotten or distorted to fit the schema. Basically, we learn to see and organize our understanding of the world through gender stereotypes.

Martin and Halverson (1981) asked five- and six-year-old children to recall pictures of people and found they recalled more gender-consistent ones (e.g., male football player) than gender-inconsistent ones (e.g., male nurse), suggesting that even at this age young children have inflexible ideas (schemas) regarding gender. In a longitudinal study of children’s beliefs about gender stereotypes, Trautner and colleagues (2005) found that gender rigidity was at its highest between the ages of five and seven. Gender inflexibility significantly decreases by age 10 and notably typically increases again during adolescence, as gender identification becomes a central task in identity development.

Erik Erikson (1970) underscored the salience of identity exploration during adolescence, noting that central to establishing and understanding the emerging self is the task of gender identity development, which he described as a crisis of identity versus identity diffusion. Expounding on the work of Erikson, James Marcia (Marcia, 1966) developed a conceptualization of identity by underscoring that the balance between identity and confusion lies in making a commitment to an ideology or identity and involves separating from childhood beliefs during a time in which exploration of identity possibilities can occur. Erikson (and later Marcia) specifically addressed the psychosocial processes of adolescent identity development as a series of four statuses to be resolved: Identity Diffusion, Identity Foreclosure, Identity Moratorium, and Identity Achievement (Erikson, 1970; Marcia, 1966). Identity diffusion is a state in which an adolescent has yet to make a commitment and choices remain uncertain. Foreclosure involves making a commitment to an identity before alternatives have been explored, often based on parental standards, beliefs, and ideas or strong peer influences. Moratorium is a period of time when a youth pursues exploration of identity possibilities, but does not make a commitment, which may endure
well into young adulthood (or beyond). Identity achievement is reached when an individual makes a commitment to and personal investment in a particular identity, after having explored options.

Families actively play a role in gender socialization by the ways in which they organize the environment for children, how they are dressed, the toys they are expected to play with, and the behaviors in which they are expected to partake (Lytton & Romney, 1991). Further, parents model sex-typing in their own behavior and preferences. Sex-typing is the development of gender-related differences in children that shifts with age and includes stereotypes around such characteristics as physical appearance, activities and interests, personal-social attributes, gender-based social relationships, stylistic and symbolic content, and gender-related values (Huston, 1983; Ruble & Martin, 1998). Parental differential treatment has a great impact on gender development, sex-typing, and self-perceptions through the emotional reactions to certain behaviors, the importance they place on acquiring certain skills and attributes (e.g., boys and athletics, girls and nurturing), and the gender-stereotypical activities and toys they make accessible (Peters, 1994). In returning to the topic of early pubertal timing, for example, girls who develop early tend to be subject to many more restrictions than are enforced on boys. For example, girls are more likely than boys to be subjected to menstrual taboos, dress codes, and increased supervision (Petersen, Silbereisen & Sörensen, 1996).

Peers also serve as an important source of gender standards. Adolescent females classified as masculine or androgynous (having characteristics of both masculinity and femininity) in gender-role orientation were found to have higher self-esteem than adolescents classified as undifferentiated (having neither strong masculine nor feminine characteristics) or feminine (Mullis, 1987). Youth are likely to react when their peers violate gender-typical behaviors, and boys’ cross-gender behaviors are more likely to meet with negative reactions from peers. Reactions from peers typically result in changes in behavior, particularly if the feedback is from a child of the same sex. This pattern of responsiveness may lead to gender segregation, which in turn provides opportunities to learn and reinforce gender-typical roles.

Modern adolescents also develop in an environment with generally easy access to technology. Male and female roles are portrayed in gender-stereotypical ways in television and many children’s books (Oskamp, Kaufman, & Wolterbeek, 1996; Ya-Lun, 2008), and children subsequently internalize these depictions of masculine and feminine roles and behaviors as part of their socialization process (Bem, 1981; Eagly & Wood, 1999). Social networking sites are quasi-public arenas for the exploration of identities and roles for many contemporary teens. Males are more likely than females to be portrayed as aggressive, competent, rational, and powerful in the workforce, whereas females are more often portrayed as involved primarily in housework or caring for children (Goodroe, 1998). In a study of gender differences in computer-mediated communication patterns in teen chatrooms, Kapidzic and Herring (2014) found
that boys tended to adopt a more flirtatious and overtly sexual tone, while girls’
communication was friendlier and less sexual. This study noted that selected
profile images (photographs) demonstrated gender differences, with girls’
self-representation in both dress and behavior being more seductive in posture,
gaze, and clothing, and boys presenting themselves in a wider variety of dress
and poses. Other researchers have found that young females in computer-me-
diated communications tend to present themselves as emotional and good lis-
teners (reactive), sexually available, and eager to please males, while young males
appear more assertive, manipulative, initiating, and visually dominant, while at
the same time more distant (Magnuson & Dundes, 2008).

Sexuality/Sexual Orientation in Adolescence

Same-sex behavior and attraction have occurred throughout history, yet lesbian,
gay, and bisexuality as categories of identity are constructs of modernity, emerg-
ing around the 19th century (D’Emilio, 1983). As shifts in dominant sexual
narratives (Hammack, Thompson, & Pilecki, 2009) give way to increasing social
space for adolescent sexual exploration, timing and sequencing of sexual iden-
tity development is increasingly individualized. Discussing sexual orientation
encompasses consideration for the myriad ways in which sexuality is experi-
enced and expressed. Sexual orientation is best described as a multidimensional
construct encompassing attraction, identity, and behavior and occurring across
a continuum (Laumann, Gagnon, Michael, & Michaels, 1994). For adolescents,
the operationalization and estimated size of the population is further compli-
cated because many youth resist strict categories and may identify strongly along
one dimension (e.g., attraction) but not along another (e.g., identity; Rosario,
Schrimshaw, Hunter, & Braun, 2006). The initiation of empirical explorations
of sexuality are often attributed to the early work of Sigmund Freud; however,
investigations into the sexual attitudes, feelings, and behaviors of adolescents
began gaining momentum only in the late 1990s, with growing complexities in
methodologies and increased clarifications in operational definitions.

Early researchers tended to approach sexual orientation as a linear and sta-
ble characteristic, unfolding predictably through adolescence, solidifying and
enduring through adulthood. For example, Troiden’s (1989) stages of lesbian and
gay identity formation generalize the process of minority sexual development
through four stages: Sensitization, Identity Confusion, Identity Assumption, and
Commitment.

During sensitization, usually occurring during puberty, youth gain expe-
riences that later serve as sources for validating their feelings as sexual minorities.
The sensitization stage is a period characterized by feelings of marginality and
perceptions of being different from same-sex peers, although a clear under-
standing of this difference as sexual is not always apparent. During the identity
confusion stage, individuals start to reflect upon their feelings and behaviors as
potentially homosexual. Confusion is the result of an initial belief that they are
heterosexual (i.e., the cultural norm) and the awareness of homosexual feelings and/or behaviors through reinterpretation of past events. This may be a time of inner turmoil, guilt, and anxiety, particularly if there is a lack of appropriate role models or persecution or alienation from peers or family. During identity assumption, identity confusion is resolved, and heteronormative expectations for behavior and desire are supplanted by models of sexual minority status. This may be the time when sexual minority identity is first shared with others and sexual experimentation occurs. Commitment is characterized by an internalization of homosexual pride and self-acceptance. Commitment may involve the integration for the sexual and the emotional aspects of sexual identity and includes one’s first same-sex love relationship. Sexual minority status is internalized as a valid and satisfying identity.

Research, particularly longitudinal studies, has since exposed sexuality as complex, culturally situated, and multidimensional, with nuanced gender- and ethnic-specific differences in developmental pathways (Rosario et al., 2006). In an ethnographic study of the processes that underlie sexual identity development during adolescence, Robertson (2014) demonstrated how sexuality is constructed for sexual minority youth through a process of meaning-making that actively violates heteronormative standards. Sequencing and timing of sexual identity development is complicated by social prohibitions for sexual minority youth. Heterosexism—the pervasive social system of attitudes, bias, and discrimination in favor of opposite-sex sexuality and relationships—Robertson notes, often makes communication of same-sex attraction dangerous, making it difficult for young sexual minority individuals to openly explore their sexual identity, delaying identification until late adolescence or early or middle adulthood. Yet Savin-Williams (1995) found that young men who described themselves as homosexual or bisexual recalled experiencing feelings of same-sex attraction by the age of 10 and reported that their first homosexual experiences occurred at around 14. The earlier a gay or bisexual male youth physically matured, the more likely he was to report an early onset of orgasms, frequent orgasms during his junior high school years, and an early age of beginning homosexual activity.

A noted delay occurs between timing of sexual attraction, sexual behavior, and sexual identification for many sexual minority men and women. For example, among gay and lesbian ethnic minority youth, a delayed timing of identity labeling and disclosure (coming out) is often associated with community stigma, internalized homophobia, and greater family pressure to conform to heteronormative standards (Manalansan, 1996). Ethnic minority youth face unique challenges at the intersection of racial and sexual identity formation, where cultural factors such as homophobia, religiosity, and familial obligations may act as barriers to fully committing to a sexual minority identity. For example, Craig, McInroy, Austin, Smith, and Engle (2012) noted that ethnic minority/sexual minority youth often use fluid and/or ambiguous terms to describe themselves, such as queer, pansexual, or straight, instead of conventional labels such as gay, lesbian, and bisexual. This language reflects the complexities of negotiating multiple, and
frequently conflicting, identities, and can certainly impact cognitive, social, and emotional functioning.

Although not a topic related only to adolescence, the issue of coming out—disclosing one’s sexual minority status—is an important one for assessors to note. More sexual minority individuals are coming out earlier, during adolescence, than ever before (Riley, 2010). Although historically, research has focused on the process of coming out as a positive one for sexual minority outcomes, such as closer relationships with others and positive personal feelings, like pride, relief, and authenticity (Evans & Brodio, 1999; Rosario et al., 2001) and even better physical health (Meyer, 2003), some research has begun to show that coming out is more complicated. Specifically, Legate, Ryan, and Weinstein (2012) found positive outcomes for coming out when the individual was in autonomy-supportive contexts but negative outcomes when he or she was in more controlling contexts. Feldman and Wright (2013) found that the components related to the positive aspects of coming out are explained by possessing a stronger sexual minority identity, which may include stronger supportive social connections. However, when taking more positive sexual minority identity out of the relationship between outness and mental health outcomes, the relationship becomes negative. The research on outness is still young, but for assessors it is important to understand the context in which individuals are coming out, including how much support they have, both online and offline (DeHaan, Kuper, Magee, Bigelow, & Mustanski, 2013).

Testing Considerations

Despite the overwhelming theoretical, and growing empirical, evidence that great gender differences exist, and specifically emerge, during adolescence, very little attention has been paid to this issue in the assessment literature. Few tests, if any, have undergone empirical scrutiny around gender differences, and those that have, have not had adequate discourse around whether gender differences are genuine trait differences between adolescent boys and girls or mere methodological byproducts. As such, the discussion of specific tests and specific testing issues in this chapter is extremely limited. Many of the empirical sources are quite old, if there are any at all. The goal is to help assessors take gender into account when using and interpreting specific tests with adolescents.

Some of the earliest inquiry of adolescent gender differences in specific assessable domains came from pioneering psychologist Eleanor Maccoby, as well as her student Carol Jacklin, who looked at gender differences in cognitive and academic abilities. While their work early on (Maccoby, 1966; Maccoby & Jacklin, 1974) concluded that there were significant gender differences in verbal ability (favoring girls), mathematics (favoring boys), and spatial reasoning (favoring boys), later work (Linn & Hyde, 1989; Maccoby, 1998) showed that these differences had disappeared and/or were certainly not consistently found.
Hyde and Linn (1988) reviewed the literature on gender differences in verbal ability and concluded that any systematic differences that do exist are negligible. Linn and Hyde (1989) also reviewed the literature on spatial ability, again finding no evidence of significant differences, except on one subtask of spatial ability, untrained mental rotation, which favors boys. Similarly, Hyde, Fennema, and Lamon (1990) found no evidence of true gender differences in mathematical ability, though others previously had found some (e.g., Benbow & Stanley, 1980; Jacobs & Eccles, 1985; Marshall & Smith, 1987). The National Science Foundation noted that high school girls are increasingly more likely to take advanced mathematics and science courses, leading to greater gender parity in scores on math performance measures (National Science Board, 2006). After an extensive review of the cross-national literature, Hyde and colleagues (2008) concluded that the gender gap in math performance is “largely an artifact of changeable sociocultural factors, not immutable, innate biological differences between the sexes” (p. 8801). A number of studies associate disparities in math performance with indicators of societal-level gender inequalities such as the gap between men and women in economic participation and opportunity, educational attainment, political empowerment, and health and survival (see Hyde et al., 2008). For example, Guiso and colleagues (2008) found a strong correlation exists between a country’s measures of gender inequity (scores on The Global Gender Gap Index) and the size of mean gender differences in math performance.

Further, psychosocial phenomena such as stereotype threat may play a noteworthy role in math performance discrepancies. Stereotype threat has been conceptualized as a decrease in test performance in situations in which individuals feel threatened by the prospect that their performance will confirm (to others and/or themselves) the accuracy of a negative stereotype (i.e., girls are not good at math) about their group’s ability in a particular performance domain (Steele, 1997). Anxiety associated with a sense of being stereotypically judged is presumed to deplete executive resources such as memory (Beilock, Rydell, & McConnell, 2007), lead to fewer attempts at solving problems on tests (Rivardo, Rhodes, Camione, & Legg, 2011), and create cognitive dissonance in one’s global self-concept (“I am smart”) and domain-specific self-concepts (“but, I am not good at math”), all of which contributes to underperformance (Nosek, Banaji, & Greenwald, 2002). Stereotype threat further results in impaired performance by offering a negative, self-blaming explanation for struggle and difficulty that feeds the internalized assumption that difficulties (e.g., in math) are due to internal, stable shortcomings. Interventions that have been successful at cognitively shifting the blame from pejorative attributions (one’s lack of intelligence) to nonpejorative ones (the difficulty of the context) have improved the math performance of female, minority, and low-income students (Good, 2003).

While it is difficult to ascertain the root cause of found gender differences across measured cognitive abilities, it may be even more difficult to evaluate personality and emotional differences. Between the cultural messages boys and girls
differentially receive, especially during adolescence, true genetic differences, and gender-biased instruments, many tests of emotional, behavioral, symptomatic, and personality issues in adolescence have opted to separate out the norms for boys and girls, comparing adolescents only within gender. While this may solve some potential bias problems within individual instruments, it also makes inquiry into gender differences and their etiology that much more difficult to examine.

**WISC-IV**

Despite the long history of inquiry into gender differences in cognitive ability, there is surprisingly little research on specific gender differences on the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV; Wechsler, 2004), the most widely used measure of adolescent cognitive functioning. As is true with all of these measures, the true reason for measured differences between boys and girls on any construct may be due to true differences or to measurement artifacts, and this has been especially argued in relation to cognitive functioning tests. Very little modern research has readdressed the question of gender differences on cognitive measures like the WISC-IV. One notable exception is a study by Goldbeck and colleagues (2010) that found gender differences on the German version of the WISC-IV. Specifically, they found that boys outperformed girls in verbal comprehension (VCI) and perceptual reasoning (PRI), but that girls outperformed boys in processing speed (PSI). Again, whether these are true differences or measurement artifacts is unclear. What is important is that we continue to be vigilant about taking contextual factors like gender into account when interpreting scores on measures such as the WISC-IV.

**MMPI-A**

Of the different widely used measures in adolescent assessment, the Minnesota Multiphasic Personality Inventory—Adolescent (MMPI-A; Butcher, Williams, Graham, Archer, Tellegen, Ben-Porath, & Kaemmer, 1992) has by far the most documented evaluation of gender differences. The MMPI-A is a self-report inventory measure designed to evaluate adolescent psychopathology. While there is a great deal of research on gender differences in the Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2; e.g., Greene, 1987; Dahlstrom, Lachar, & Dahlstrom, 1986), the equivalent adult measure, much less has been written about the MMPI-A. Still, there is more on the MMPI-A than most adolescent measures. Again, it should be noted that most of the research has been on using the MMPI-A to establish “true” gender differences on different traits, rather than addressing whether specific items or scales are gender-biased on the instrument itself.

A PsychInfo search in July 2014 on “MMPI-A” and “gender” yielded 38 results. However, 24 of those 38 results are dissertation abstracts, with no
peer-reviewed journal articles resulting from them. This suggests that more inquiry has been made, and likely there are more gender differences in MMPI-A responses than is currently accounted for in the literature. The MMPI-A is one measure that separates out norms for boys and girls, implicitly acknowledging an assumption that response rates are different between adolescent boys and girls.

Researchers have started looking at gender differences in responses to individual items of the MMPI-A. Archer (1997) found significant differences in response rates (at least 10% difference) between adolescent boys and girls on nearly 100 items. Many of these items were related to Scale 5, which is a measure of Masculinity/Femininity, which makes intuitive sense; many items on Scale 5 ask about stereotypical gender-based preferences, such as preference for fashion or auto mechanic work. However, some of the items were related to emotional factors like sensitivity to criticism and crying easily, showing significant gender differences. Han and colleagues (2013) found fewer gender-related differences on individual items on the MMPI-A than on the MMPI-2, but they did still find differences. These differences were consistent across cultures (American vs. Korean), and they were again related to stereotypical gender-based interests, emotions, and behaviors.

Beyond individual items, some researchers have looked at gender differences in the scales produced by the MMPI-A. Different researchers have found significant gender differences on several scales, including Scale 3 (Hysteria), Scale 4 (Psychopathic Deviate) Scale 5 (Masculinity/Femininity, which will be discussed later), Scale 8 (Schizophrenia), Scale 9 (Hypomania), Scale 0 (Social Introversion), the Immaturity Scale, and Alexithymia, among others (Bagby, Taylor, & Atkinson, 1988; Hathaway & Monachesi, 1963; Krishnamurthy & Archer, 1999; Moore & Handal, 1980). Others (e.g., Wrobel & Lachar, 1992) have reported significant gender-related single-scale correlate differences.

Martin and Finn (2010) evaluated the concept of masculinity and femininity (primarily from Scale 5 items, but also more broadly) on the MMPI-A. Some specific findings included the fact that Scale 5 correlates with the Immaturity scale and that the measure itself seems to conflate issues of stereotypical gender-based interests with gender identity, in a way that the MMPI-2 does not, in its measure of masculinity/femininity. More broadly, though, they found differences in the way adults and adolescents approach the issue of masculinity and femininity; adolescents “appear to make fewer distinctions between different aspects of masculinity-femininity” (p. 209). That is, the way the adolescents evaluated masculinity-femininity was less dichotomous and stereotyped than the way adults evaluated. It is important to note that there are likely both developmental/age effects and cultural/generational effects on the internal working definitions of masculinity and femininity.

Finally, although there is a dearth of work in the area, the MMPI-A has been applied to adolescent transsexuals identified as having Gender Identity Disorder (GID). De Vries, Kreukels, Steensma, Doreleijers, and Cohen-Kettenis (2011)
found that the adolescents in their sample with GID had significantly fewer MMPI clinical scales in the clinical range than did adult transsexuals with GID. It is important to note that the adolescents were given the MMPI-A and the adults were given the MMPI-2. Additionally, much like most of the research in this area, the purpose of this study was to use the MMPI to evaluate psychological difficulties, not to evaluate the application of the MMPI-A itself.

The MMPI-A has presented with enough evidence of significant gender differences between individual items, scales, and code types (scale correlates) to warrant caution when interpreting the measure. Archer and Krishnamurthy (2002) called for interpretation to be “appropriately conservative” (p. 148) when using the MMPI-A with non-white adolescents. Although the norms are separated for boys and girls, a similarly conservative strategy should be used when evaluating the effect of gender on the outcomes of the MMPI-A.

**MACI and PAI-A**

Much less research has been conducted on gender differences on the Millon Adolescent Clinical Inventory (MACI; Millon, Millon, Davis, & Grossman, 2006) and the Personality Assessment Inventory–Adolescent (PAI-A; Morey, 2007) even than the relatively meager amount of research on the topic of the MMPI-A. The MACI is a self-report inventory measure designed to evaluate personality patterns, personal concerns, and clinical symptoms in adolescence. The PAI-A is a self-report inventory measure designed to assess personality and symptomatology in adolescence. The MACI uses gender-separated norms, again seemingly in an attempt to pre-correct for gender bias in response rates to items and scales.

Although there are no specific studies on gender differences on the MACI, it is patterned closely on the Millon Clinical Multiaxial Inventory, 3rd Edition (MCMI-III), which has had some attention paid to gender. Specifically, Hynan (2004) cautioned that some of the personality disorder scales on the MCMI-III include items with significant gender-differential response rates that are not otherwise supported in the literature, implying that the measure may be biased in specific ways. Further research on both the MACI and the PAI-A is needed in order to evaluate the impact of gender on the data they collect.

**Rorschach Inkblot Method**

Depending on the system being cited, the Rorschach inkblot test is either a projective measure of personality functioning or a performance-based behavioral task that illuminates personality features and processing styles. It has long been used with adolescents to add clinically relevant data to psychological assessments as an indicator of discrete aspects of personality. Some work has been done on gender and the Rorschach (using multiple systems of coding the task, including the Comprehensive System [Exner, 2003]), but very little has been
investigated around this issue in adolescence. A notable exception is that Exner and Weiner (1982) found elevations in several individual codes from the Comprehensive System in adolescent girls, as compared to adolescent boys, including the code Y (an indicator of anxiety) and the Egocentricity Index. Although it is an extremely old study, Ames and colleagues (1959) found that adolescent girls tend to have greater response frequency (coded as R) than do adolescent boys; adolescent girls produced more responses to the vague task than do adolescent boys. Although seemingly a minor finding, Meyer (1993) found that response frequency significantly impacts many other scores and indices on the Rorschach. Thus, the fact that adolescent girls produce more responses may cause apparent gender differences on many other indices, whether or not they are in fact indicative of true gender differences. More recently, Meyer and colleagues (2014) examined gender differences on individual variables on the Rorschach in a youth clinical sample and found no significant differences.

**BDI-II**

The Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996) is a measure of self-reported depressive symptomatology. As noted above, rates of depression have been reported as much higher in adolescent girls than in adolescent boys (DeRose, Wright, & Brooks-Gunn, 2006). Albert and Beck (1975) found this to be true, using the original version of the BDI. In their study, they found that by age 13, 57% of girls reported moderate to severe depression, as compared to 23% of boys. It should be noted, however, that the normative standardization sample for the BDI-II is extremely limited (Beck, Steer, & Brown, 1996). Beyond only being 500 individuals, nearly two-thirds of the sample is women, and over 90% of the sample is white. They found for the BDI-II that women (both adolescent and adult) scored significantly higher (more than three points higher) than men on the measure. While similar results have been found more recently (Dolle et al., 2012), as always, it is unclear whether this reflects true sex differences in depression or gender bias in the measure.

**SII**

The Strong Interest Inventory (SII; Hansen & Campbell, 1985) is a widely used test geared toward assessing vocational interest. Vocational interest (and ability) may be important issues for adolescents, who are building their identities and preparing for their futures. As with all adolescent tests, not much is known about gender differences on the SII, though it does use separate norms for boys and girls, suggesting that there are significant differences in response rates to different items. In fact, Harmon, Hansen, Borgen, and Hammer (1994) found that between one-quarter and one-third of the items on the test, which presents job task possibilities and asks respondents to endorse interest or not, had significantly different response rates between men and women. These differences
were primarily in gender-stereotyped tasks, such as decorating, mechanic work, and fighting. It should be noted that these findings were specifically looking at respondents across the normative sample (all ages), and not just adolescents.

**Assessing Sexual Orientation**

Although there is rarely cause for the assessment of sexual orientation in an individual psychological evaluation, there is some research on best practices for evaluating sexual orientation on surveys. Saewyc and colleagues (2004) reviewed eight major school-based adolescent surveys that included questions about sexual orientation, comparing outcomes and wording. They concluded that in the evaluation of sexual orientation in adolescence, at least three different dimensions should be addressed: attraction, behavior, and self-labeling. However, they found that no single measure adequately addressed all three of these dimensions, and so when evaluating sexual orientation, multiple instruments may be useful.

**Assessing Gender Identity**

The literature on assessing gender identity and gender dysphoria in adolescence is less well developed than comparable literature on younger children. However, as a major task of adolescence is developing a sense of identity, which can include gender and sexual identity, it may be important to find ways to evaluate the extent to which adolescents are gender dysphoric or unclear or unhappy with their gender identity. There is some indication of an increase in the number of individuals who identify as transgender (Feldman & Bockting, 2003), perhaps related to slightly less stigmatization and negative sentiment toward gender and sexual identity issues. Gender dysphoria and identity problems have the potential to influence (and even underlie) many other issues in adolescence, and so it should be considered important to evaluate and take into consideration when interpreting other test data.

Zucker (2005) collected the primary instruments used to evaluate these different aspects of gender differentiation in adolescence. Among them were interviews (like Ehrhardt and Meyer-Bahlburg’s [1984] Gender-Role Assessment Schedule for Adolescents and Adults), questionnaires (like Berenbaum’s [1999] Activity and Occupational Interests and Berenbaum and Resnick’s [1997] Reinish Aggression Inventory), and even the use of specific components of projective measures (such as the Draw-a-Person test, reported by Hurtig and Rosenthal [1987]). However, most of these measures were not originally developed for studying gender identity or gender dysphoria, and most have questionable psychometric properties.

More recently, two measures have showed some promise in dimensionally assessing issues related to gender identity and gender dysphoria, as well as discriminating adolescents who have gender identity problems from those who do
not. Although psychometric data are sparse, the Utrecht Gender Dysphoria Scale (GDS) is a brief dimensional measure aimed at evaluating people’s daily stress related to feeling uncomfortable or distressed about being assigned to their biological sex (Cohen-Kettenis & van Goozen, 1997; Doorn, Kuiper, Verschoor, & Cohen-Kettenis, 1996). The Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIDYQ-AA) is a slightly longer, though still brief, measure that evaluates subjective, social, somatic, and sociolegal indicators of gender identity and dysphoria (Deogracias et al., 2007). Like the GDS, the single factor that emerges from this measure reportedly significantly discriminated between adolescents (and early adults) with gender identity disorder from those without (including nonheterosexual participants). The stronger psychometric information on this measure currently makes it the instrument of choice for gender dysphoric thoughts and feelings.

Conclusion

Clearly, with what is known developmentally about sex, gender, gender identity, and sexuality and their distinctive traits during adolescence, not enough effort has been made toward understanding their effects on testing. Much of the research cited above is quite dated, and many tests have simply made the assumption that adolescents should be compared only with others of their same biological sex. However, adolescents do not live only with others of their same biological sex. The world of adolescents is complex, diverse, and more nuanced than the binary labeling may lead some to believe. Gender becomes more salient with the onset of puberty; gender identity and sexual orientation become more pressing as individuals negotiate their own identities (a primary task of adolescence). Psychological assessment must take this context into account, even with the relatively sparse data on specific tests.

Practical Points

• As adolescence is a time when significant gender differences emerge in rates of specific types of psychopathology, as well as a transition period between childhood (when many disorders look like disruptive behavior, acting out, and/or irritability) and adulthood (when many disorders are more clearly discriminable), special attention should be paid to likelihood of certain pathology by gender, as well as social and societal factors that may influence the presentation of symptoms differently by gender.

• As most assessment tools for adolescents have not undergone serious scrutiny as to why different outcomes emerge for different genders (i.e., because of true population differences, problems with the social construction of certain disorders, or test bias), assessors should take gender, sex, and sexuality issues into account when interpreting data that emerge from these instruments.
• When sexual orientation and/or gender identity seem related to the overall psychological picture of the individual being assessed, assessors should consider including into the battery of tests some narrowband instruments related to these constructs, as they may modify interpretation of other measures employed.

Annotated Bibliography

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Robertson, M. A. (2014). “How do I know I am gay?”: Understanding sexual orientation, identity and behavior among adolescents in an LGBT youth center. *Sexuality and Culture, 18*(2), 385–404. doi: 10.1007/s12119-013-9203-4 *Comment:* The author presents a four-process model for how sexual minority adolescent boys construct their identity in a heteronormative, patriarchal society in which homonegative and masculine symbols abound and reinforce heteronormative development. From ethnographic work with gay male youth in an LGBT drop-in center, she suggests the four processes include violating their expected heterosexuality, seeking explanation for their sexual minority identity, exploring their own sexuality, and negotiating the different aspects of their identity.

References


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Accessibility

Access to information is rapidly increasing, from both the private and public sectors. Non-governmental organizations (NGOs), private organizations, and the public are all making information more easily available to the public. Yet, the challenge remains to provide access to information in an easily understandable format.
WHO I WAS, WHO I AM: GENDER AND GENERATIVITY IN THE ASSESSMENT OF OLDER ADULTS

Mary Languirand

As a geropsychologist, I spend a great deal of time participating in life review, both as change agent and audience. As people age, they often feel compelled to write and edit (and re-edit) their life stories, to “make sense of it all” and leave some moving narrative as legacy. Gender and sexuality shaped their experiences as deeply as did the times and places where they lived their lives, as intertwined as language and meaning, color and form. You can’t really perceive one without the other, and a gender-neutral history is unfathomable, lacking depth and dimension.

In this chapter I provide a brief overview of how gender, sexuality, and cohort effects contribute to and help shape the aging process. I address some existential and practical issues to consider in the assessment of older adults and the role of assessment in furthering self-understanding through life review.

Biology as Destiny: Gender Differences Across the Ages

Life expectancy is increasing in most Western societies (Laidlaw & Pachana, 2009), but women outnumber men at every age band, and live seven to eight years longer on average (U.S. Census Bureau, 2008; Kinsella & He, 2009). Because women live longer, they are more likely to be widowed and to live alone at some point. They are also more likely than men to be primary caregivers for others and to cope with their own chronic illnesses. As family and social structures are changing and becoming more fluid and more complex, new and different relationship patterns are emerging, and these changes are playing key roles in how care needs are met. Of necessity, women are becoming more adept
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at caring for themselves and at finding help in late life beyond traditional relationship patterns, better supporting their longer life spans.

Men and women traditionally engage in different activities and are exposed to different challenges, opportunities, stressors, and environments. Men are more “fragile” physiologically from cradle to grave, with higher rates of miscarriage, infant mortality, childhood illnesses, death by high-risk behavior, and ultimately, higher numbers of ailments in old age (Legato, 2008). This is due in part to genetic and biologic factors and in part to men’s greater exposure to higher-risk settings, violence, and toxic behaviors (alcohol, drugs, smoking), coupled with men’s lower likelihood to seek or accept help (Kaye, Crittenden, & Charland, 2008). As more egalitarian career access patterns emerge, observed gender differences may change (although see Calasanti, 2010, for a discussion of deep-rooted economic and social inequalities between the sexes). These societal shifts notwithstanding, for the foreseeable future you will be more likely to encounter women in your work with older adults.

Kryspin-Exner, Lamplmayr, and Felnhofer’s (2011) excellent review of some of the factors accounting for gender differences throughout life illuminates the complex interactions among brain/neurophysiology, hormonal impact, education, and the degree to which an individual can engage in the process of healthy, active aging. As the authors note, there are many studies looking at age or gender differences, but few assessing age and gender differences, and findings from studies that do exist tend to be equivocal or contradictory. While some trends suggest the existence of global performance differences between men and women throughout life on certain tasks (e.g., women show slightly better verbal task performance and men have better motor speed and visual accuracy), there is also evidence that these differences are modest in magnitude and get washed out by other individual difference factors when old-old individuals are considered. In short, the older you get, the greater the impact of person-specific experiences and interactions. As the oldest old (i.e., those over age 85) are the fastest-growing age group globally (U.S. Census Bureau, 2008), appreciation of individual variance—including individual variance within sex and gender—is key in the assessment of the elderly.

Not surprisingly, sexual orientation—like sex itself—plays an important role in aging. Currently, approximately 3 million older adults in the U.S. self-identify as lesbian or gay, and those numbers are predicted to increase proportionately as the population ages (National Gay and Lesbian Task Force, 2006). Databases are developing to describe the specific characteristics of these populations, who present with different patterns of age-related problems than do their heterosexual peers, due in part to the influence of prior discrimination and past and current social structures. Lesbian and gay elders are twice as likely to live and age alone (i.e., without a steady partner) and four times less likely to have adult children to call upon for help (Espinoza, 2011; Hillman & Hinrichsen, 2014). Lesbian and gay baby boomers are somewhat more likely to live with elderly parents than are their peers, providing and receiving care (MetLife, 2010).
Negative experiences with healthcare, less access to resources, internalized homophobia, and other factors specific to cohort effects can also contribute to delays in seeking treatment that lead to poorer health outcomes. Of interest, different groups appear to present different levels of risk for some health issues. Fredriksen-Goldsen, Kim, et al. (2013) note that lesbian elders are significantly more likely than their heterosexual female age peers to struggle with obesity and cardiovascular disease; Anderson (2009) found higher levels of alcoholism among lesbians than among their heterosexual counterparts.

**Gender and Personality Styles**

Cramer’s (2002) studies of the development of defense mechanisms in males and females suggest that they generally use the same defenses, but with different frequencies and in different ways, due in part to societal expectations and differences in socialization. (Of interest, she notes that one’s sexual orientation—rather than one’s biological sex—plays a particularly significant role in defense choice and expressed style.) Men typically employ defenses that externalize conflict and affect, while women are more likely to use defenses that entail modification of internal reality. Thus, males more often utilize projection, while women opt for denial and reaction formation. Because defense style impacts achievement motivation, creativity, self-regulation, and self-determination, women and men show different patterns of educational and career achievement, earning power, and other real-world outcome measures. For example, men who are high in the use of identification showed evidence of greater ego resiliency and lower alienation, while women who used more male defenses scored higher on measures of authority, superiority, and self-sufficiency—those positive aspects of narcissism that correlate with real-world success (Cramer, 1998). The data on members of both sexes who used the more primitive defenses such as denial indicate that such individuals are unpredictable and likely to engage in “fuzzy thinking.” However, women with these defensive styles were also rated as being interesting, expressive, and funny, while men were perceived as unstable and unreliable. Men who relied primarily on projection were perceived as paranoid, whereas women with similar styles were sociable and lively. The profound differences in the way the same behaviors are interpreted and reinforced socially yield very different outcomes in and for the sexes. Thus, in the process of assessing personality and preferred defensive style, the assessor should also try to get some idea of how the patient’s way of expressing him or herself is received by others.

The interaction of age, gender, and defense style needs further research. Of interest, personality change in the elderly is often associated with the onset of the initial phase of Alzheimer’s dementia (Balsis, Carpenter, & Storandt, 2005; Chatterjee, Strauss, Smyth, & Whitehouse, 1992) or other age-related cognitive changes (Donati et al., 2013). As a result, assessment findings that reflect evidence of departure from earlier personality styles may be used as early red flags of probable comorbid cognitive issues (as in Marijnissen et al.’s, 2014, vascular apathy
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hypothesis). Beyond these global shifts, the literature on age-related changes in personality/defense style in men and women yields some hard-to-interpret findings. Birditt (2014) found that old-old women used avoidant defense strategies more effectively than younger peers, but they did not include men in the study and did not collect longitudinal data. Hill Payne, Jackson, Stine-Morrow, and Roberts (2014) found increases in conscientiousness in elderly people with good social supports over time, suggesting that personality can and does change positively with age, but the study did not address gender differences.

One’s roles, relationships, and physical function all change with time, yet most of us retain a sense of self-constancy and essential core of sameness throughout life. There is much research to support the stability of many personality traits across the lifespan (summarized by Zweig, 2008). Negative as well as positive traits persist; the incidence of personality disorders in older adults is estimated at around 10% (Gutierrez et al., 2012; Widiger & Seidtitz, 2002). Rosario, Schrimshaw, and Hunter (2009) offer an extensive review of the research findings on personality development among GLBT youth, concluding that being a member of a sexual minority group per se does not appear to correlate with higher levels of adjustment issues. Conversely, Grant, Flynn, Odlaug, and Schreiber (2011) studied personality disorder incidence among older GLBT populations with substance abuse issues and found that borderline, obsessive-compulsive, and avoidant personality styles were overrepresented. Time does not always lead to positive growth and maturity. However, positive changes can and do occur, as people tend to become more conscientious and emotionally stable as they mature and assume socially responsible roles (Roberts, Walton, & Viechtbauer, 2006). While loss is inevitable, healthy people manage to adapt to new demands while preserving a sense of continuity with the past, integrating old knowledge with new insights. This often allows the older person to tap into previously unrecognized sources of strength and creativity.

Some disorders associated with volatile behavior and acting out (such as antisocial personality disorder, intermittent explosive disorder, and substance abuse disorders) decrease over time because of the increased mortality rates generated by the behaviors in question (American Psychiatric Association, 2013). Most of these disorders are more prevalent in men, offering yet another explanation for the feminization of older age cohorts: Men given to acting-out and self-destructive behavior tend to die off, the victims of their own choices.

How Gender Roles Are Affected by Cohort and Zeitgeist

Cohort counts: When and where one grew up, lived, worked, and raised one’s family (or opted not to raise a family) all affect gender roles profoundly. How we perceive and define female and male roles is shaped by the times and places where we live our lives. The impact of cohort is multifaceted, touching on beliefs, values, attitudes, expectations, financial/resource status, legal rights, health and educational opportunities, attitudes toward religion—virtually every
aspect of one’s experience. We internalize the views and beliefs of our surroundings, overt and covert, and incorporate them into our self-concept and sense of who and what we are. A decade’s separation in experience can sometimes be the equivalent of growing up in a totally different culture, even among those of similar background raised in the same city or neighborhood, and gender differences are profound. The complexity of the interactive effects of sex, sexuality, gender, and cohort is illustrated nicely by the differences between older and younger groups of gay and straight men and women with respect to attitudes toward homosexuality, particularly as regards the concept of gay pride. Older people readily recall when homosexuality was perceived as sick, illegal and/or sinful, and treatable and/or punishable, rather than something that could elicit pride or celebration. The younger group may find these ideas incomprehensible, having been raised to think of homosexuality as more mainstream. Factor in the effects of internalized homophobia for the older (and even the younger) LG groups, and you may well wonder how the discussion can go forth at all. Further issues arise when transgender variants—arguably even less well-understood and accepted than LGB populations—enter into the mix. Life story interviews with older transgender adults gathered by Siverskog (2014) present some invaluable accounts of how transphobic beliefs were conveyed and internalized in childhood (even when never overtly discussed), as well as how others reacted when the individual came out.

Many good assessors are also skilled historians, with much knowledge and curiosity about their patients’ lives and formative experiences. The better you grasp what it felt like to have lived in the timespaces that shaped your patients’ worldviews, the better you will be able to understand their current beliefs, behaviors, concerns, and needs.

**Culture, Subculture, and the Challenges of Assimilation**

Psychologists are trained to be sensitive to cultural factors. With that sensitivity comes the realization that no two people, no matter how similar their experience may appear, inhabit precisely the same world. Even within insular groups and closed settings, small variations can lead to substantial differences in experience. Cohen (2009) addresses some of the challenges and complexities associated with efforts to define and address the factors that significantly impact culture, including gender and cohort. Meaningful assessments need to consider and integrate these data—and those of sexual orientation and alignment—into the mix, as they can be important in contextualizing and interpreting an individual’s behavior (see Dadlani, Overtree, & Perry-Jenkins, 2012). Consider the experience of a heterosexual woman hailing from a culture that prizes subservience who spent her working years in a setting that requires assertiveness and strength to succeed, while maintaining a mild persona within her faith community. Which of her guises is the real person? Which of her personae will you access and assess when trying to determine whether she can manage her own
finances or make her own healthcare decisions? A gay man from a background that perceives homosexuality as deviant may have spent a lifetime hiding his true feelings and relationships; how would he be likely to react to a woman (or heterosexual men) assessor asking a neutral question about his marital history? The impact of such separateness and social marginalization on one’s feelings of masculinity or femininity, agency, and trust in the world are profound—and hard to fathom to an assessor raised in a far freer society.

In this context, DaRosa and colleagues (2014) studied which life experiences were considered most important among centenarians in the U.S. and Japan. Events related to marriage and family were the domains most cited in the U.S. sample, while the Japanese participants recounted historical events. American men were more likely to mention work and retirement, while American women valued family and children. Japanese women were more likely to mention marriage, death, and grief more than were their male counterparts, who focused primarily on work and retirement. Overall, the U.S. sample recounted more happy or positive events than did their Japanese peers. While these findings are challenging to interpret, they reflect the enormous complexity of factors involved in determining cohort effects.

Special Populations: Multiple Minority Status

Just as one’s cohort impacts gender role and personality, being a member of an ethnic or sexual minority group, or being differently abled, can complicate personality development and aging, as discrimination may have hindered access to healthcare, education, legal representation, and myriad social and career opportunities (APA, 2012; Hillman & Hinrichsen, 2014). A study by David and Knight (2008) addressed some of the difficulties in measuring and interpreting the interactions of sexual identification, race, age, and setting on attitudes and beliefs. On the positive side, these researchers also found that the energies directed toward defining gender and crafting gender roles outside of traditional paths allows for greater choice and mindfulness about relationships and lifestyles as one ages.

Of interest, some research suggests that the stress of having been marginalized and oppressed can sharpen survival skills that increase resiliency and optimize functioning in people of color (Constantine & Sue, 2006) and in gay men and women as well (Wolf, 1982; Riggle, Whitman, Olson, Rostosky, & Strong, 2008). Some older gay men and women also exhibit greater gender role flexibility, which allows for better adaptation to the demands of aging, affording a “wider repertoire of available coping tools and responses at their disposal as they age” (Ritter & Terndrup, 2002, p. 141). In assessing these patients, it is important to identify strengths and the ways in which they have grown or benefited from the obstacles they faced and surmounted. A good assessment experience may help them name and own those strengths.

Mabey (2011) identified an aspect of discrimination that may actually have had positive consequences for some of the oldest-old GLBT elders: Many of
those who felt forced to marry and procreate to hide their sexuality actually have larger social support networks than baby boomer GLBT peers who did not feel the need to conform. However, on average the GLBT elders still have smaller support systems than their heterosexual peers (Grant, 2010). Fredriksen-Goldsen, Kim, et al. (2013) estimate that one-third to one-half of elderly gay men live alone and lack adequate services and social support networks, while transgender elders have the highest levels of disability, stress, and poor mental and physical health (Fredriksen-Goldsen, Cook-Daniels, et al., 2014). MetLife’s (2010) seminal survey on GLBT groups found that bisexual adults had the sparsest social networks and fewest resources. These factors can increase risk for depression, substance abuse, victimization, and other late-life health and mental health problems.

The enhanced coping skills developed through adversity may be helpful in dealing with one’s cohort’s current response to one’s choices, which is often quite negative, per Kuyper and Fokkema (2010) and Siverskog (2014). I recall assessing a mildly developmentally disabled man with numerous long-standing chronic medical problems who had been admitted to a long-term care facility after the death of his elderly mother, who was also his primary caregiver. While still in the “getting to know you” phase of entry into that community, he appeared for breakfast in the common dining room wearing a frilly pink peignoir set. It was autumn, and his peers interpreted the behavior as a Halloween prank. He was hailed as a jokester and good sport and welcomed into the group, especially by the men. However, when his unusual wardrobe persisted and expanded to include elaborate wigs and decidedly feminine costume jewelry, the response changed significantly, and he was termed freakish and avoided by his peers. Educational efforts by the facility’s administration fell entirely flat; the group was not at all open to embracing this type of difference. The staff respected his choice (although many privately thought it strange). The treatment team realized that change in the milieu’s zeitgeist would come slowly, if at all, and wondered if he would be better served in another setting (although nobody could identify such a place locally).

As part of an assessment, I was asked to determine if this man understood the impact of his behavior on his probable acceptance by the group. He did. He had decided that he wanted to be “who he really was” once his mother would no longer be affected (as she had definitely not been accepting). He had always felt that his body “didn’t reflect who was really inside,” and he had yearned for greater congruence. Having been in special education classes and dealt with peers’ responses to his cognitive issues for many years, he was familiar with rejection from others, and he wasn’t worried about being ostracized. He insisted on being taken as is, even at the risk of further marginalization.

Assessment included discussion of his courage, sexuality, sense of self, sensitivity and consideration for his loved ones’ beliefs, and willingness to try on new behaviors (a phrase he really liked). Time passed, and the newness wore off. Some peers shunned him, but others risked social censure and got to know
him. He ultimately made some good friends who appreciated his strengths (a few even borrowed his clothes). They did not sway the attitudes of the majority, but he was left in peace and was at peace with his choices. He was ultimately buried next to his mother, wearing his favorite dress, appropriately coiffed and accessorized.

**Time Marches On: Age Matters**

We really do change with time; bodies fail, but ideally wisdom accrues and defenses improve. We become more able to use the knowledge gained from life experience. Who we were as adolescents and young adults morphs into someone more nuanced and complex. In assessing an older patient, the assessor must try to get a sense of who the person was and is and how he or she has changed and matured.

**Acceptance of Age-Related Physical Changes—Gender Differences, Global and Specific**

Laidlaw and Pachana (2009) and Levy (2003) note that negative stereotypes about aging can influence self-concept, self-esteem, health status, and will to live, with growing dread about what aging will bring. Signs of aging are perceived as harbingers of frailty, pain, and death, and they are resisted by both men and women. Both sexes have less positive attitudes toward body functioning with advancing age (Franzoi & Koehler, 1998), but older men exhibited slightly more positive body attitudes than did older women.

Solimeo (2008) studied gender differences in health behaviors and concerns and found that men more than women tend to focus on how symptoms make them appear to others, while women are particularly concerned about how symptoms impact on their abilities to fulfill their responsibilities. (One significant exception to this observation relates to the impact of treatment for prostate cancer on men’s ability to ejaculate, which was found to have particularly intense, negative effect on gay men’s sexual identity; see Martinez, 2005.) Laz (2003) conceptualized men’s pursuit of more youthful appearance as a means of alignment or identification with high-status social networks. Women’s body self-perception tends to be more negative than men’s from youth onward (Tiggemann, 2004), and it remains remarkably stable throughout life (Stokes & Frederick-Recasino, 2003). However, exceptions exist, tempered by orientation. For example, Thompson, Brown, Cassidy, and Gentry (1999) studied a small group of older lesbians, who felt that they rejected many societal definitions of beauty as they aged and became more accepting of broader, more encompassing definitions—with greater self- and other-acceptance with age.

When the American Association of Retired Persons (AARP, 2001) conducted a poll examining older Americans’ attitudes regarding aging and beauty, they found that the majority of older women (86%) and men (94%) who
responded were satisfied with their appearance. While few deemed “staying young looking” to be highly important (only 24% of women and 15% of men), women on average ranked this higher than men. Further, 60% of women and 57% of men acknowledged that they would opt to have procedures done that would make them look younger if cost and risk were not factors, with women tending to opt for surgical procedures and men for hair replacement. While people are not necessarily defined by appearance, it can play a significant role in self-esteem and life satisfaction, and a thorough assessment should tap this domain of self-acceptance.

There may be at least one practical reason for appearance consciousness in the elderly: Sexual interest remains moderate to high for the majority of women and men in their seventies. About half of men and over 20% of women age 70 to 80 remain sexually active, and the discrepancy is generally attributed to women’s relative longevity and resulting partner losses, rather than diminished interest (DeLamater & Sill, 2005). Of note, rates of HIV/AIDS infection are increasing significantly faster among older than younger adult males, particularly in African American and Hispanic gay men (Centers for Disease Control and Prevention, 2008). The skilled assessor will be mindful of the importance of determining patients’ current sexual behaviors and attitudes in the context of collecting a thorough history. The information can offer important context for interpreting individuals’ attitudes toward aging and sexuality.

**Perception of the Experience of Aging in Women and Men**

Traditionally, it was thought that men were more likely than women to struggle with age-related losses of career, role, and power, and to respond to these narcissistic injuries with depression and regression. In contrast, with age women were freed from nurturing duties and more able to seek new directions for self-fulfillment (Gutmann, 1981). However, recent studies have found that women are more likely to struggle with retirement (both their own and that of their partners; Van Solinge & Henkens, 2005). These differences are attributed primarily to financial concerns, as women tend to be more risk-adverse in their investment patterns and concerned about outliving their resources than are men (Lusardi & Mitchell, 2011). Calasanti (2010) argues that deep-rooted sociopolitical gender stereotypes and beliefs have generated and propagated significant differences in the power and financial resources available to men and women, which in turn had a profound impact on men’s and women’s perceptions of age. Thus, men respond to age-related changes as encroachments on their strength and privileges—foes to be fought and problems to be solved—whereas women see these changes as signs that they are losing their abilities to perform their traditional duties. They fear that in losing their usefulness, they may be less likely to be supported financially and emotionally as they age.

Like their heterosexual peers, older lesbian, gay, and bisexual people often get some social/affiliative needs met through their jobs, and many worry about
loneliness post-retirement (Kuyper & Fokkema, 2010). Wallace, Cochran, Durazo, and Ford (2011) found that older lesbian and bisexual women and transgender persons are more likely than their heterosexual peers to live in poverty, which may add further practical post-retirement concerns. MetLife (2010) surveys of GLBT populations also identified more financial issues in these groups and significantly fewer safety nets and resources (e.g., legal partner protections, long-term care insurance) in place. Presence of a steady partner and a reliable GLBT social support network ameliorate these concerns somewhat, but the fear of being in need and alone remains significant for many older lesbians (Averett & Jenkins, 2012). Heaphy (2009) illustrates how many GLBT elders address these fears by forming close, loving, families by choice who meet one another’s care needs Given the importance of these practical factors, the assessor should be sure to get some idea of the patient’s actual finances and resources, which can substantially impact attitudes toward aging.

**Generativity: Making Sense of It All**

Until relatively recently, theories of personality tended to focus almost exclusively on childhood events, largely ignoring what followed. While those developmental tasks are crucial, negating the importance of what happens during the bulk of one’s life makes little sense. Many key relationships and experiences don’t begin until adulthood has onset and subsequently persist for decades; those data must also be included in a meaningful review of older patients’ experience.

**Psychosocial Stages in the Second Half of Life**

Erik Erikson (1968) is generally credited with developing one of the first and most influential theories of how psychosocial development evolves throughout the lifespan. He identified generativity, or “concern for establishing and guiding the next generation,” as the essential task of mid- to late adulthood. Successful resolution ideally leads to the state of ego integrity, marked by a profound acceptance of one’s life as it happened, responsibility for one’s choices, and owning kinship with history. This experience is filled with wisdom, tradition, dignity, love, and “maintenance of the world” as the individual looks back in the last years of life—a pretty keen ending (especially given Erikson’s view that failure to successfully resolve generativity issues leads to “disgust and despair”). The importance of history—especially of the individual’s sense of his or her personal place in history—is central to achieving these final goals and offers a natural niche for personality assessment.

Of note, Erikson’s concept of time was heterogenic; that is, he conceptualized normal development and life milestones through a heterosexist progression of events. Halberstam (2005) and others raise the importance of considering “alternative temporalities” such as “queer time,” which is a life trajectory not scripted by heterosexual conventions and expectations of inheritance, marriage,
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and childrearing, but by key events in one’s establishment of a homosexual persona. It is postulated that life perspectives that are not bound by heterosexual patterns result in very different values, perspectives, and choices, and different life experiences might factor as important formative events. That said, it is reasonable to hypothesize that meaningfulness would remain a key value in any alternative temporality, even if generated by different experiences (see Rosario et al., 2009, for a discussion of GLBT sexual identity development in terms of Eriksonian theory). In examining elderly transpersons’ views on aging, Fabbre (2014) noted that the balance of time wasted or served versus time left to savor life in an authentic, mindfully considered gender experience is an extremely important concept as individuals within this group contemplate how they want to spend their last years. While very different in executed detail, making it count remains a central theme in these elders’ lives—and a key focus of assessment.

**Life Review as a Therapeutic Tool**

Revisiting Erikson’s (1968) model of the crucial developmental tasks of adulthood, life review allows individuals to interpret and integrate their experiences to make sense of their life’s meaning—and to manage anxiety regarding the prospect of their own death. To the degree that assessment furthers that review process, it can make a significant contribution to the individual’s sense that her life mattered, in that she can show that she mastered important skills or traits that allowed her to achieve her goals and to leave a lasting legacy. One’s life may not have been perfect (few are), and may have had much sorrow and loss (many do), but as long as it had meaning and purpose, it could be termed good. Greene, Graham, and Morano’s (2010) study of resilience in Holocaust victims’ life stories provides some excellent examples of the importance of how one made sense of one’s experience—even when that experience is fraught with pain and loss. Emlet, Tozay, and Raveis (2011) similarly showed how many older adults living with HIV developed positive coping and compensatory beliefs and behaviors, including self-acceptance and self-care, service to others, social support and connections, and personal responsibility.

**The Role of Gender in Life Review and Life Satisfaction**

Numerous studies of life satisfaction among older adults identified the importance of activity and health in both sexes (Smith, Kielhofner, & Watts, 1986; Umstattd, Wilcox, & Dowda, 2011). The ability to spend time on important relationships was also a key correlate of life satisfaction for both men and women (AARP, 2001). Income plays only an indirect role to the extent that it impacts on access to activities and people, but income per se was not directly predictive of life satisfaction. Instead, a sense of purpose or meaning in life is central to life satisfaction in older people of both sexes (Krause, 2007). Pinquart and Sörensen (2001) found that men tend to report more life satisfaction and
subjective well-being than women across the lifespan. Overall, the more active and socially engaged an individual is, the happier he or she will be, regardless of gender or orientation. Thus, Erich and colleagues (2008) found that transsexuals with good family support and relationships reported greater life satisfaction. Borglin, Edberg, and Halberg (2005) found that the meaning of home, how life was viewed, thoughts about death and dying, and telling one’s story proved to be areas of importance for quality of life in old-old people of both sexes. Being in a safe, known place where one can tell one’s story and connect with loved ones made an enormous difference in reported life satisfaction. A thorough assessment should address the patient’s baseline sense of past and current satisfaction with life.

**Existential Considerations: Will They Miss Me When I’m Gone?**

With advancing age, losses are inevitable. Loved ones die, children grow up and leave, work ends, things one cherished are no longer there. Resilience—the ability to go with the flow and accept those changes—has been studied extensively (see review by Denckla & Mancini, 2014), as have the personality correlates that allow one to coexist more or less comfortably with awareness of the idea of one’s own death (Kosloff, Maxfield, & Solomon, 2014). Gender affects both the types of concerns likely to be most prominent and the coping responses used to face them.

**Coping With Loss and Change**

Terror management theory is a framework initially proposed by Greenberg, Pyszczynski, and Solomon (1986), which posits that people respond to awareness of death with terror; reaffirmation of meaning and value in life help to manage this anxiety by reinforcing belief in literal or symbolic immortality. According to terror management theory, to the degree that age-related losses trigger death anxiety, more resilient people will buffer that anxiety by reaffirming their cultural worldview—including religious beliefs about immortality—and by seeking validation of self-esteem stemming from beliefs about the degree to which they fulfilled the criteria that would enable them to access said immortality. We deal with fear of death by reaffirming our sense of having purpose-driven, meaningful lives (Frankl, 1946/1984), and personality style impacts how one opts to ease these anxieties. Evidence indicates that certain repressive defensive styles actually afford better protection from terror. As these happen to be the more feminine coping styles, women (or anyone who relies on these styles) would be expected to manage terror better than men, but more research is needed to substantiate this hypothesis. Elders who practice active aging—women and men alike—report an enhanced sense of purpose and connection with loved ones and increased life and self-satisfaction (Umstattd et al., 2011).
While one’s own death is thought to be the ultimate source of terror, the loss of significant others also factors very significantly. Sexual orientation can complicate the experience of partner loss. GLBT persons who lose partners often face disenfranchised grief, as families and communities ignore their partner losses or perceive them as less important or less profound than those of heterosexual couples (Jenkins, Edmundson, Averett, & Yoon, 2014). They also often face significant legal and financial barriers to inheritance and death benefits that would automatically accrue to heterosexual partners and must therefore deal with daunting financial burdens as well as profound grief. The prospect of having to face these additional negative factors may further color these elders’ perceptions of death and loss, heightening anticipatory anxiety and defense.

**Facing Death: Writing the Final Chapter to Finish the Book**

Research on attitudes about death in the elderly reflect some interesting findings: Poorer perceived physical health is associated with the view of death as an escape and a relief, while poorer mental health (i.e., depressive symptoms) correlated with greater fear of death (Lockhart et al., 2001). Those attitudes, in turn, impacted decision-making about medical treatments, including end-of-life care; to the degree that you fear death, you may try to postpone it as long as possible, with little attention to resulting quality of life. However, there are many conflicting findings in this area. Bozo, Tunca, and Simsek (2009) offer an extensive review and discussion of the complex interactions between age, gender, and overt and covert triggers of death anxiety in the context of terror management theory. Generally, older adults are less defensive toward overt death reminders than are their younger counterparts, and they engage in more health-promoting behaviors without prompting than do younger peers. Overt mortality priming is more effective with younger people, who engage in more health-promoting behaviors than their elders in response to conscious threats to life and health. Some research suggests that women may endorse greater fear of some of the more literal/concrete aspects of death; for example, women voice more fear of being in the presence of dead bodies than do men (DePaola, Griffin, Young, & Neimeyer, 2003). Russac, Gatliff, Reece, and Spottswood (2007) found that women endorse more death anxiety than men at midlife but not in later years. A study by Missler and colleagues (2012) found that women had more fear of death than men, more anticipatory fear of the death of loved ones, and more fear about the impact of their own death on loved ones. The MetLife (2010) study of older GLBT groups found low fears of death in general in these groups but greater concerns about dying alone or dying in pain than heterosexual age peers. Culture and setting apparently play significant roles as well: Madnawat and Kachhawa (2007) found significantly more death anxiety in older women who lived with family in an Indian sample, but noted that this is in sharp contrast to Western findings. In the context of history gathering, the assessor should
try to get a sense of patients’ attitudes toward and expectations about death, contextualized within the framework of their cultural background and identity (Dadlani et al., 2012).

**Legacy and Peacemaking**

When we think about death, we increase our efforts to see ourselves as valuable people living in a meaningful universe (Pyszczynski, Greenberg, & Solomon, 2000), as these percepts allow us to access early feelings of security and protection ideally gained from relationships with strong, loving others in infancy. We also tend to increase our efforts to bond and ally with those we see as holding worldviews similar to ours, and those efforts can be an important part of life review, as we reaffirm our ties to predecessors and heirs, both real and symbolic (or as Erikson put it, become “part of history”). While the predecessors and heirs in question are often the patient’s actual family members, others may also be included, such as role models or mentees from the GLBT community. Coming to terms with our own mortality can also include mourning those paths not taken in life, the could-have-beens and should-have-beens that may have resulted if we had chosen differently. While people of both sexes often have some ambivalence and regret about these losses, the GLBT community may struggle with the additional sorrow of wondering what life would have been like if their lifestyles had been celebrated. A good assessment experience can reinforce the person’s sense of history and agency, reminding her of lessons learned, losses survived, connections with loved ones and role models, and strengths that helped her achieve her goals.

**Assessment of Older Adults: Practical Considerations**

When you assess an older person, you are reconstructing a life history (McAdams, 2013). The longer and more complex the journey, the more challenging this task becomes. Making sense of current capacities and strengths is best done in the context of the experiences that led to today. While straightforward narrative is important, you cannot meaningfully grasp history and personality through narrative alone; multimodal assessment is essential to broaden and deepen one’s understanding of the person (Hopwood & Bornstein, 2014). In addition to standardized tests, structured interviews, behavior samples, and direct observation of natural and structured tasks, you may have to rely on collateral sources or nontraditional means of gathering data, with appropriate cautions and awareness of potential biases (e.g., you may have to get some information from spouses, partners, or children, who might not have been around during crucial periods or who may be invested in perceiving and presenting the individual in a particular way). Unexpected sources can be helpful as well; in some cases, you may even be able to gather useful data from cohort peers from the same ethnic or cultural group.
Many resources address some of the issues of particular importance in the assessment of the elderly (including gender and orientation issues). The APA’s *Practice Guidelines for Psychological Practice With Older Adults* (2014) and *Practice Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* (2012) are essential reading, as are the handbooks developed jointly by the APA and the American Bar Association (ABA Commission on Aging and APA, 2008), which offer a wealth of practical information on proper capacity assessment in older adults. Familiarity with neuropsychological testing, functional skills assessment, and all forms of classic personality assessment are also priceless in this endeavor. You will want to become adept at smoothly accommodating all manner of perceptual, sensory, motoric, and ambulation differences. Forensic experience could be helpful, as evidence of age and gender discrimination in the workplace and GLBT bias in healthcare may arise from your work, and your report may prove helpful in righting some of those wrongs.

The experience of being assessed affects both the person assessed and the assessor (Bornstein, 2009). If you are going to work with older patients, you must confront your own ageism, which is sadly rampant among many otherwise-enlightened assessment psychologists. In fact, when Koder and Helmes (2008) studied attitudes toward aging in psychologists working with older adults, they found that these professionals actually held very negative attitudes about aging—especially the prospect of their own aging! This negativity was thought to be due to their high exposure to the minority of elderly experiencing high levels of distress, loss, depression, anxiety, and suicide. Further, most of their work was in assessment, rather than treatment, so it was thought that they rarely got to see progress, affirmation, and other positive outcomes. Zweig (2008) frankly references psychologists’ tendencies to hold lower reference points for normal personality functions among older adults; they unwittingly believe that normal aging invariably leads to emotional frailty, dependency, rigidity, and hypochondriasis, in spite of ample data to the contrary. It appears that many psychologists respond to exposure to older adults—or even the thought of their own aging—with increased death anxiety and concomitant defensiveness. The resulting distancing is in part a terror management strategy. Good training experiences and ongoing supervision can allow for more effective embrace of existential issues and more effective clinical work with older patients.

As a real-world stimulus with obvious age and gender characteristics, the assessor can affect the assessment process significantly, as Brabender and Mihura discussed in Chapter 1 of this volume. Whether the assessor is perceived as an insider or an outsider—ally or opponent—also matters. To the degree that your age, gender, orientation, race, language, and myriad other factors are apparent to your patient, you will by definition be perceived as an insider in some domains but an outsider in others (Dadlani et al., 2012). Your patients may assume that you easily grasp (or could not possibly grasp) certain things about their beliefs and values because of who or what you are or appear to be. This can be useful in allaying or empathizing or in eliciting patients’ willingness to teach you about
their worlds. However, such factors can also close a lot of doors until you learn to work around the resistances. That said, I have found that the vast majority of elderly people I have assessed were eager to tell their stories, to teach and explain. Good interviewing skills are priceless in this endeavor; you will, in essence, help people begin or continue the life review process in recounting their stories. You want patients to tell you how they came to where (and who) they are today. The tale is always a mingling of subjective experience, objective truth, presentation bias, and selective attention, but it is an essential part of the assessment process. As happens in clinical work, you won’t always get a sequential, logical narrative, but detours are often rich in material.

The longer a life, the larger the cast of characters and the greater the likelihood of unusual or unique events. In addition to all of the data you usually glean, you want to get a sense of who and what was important at each stage of life, who has come and gone, what resources were and are available to help them through transitions, and how they felt about themselves throughout life. Harking back to some queer time concepts, chronology and sequence may not be the most salient characteristics of the account; some events that were actually quite short-lived may be extremely influential, while long years—even decades—may be compressed into a sentence.

If you’re going to work with older adults, you are well advised to become conversant with age-related health issues and treatments, as they will make up a good portion of the interaction. That said, quite often, you will read a list of ailments and medications prior to meeting a person and assume that he or she is at death’s door, only to be greeted by a very robust individual who makes light of limitations. Older people are likely to have lived with chronic diseases for years (Laidlaw & Pachana, 2009) and to have made peace with the need to manage and accommodate those conditions. Try to develop a working knowledge of commonly used medications and their effects (including gender-specific effects). You might also want to learn how common ailments are addressed in your particular setting, as treatment patterns vary significantly depending on gender, location, income, and other factors. Departures from usual and customary treatment patterns can be important clues about how the patient is responding to the aging process. Departures may also reflect how the system is responding to the patient’s needs. A massive survey of healthcare experiences of GLBT persons by Lambda Legal (2010) found that many—especially minorities and those struggling with poverty—receive rough, prejudicial, substandard, or inappropriate healthcare. Some circuitous health paths may reflect the search for providers who will meet their needs.

Typical Referral Scenarios

Capacity

Many assessments ordered on older adults are done to assess functional cognitive capacities, usually with the aim of determining degree and/or type of dementia
and predicting the probable trajectory of functional decline. Often these evaluations are part of the legal determination of need for appointment of an agent or guardian to make practical, financial, or health-related decisions on the patient’s behalf. The patient rarely requests this type of assessment and may not fully grasp how the findings could be used. Test outcomes may have a very real, meaningful impact on the patient’s independence, safety, and quality of life.

Much has been written on the financial inequalities between elderly men and women, and women are far more likely to face poverty and limited resources. However, women are also more likely to accept financial advice and help from others (MetLife, 2011), and they may be more open than men to guidance and assistance that would allow them to continue to live more independently. Of note, there’s a dark side to this trust/dependence: Elderly women are twice as likely to be victimized financially as are their male counterparts, and perpetrators are usually friends or family members (MetLife, 2011). Surprisingly, research suggests that victims actually have higher financial literacy scores than nonvictimized counterparts, although they may have fewer social support resources (Acierno et al., 2010). Even among those who “should know better,” financial victimization is quite common and often a matter of intense shame and embarrassment. As some capacity evaluations follow events that reflected poor judgment, the assessor will take pains to avoid further shaming.

When doing capacity and guardianship need assessment, be sure to get an idea both of the person’s actual resources and of his or her attitudes and beliefs about them. Many financially comfortable women believe themselves to be destitute, while some with little beyond modest Social Security income assume that they’re well-off because they’re getting a monthly check. The resulting frugality or generosity could well impact quality of life. You also want to determine whether patients managed their own finances or relied on others for assistance with these matters and the degree to which they understand basic fiscal concepts (e.g., interest rates, credit scores).

Collecting Baseline Measures

These tend to be primarily cognitive or neuropsychological assessments. Quite often, these evaluations are requested by the patient, who has reason to believe that disease processes may lead to future impairment in cognitive functions or other capacities. Harking back to the different ways that men and women view the prospect of aging discussed earlier, women’s fears of being unable to perform their duties with age may trigger many of these assessments, while men’s need to defend their turf looms large. Some seek reassurance that they’re still fit to run a business, drive a car, or live alone, while others want the information to begin putting plans in place to ensure that they will get the type of care they want when they are unable to care for themselves, in a proactive terror management strategy. Still others seek the information as an impetus to provide for others’ welfare—often noted among older gay and lesbian patients,
who are concerned about the impact of their own mortality on their partners. Occasionally, patients seek to prove their capacities to loved ones, employers, or others who may have voiced some doubts, and outcomes can lead to some interesting therapy exchanges to address how those doubts impact the relationships in question.

**Determining Appropriateness for Psychotherapy**

Cohort-related challenges aside (several decades ago, seeking psychotherapy was considered taboo by many), as more older adults embrace active aging, they are also becoming more accepting of psychotherapy as a means of addressing their psychological challenges. Moreover, considerable research shows that many older patients use therapy very well, making significant gains and changes (CDC, 2008, 2009; Gum & Arean, 2004; Pinquart & Sörensen, 2002). Changes in how psychotherapy services are funded and made accessible to older patients may also lead to greater service utilization. Knowing that men may be more reluctant to seek or accept help, the skilled assessor can convey permission to older men struggling with issues that could respond positively to treatment and reinforce treatment-seeking behavior in older women as well, who may not be comfortable in a care-receiving role. Both sexes can be urged to use the tools available to help them make the most of their years—concepts that may also resonate particularly well with transpersons mourning “wasted” time. Elder-focused personality assessment may well emerge as a new niche for assessment specialists seeking to help therapists choose the best therapeutic approaches for their older patients.

**Tracking Progress/Documenting Change**

As funding increases, so will accountability, and therapies will have to demonstrate effectiveness more rigorously and more frequently. Assessments that measure how well older patients respond to psychotherapeutic approaches, new settings (assisted living or long-term care), rehab efforts, and other interventions may take on greater weight. Whatever the formal referral question, the assessor needs to determine what information the patient hopes to get from the experience, and to be mindful of how to craft the data-gathering and feedback processes to further that end. Ideally, the person will gain a new way of looking at herself, complete with articulation of her strengths, skills, vulnerabilities, and resiliencies. Those factors can go a long way in the process of self-understanding and self-acceptance that help one feel a part of history.

**Assessment Feedback**

A really good assessment report would make a great novel—or at least a riveting short story. Sadly, all too often your job is to write short, condensing
observations and findings into a few pithy paragraphs that your busy referral source can read quickly. Fortunately, the feedback session with the patient often provides an arena in which to provide affirmation, acknowledgement, and concrete suggestions to help the person make sense of it all.

Depending on the referral question, your feedback could truly prove life-changing to your patient and his or her loved ones. You may be able to illuminate some aspects of his or her experience and achievements that help form a real sense of generativity and purpose, bringing meaning (and even closure) to years of conflict or unfinished business. For every limitation, try to identify a strength or defense that might help to address, resolve, or circumvent it. (“You’re having some problems with memory, but you’re good at getting other people to help you.” or “You need more help now, but your determination to do things your way will help you figure out how to keep doing the things you love doing.”) You will have the unique opportunity to help the patient see how gender and sexual orientation spoke to these strengths, bringing color and style to the story. You’ll also get a great seat from which to witness—and influence—history.

**Conclusion**

Assessing patients long in years gives you a rare privilege to access living history. Maintaining mindfulness of cohort, gender, and sexual identification factors—and all their possible interactions—renders the task more challenging but infinitely more nuanced and full. As research and open exposure expand our understanding and acceptance of aging and of experiences outside of the heterocentric spectrum, assessors should be able to craft ever-better accounts of all the ways people live as sexual beings in a gender-rich world and to help them to celebrate the styles and strengths that enable them to do so for many decades.

**Practical Points**

- The population is aging, and assessors will be called on increasingly to address the needs of older men and women.
- Gender shapes experience throughout life; men and women experience and view age differently. The sensitive assessor will work to understand the interactions between gender, orientation, age, and other key factors across the lifespan.
- Cohort counts, and the skilled assessor will continuously be building working knowledge of the impact of the times and places that affected patients’ experience, especially as regards gender and orientation issues.
- Life satisfaction in older men and women correlates positively with activity, positive engagement with others, and the chance to share their experiences meaningfully and purposefully regardless of gender and sexual orientation, all of which can be furthered by a good assessment.
Gender and Generativity in Older Adults

Annotated Bibliography


Comment: This is essential reading for anyone assessing older adults.


Comment: A classic text, offering much practical instruction in assessment technique.


Comment: This volume captures some of the challenges of doing assessment with older adults.

References


Gender and Generativity in Older Adults


Gender and Generativity in Older Adults


Mary Languirand


PART VI

Looking Forward
As psychologists, we often are called to occupy multiple roles—that of therapist, assessor, researcher, scientist, supervisor. The list could be expanded upon, revised, and updated endlessly as we situate ourselves in a world that is continuing to develop and change. One important though not uncomplicated role we often find ourselves in is that of an advocate and an ally to underserved populations. We do advocacy because of personal desires to help those people in need and ethical principles that encourage us to take responsibility to reduce harm and increase well-being. Psychologists have been involved in testifying in court cases related to controversial practices, including segregation, torture, and recently conversion therapy (though sometimes on both sides of the debates). Cultural and system-level changes do not start, however, in the courtroom, and similarly psychologists do not only do advocacy through participation in large legal cases, local state amendments, and high-profile, newsworthy stories; we do so at an individual level too, when we work with our patients and when we train future professionals in our field.

This chapter seeks to provide guidance to psychologist supervisors and instructors in how to train assessors and clinicians to be culturally competent in working with diverse sexual and gender identities, including (a) emphasizing the importance of this dimension in assessment, (b) exploring various methods for conducting training, and (c) acknowledging challenges that may arise and possible solutions to address these challenges. Though sexuality and gender are very large domains that can encompass supervision issues around sexism (e.g., Bertsch et al., 2014) and gender-specific clinical presentations (e.g., Cochran & Rabinowitz, 2003), we primarily focus in this chapter on nonheterosexual and noncisgender populations to illustrate the factors involved in training in these
domains. At the heart of this work is motivating assessors and supervisors not only to be competent but also to be allies of gender and sexual minorities.

Importance of Training in Gender and Sexuality Assessment

Clinical work always requires an understanding of the culture and environment relevant to the client, and this understanding can be particularly important when working with sexual and gender minority clients. Unfortunately, clinical training programs often provide little, if any, specific training in the complexities of sexual orientation and gender identity, leaving trainees feeling unprepared to provide clinical services for these populations (e.g., Murphy, Rawlings, & Howe, 2002; Phillips & Fischer, 1998). It is important to remember that, both historically and currently, heterosexuality is assumed as the definition of normalcy, against which virtually every aspect of an individual is measured, with deviation from this norm viewed pejoratively (Herek, 1998). This heterocentric bias is often reflected in common assessment tools (e.g., Weiss, Hope, & Capozzoli, 2013). As a result, individuals who experience same-sex attractions or fantasies are many times witnesses or recipients of prejudice, stigma, and even violence when such norms are violated (Kilmer, 2004). In a seminal article on the mental health of gay men, Maylon (1982) noted:

Conformity brings acceptance, whereas differences, especially stigmatized divergences, result in alienation. . . . As a result, the adolescent psychosocial and ideational environment is not conducive to psychosexual congruency for the incipient homosexual. Instead, the adolescent homosexual is encouraged to obtain peer-group validation through the development of a false identity, that is, by the suppression of homoerotic promptings and the elaboration of a heterosexual persona.

(p. 60)

Thus, as a consequence of growing up in a heterosexist society, as well as the likely possibility of witnessing or receiving punishment for such social deviation from the heterosexual norm, a sexual minority individual may internalize society’s negative attitudes toward and perceptions of sexual minorities (Herek, 1995). These negative beliefs are characterized by both overt and covert pejorative views of same-sex attraction and behavior and sexual minority features that the individuals perceive themselves possessing.

Reviewing the historical antecedents of the current societal climate toward same-sex attraction and behavior (see Herek, 2009, for a review) is important for understanding the presenting concerns of sexual and gender minority clients. Indeed, much research has investigated the link between perceived societal discrimination and psychological well-being among sexual minorities (e.g., Gilman, Cochran, Mays, Hughes, Ostrow, & Kessler, 2001; Herek,
Gillis, & Cogan, 1999; Mays & Cochran, 2001; Mays, Cochran, & Rhue, 1993; Meyer, 1995; Remafedi, French, Story, Resnick, & Blum, 1998; Sandford, de Graaf, Bijil, & Schnabel, 2001). Mays and Cochran (2001), in a population-based study, found that over three-fourths of lesbian, gay, and bisexual women and men had experienced discrimination—more so than heterosexual individuals, even after controlling for demographic correlates of discrimination. They also found an association between these experiences of discrimination and indicators of psychiatric morbidity. Additional population-based research has found gay/bisexual men more likely to be diagnosed with major depression (3.0 times more likely), generalized anxiety disorder, panic disorder (4.7 times more likely), alcohol dependency, and drug dependency, as well as comorbidity for two or more disorders, as compared with heterosexual men (Cochran, Sullivan, & Mayes, 2003). Additionally, Cochran and Mays (2009) found that the 12-month prevalence rates for major depressive disorder, generalized anxiety disorder, alcohol dependency, and panic attacks were higher among lesbian and bisexual women compared to women who identified as heterosexual. Further, some evidence suggests that bisexual individuals may be at the highest risk for psychiatric morbidity (Balsam, Beauchaine, Mickey, & Rothblum, 2005).

While various explanations for the higher prevalence rates of psychiatric disorders among sexual minorities have been posited, most emphasize the role of stigma. For example, Cochran (2001) argues that the elevated rates of psychiatric morbidity are likely related to the effects of social stigma regarding same-sex attraction and behavior. Thus, this social stigma may become internalized and manifested as various psychiatric morbidities and psychological distress. This is consistent with the Minority Stress Model (Meyer, 2003), which suggests that socially disadvantaged minority groups experience chronic psychological distress due to actual and perceived prejudice and discrimination. Indeed, perceived discrimination, in general and specifically related to one’s sexual orientation, is related to negative affect (Pachankis, 2007), poorer mental health (Kessler, Mickelson, & Williams, 1999), and decreased quality of life (Weiss & Hope, 2011). Similarly, social stigma is related to increased psychological distress (i.e., high prevalence of depression, anxiety, and somatization) among both male-to-female and female-to-male transgender persons (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). The impact of concealing a stigma, which is often the case of sexual and gender minorities who are not yet “out,” can be especially insidious (Pachankis, 2007) and should be taken into consideration during assessment. This is particularly important since persistent perceived stigma can result in vigilance toward threat cues, which are often mistaken for anxiety disorders instead of a reflection of the client’s environment (e.g., Pachankis & Goldfried, 2006). Additionally, clinician bias and not taking into account the impact of societal stigma can often lead to inaccurate diagnoses, such as misdiagnosing a sexual identity crisis as borderline personality disorder (Eubanks-Carter & Goldfried, 2006).
Approaches to Training: Strategies and Choices

There are several points we wish to convey, in light of the information presented in the preceding section and in the rest of this handbook, regarding the importance of and approaches to training in assessment of sexual and gender minorities. First, one should avoid making assumptions about a client’s sexual orientation or gender identity. While we are mindful of the time pressures and multiple demands that assessors face, it is incumbent that clinicians make no assumptions regarding the client’s sexual orientation, gender identity, and experience with societal stigma and overt and covert discrimination. It is also the assessor’s responsibility to ask for such information, rather than relying on the client to volunteer such details. In fact, asking these questions may convey to the client that the assessor is accepting and affirming of sexual and gender minorities, which is important for building trust and comfort. Conversely, not asking such questions may result in alienating such clients, seeming as if the clinician is either making assumptions or does not find such information relevant. Relatedly, the assessor should not assume that sexual and gender identities are directly observable. For example, a male who does not act stereotypically masculine or a female with stereotypically feminine traits should not be assumed to be gay or heterosexual, respectively. Additionally, one’s gender identity may differ from one’s current outward gender expression. It is important, however, to ask such questions in a precise and respectful manner. One common mistake we often see clinicians make is to confuse sexual orientation and gender identity. While some clients may be understanding of the clinician’s error, it is likely to alienate many clients and result in the assessor appearing uninformed or uncaring. In this chapter, we have provided several suggested assessment strategies that can be utilized in clinical interviews and intake packets (see Table 25.1).

Similarly, when training assessors to work with sexual and gender minorities, one may seek to educate trainees on the nuances and history of sexual and gender diversity, even if they identify as lesbian, gay, bisexual, transgender, or queer. We recommend that supervisors query their trainees regarding their knowledge regarding sexual and gender diversity (most likely within the context of a broader discussion of diversity) and their experience working with sexual and gender minority clients. Didactic and experiential training strategies will likely be a necessary next step. For example, a discussion of the complexities in various expressions of sexual orientation (including the correspondence or discordance between attractions, fantasies, and behavior; e.g., Klein, 1993; Morales Knight & Hope, 2012), gender (see Muehlenhard & Peterson, 2011), and gender identity (see Egan & Perry, 2001) should be a starting point. The trainee’s knowledge and experience can then be augmented with suggested readings (such as Eubanks-Carter, Burckell, & Goldfried, 2005; Herek, 2009; Walsh & Hope, 2010), role-plays, experiential exercises, and possibly live observation, depending on the needs of the trainee and resources of the supervisor. Implicit within this suggestion is that the supervisor is knowledgeable and up-to-date regarding clinical
considerations of sexual and gender minority clients. This groundwork likely requires continuing education, as important considerations such as preferred terminology are constantly updated as our knowledge on sexuality and gender becomes better developed.

**An Example: The VA Safe Space Campaign**

Given the need for systematic training in sexuality and gender, how might psychologists create change in their local settings? One way is through participation in and/or creation of local social justice–oriented training programs. Examples include safe space (also known as safe zone) programs. These programs have traditionally been used to address the creation of LGBTQ-friendly allies in high schools and on college campuses. As defined by Ayvazian (2004), “An ally is a member of a dominant group in our society who works to dismantle any form of oppression from which he or she receives the benefit” (p. 598). The focus on allies is key since larger cultural change cannot occur from the efforts of minority populations alone.

Recently, within the local Department of Veterans Affairs (VA) medical centers in the San Francisco Bay Area, we have begun adapting such a program to medical settings. Instead of creating safety for only students or trainees, however, we are creating safety for the veterans we serve as well as our LGBTQ colleagues. This VA version of the Safe Space Campaign is a comprehensive, adaptable training program open to all VA employees interested in increasing their ability to care for LGBTQ veterans and creating safety in their workplace. The goals of the training are to increase (1) awareness through gaining insights into the lives and experiences of LGBTQ people and of oneself, (2) knowledge through introduction to LGBTQ-related demographics, research, and history, and (3) motivation and ability to use one’s increased awareness and knowledge to create positive changes in one’s professional setting. Through partnerships among direct care services (psychology, social work), Equal Employment Opportunity (EEO) programs, and local hospital leadership teams, mental health workers are leading the way in making sure that not only are their own individual practices LGBTQ-friendly but also that the larger system as a whole is moving toward becoming a welcoming environment.

How can a student-body-oriented training program be adapted for more professional, clinically oriented settings? Put simply, we have creatively adapted traditional, experientially oriented practices (e.g., privilege awareness exercises) with an overview of clinical research data and active problem-solving exercises tailored to the individual settings. A danger we must confront in training professionals, however, is assuming that some information is too basic for medical providers (e.g., appropriate terminology, asking about gender and sexuality in the first place). In our experience, assuming basic competency is dangerous and often inaccurate (as will be discussed later in this chapter). Though psychologists are not always trained in depth on gender and sexuality, other medical
professionals often are even further lacking in such training. Nevertheless, the ethical codes of most helping professions address basic nonmaleficence and beneficence, and most professional settings emphasize good client/patient/veteran-centered care. Through these two avenues, psychologists can advocate for the need and creation of such training programs.

Systems-level changes do not occur overnight, and they do not happen through simple, single-target strategies. If leadership says, “You have to do this training because it is required,” one’s primary motivation comes from an external source. Not only that, but any internal motivation, however inchoate, is potentially squashed (Deci, Koestner, & Ryan, 1999; Deci & Ryan, 2002; Patall, Cooper, & Robinson, 2008). Similarly, if a single individual wants to create change, her or his efforts will be limited without the support of the larger system and leadership. For these reasons, Safe Space programs need to (a) garner support from both national and local executive leadership committees and front-line clinical staff and (b) incorporate strategies that enhance motivation (e.g., appeal to human empathy, share compelling stories and scenarios, emphasize common shared values such as social justice) and acknowledge the role of personal choice. In other words, dissemination strategies for trainings must come from top-down support and bottom-up cultural shifts and word-of-mouth (Darling-Hammond, 2005; Rogers, 2003). Through empowering staff and trainees, we are empowering our underserved clientele, a goal with which most of us can be on board.

As described above, the unique abilities and wide-ranging skills of psychologists also allow us to utilize effective, evidence-based strategies related to teaching, program development, and program evaluation. Training programs should be living organisms that grow and adapt to their ever-changing environments, while consistently utilizing teaching strategies that have been shown to be effective. Effective teaching strategies are often multifaceted and depend on the context but include active learning that incorporates role plays, discussions, experiential exercises, active problem solving through application of knowledge, and/or reminders to use acquired skills after the initial training has occurred (Davies, 2000; Stuart, Tondora, & Hoge, 2004). Fortunately, psychologists are uniquely equipped to put these practices, especially program development, in place and to ensure continued growth.

**Addressing Challenges: Potential Problems and Possible Solutions**

With initially high hopes and a sense of empowerment, we as supervisors and motivated agents of change inevitably confront challenges in training others. Though confronting challenges is inevitable, we can anticipate them and even turn them into opportunities to deepen our work and the work of our trainees.
Potential Problems

Challenges may be broadly categorized into issues around (a) implicit and explicit attitudes and discomfort, (b) dangerous assumptions, (c) difficult choices in assessment strategies, and (d) negotiation of boundaries.

Implicit and Explicit Attitudes

Research on the influence of personal attitudes on behavior has spanned decades. Though not without complexities and controversies, research has generally found that both implicit (unconscious, automatic) and explicit (conscious, thought-out) attitudes have overlapping and unique influences on behavior (e.g., see Greenwald, Poehlman, Uhlmann, & Banaji, 2009; Petty & Briñol, 2014). While the American Psychological Association (APA) has issued reports and practice guidelines related to the explicit attitudes and behaviors expected of psychologists (APA, 2012; APA Task Force on Gender Identity and Gender Variance, 2009), not everyone is aware of these reports. Furthermore, we believe the more insidious danger is often in implicit, unconscious forms of bias. Though personal religious, political, and cultural beliefs are important to value and respect, one’s role as a psychologist is guided by larger shared principles and ethics. When someone chooses the field of psychology, that individual is also accepting these larger values of the profession. Thus, programs and practitioners who actively go against these guidelines clearly need to be addressed.

Nevertheless, as explicitly LGBTQ-affirmative attitudes become more mainstream and popular, outward expression of underlying beliefs will likely go more and more into the closet, so to speak. Just as racism did not end after the civil rights movement, negative attitudes or general discomfort related to sexual orientation or gender identity will unfortunately persist. For example, a recent study including physicians and other professionals found negative biases against African American patients decades after the United States civil rights movement of the 1960s (Sabin, Nosek, Greenwald, & Rivara, 2009).

One way psychologists and trainees can exhibit negative attitudes and beliefs about LGBTQ clients is through diagnoses, case conceptualizations, or research studies that either do not take into account minority stress or underemphasize or overemphasize the role of sexual orientation or gender identity (Davison, 2001; Meyer, 2003). Gay and bisexual men, for instance, may be more likely to be diagnosed as having Borderline Personality Disorder when their presentation may be more consistent with difficulties in the coming-out process (Eubanks-Carter & Goldfried, 2006). Discovering biases like these is not a simple matter of asking trainees or colleagues whether they harbor a bias. Because of the social and professional expectations inherent in the area of multicultural competency, the already rocky nature of self-report—a data source heavily influenced by social desirability—is thrown into further question (e.g., see Boysen & Vogel, 2008).
While both of the authors work in a relatively liberal and affirming area of the United States, we have often encountered clinicians displaying implicit negative attitudes toward sexual minorities. One example witnessed by one author (BW) was a clinician who assumed that, because a client was accepting of her daughter identifying as a lesbian, she must have “latent gay desires” that were causing her psychological distress. This clinician’s theory was in spite of the client’s identifying as heterosexual and giving no indication of any same-sex attraction or desire. While we believe that this clinician was likely well-meaning, the remnants of underlying heterocentric attitudes, reliance on assumptions, and lack of direct assessment unfortunately led to an inaccurate case conceptualization.

As another example, one author (KO) worked with a veteran who was interested in exploring his gender identity. Though outwardly presenting as very masculine and preferring male pronouns, this veteran disclosed a lifelong struggle with his sense of being female. Other providers had heard his disclosure on an intellectual level, but because of his outward masculine presentation and heterosexual orientation, they did not assess further or aid the veteran in exploring his gender identity. All of his providers were knowledgeable, competent, and very LGBTQ-friendly, but they were still deterred by the lack of congruence between the veteran’s gender identity and expression. They assumed that if the veteran were “really female-identified,” he would dress and act like a woman. In cases like this one, the more psychopathology-related domains of assessment and treatment (being usually more familiar and observable) tend to trump the deeper, more complex work that may be most important to the client.

Notably, trainees must be assisted in recognizing that all of these issues around implicit and explicit attitudes can very much be present in clients themselves, regardless of their personal sexual or gender identity. Clients may be uncomfortable with questions about sexuality and gender for any number of reasons, including their own personal religious and political beliefs and internalized homonegativity, heteronormativity, or cisgender normativity. Client discomfort can create barriers to disclosing openly, working toward acceptance of one’s own attractions and/or identity, and accessing support socially or professionally.

Client discomfort, or the expectation of it, in turn, can also increase the trainee’s potential discomfort in even raising the issues of sexuality and gender. This discomfort can manifest in visible anxiety or ineffective and even silencing questions. An all-too-common example is when breaching the topic of sexuality or gender, the student-assessor asks questions or make statements like, “You’re straight, right?” or “I assume you aren’t transgender.” These utterances are compromises formed to address the conflict between the utility or need to ask and the desire not to pry or offend. Even the fear that one may offend is an example of the heteronormative and cisgender-normative culture within which we are all embedded. In order to assist readers, we have provided a brief guide for trainees (see Table 25.1) with suggested phrasing for interview and survey items to assess sexual orientation and gender identity in a culturally competent, respectful manner. These questions or others can even be incorporated into
intake forms along with other demographic information (e.g., ethnicity, age). Other options exist, to be sure, but these questions may provide important groundwork for adapting questions to fit the setting and goals of any particular assessment.

Though we have listed implicit and explicit attitudes as a separate potential barrier, they intersect with many other barriers. At the core of much of the following potential problems is this issue of implicit and explicit attitudes and beliefs. Keep in mind that it is not only negative attitudes or beliefs that are a danger but also those beliefs that oversimplify or ignore complexities of sexuality and gender.

**Dangerous Assumptions**

As mentioned earlier, a common issue highlighted throughout this chapter is the dangerousness of making assumptions. This danger is present on multiple levels. Given that implicit attitudes and beliefs are active and present in all of us, assuming our own competency and comfort with assessing sexuality and gender is a particular danger. When biases are unacknowledged or even projected onto others, they can exert more influence on our behavior. Blind spots can be present and remain unaddressed. For example, both of the authors have come across more than a few healthcare professionals who personally identify as LGBTQ or as allies but who still fail to ask about sexual orientation when it is relevant to their work, to confront negative attitudes of other providers (particularly transphobia), or to acknowledge a lack of competency when it comes to a particular subset of LGBTQ individuals.

Bisexuality tends to be a particularly confusing topic for professionals. One author (KO) has heard many colleagues share their agreement with the “bi now, gay later” stereotype present within both the heterosexual and the gay and lesbian communities alike. This assumption not only biases individuals against the validity of bisexuality as an identity, but it also assumes a single direction of any potential instability, which also differs by gender. That is, bisexual men end up with same-sex attraction only. For women, the stereotype is that bisexual women are just experimenting and will end up with a man in the end. Sexuality is much more complex than any single configuration or trajectory (e.g., see Diamond, 2008; Klein, 1993; Rosario, Schrimshaw, Hunter, & Braun, 2006; Vrangalova & Savin-Williams, 2012). The human mind, unfortunately in this case, often prefers heuristics and shortcuts over complexity.

Transgender individuals also regrettably confront ignorance and negative attitudes from providers. For example, even well-meaning providers who want to be allies may find themselves asking their clients inappropriate, irrelevant questions about whether full surgical transitions have occurred. If transgender clients feel safe, then they will be more willing to bring up these details, if they are relevant to care. In psychological assessments, personal curiosity is not the primary motivating factor for asking personal questions.
Recognizing personal blind spots can be particularly threatening to professionals or trainees who consider themselves generally knowledgeable and supportive of sexual and gender diversity. However, recognizing these blind spots is essential to providing competent care. As the editors of this handbook noted in their introduction, it is sometimes the mid- and later-career psychologists, who are often supervising, that may be lacking in formal training in sexual and gender issues. Instead of trying to cover up any areas we may be lacking in as supervisors, we should explore these openly and model for our supervisees how to develop competencies even after formal graduate training has ended. Learning is a lifelong process and one we can embrace, especially when it comes to areas of diversity.

**Difficult Choices**

Even with full awareness of the potential implicit and explicit biases we may hold and a greater understanding of the dangers of making assumptions about sexuality and gender, trainees and their supervisors still face difficult choices in selecting how to assess sexual orientation and gender identity. As with many other assessment topics, it is a careful balance between being comprehensive and being efficient. This can be especially challenging for trainees, who are learning and practicing a variety of complex clinical techniques while simultaneously attempting to maintain a variety of cultural competencies. Efficient approaches would include self-report-only methods with preselected categories based on the most common possibilities (e.g., checkboxes for heterosexual, gay, lesbian, and bisexual identity and male, female, and transgender ones for gender). Though many individuals may feel like they can answer these questions easily, many may not. Having your identity excluded in an intake questionnaire or form is a particular type of microaggression (see Sue, 2010), essentially implying that one does not fit within the accepted standards, whatever they may be.

A simplified, categorical approach also collapses across the many dimensions and components of sexuality that may all be equally important in a psychological assessment. For example, Klein (1993) conceptualized sexual orientation as comprising sexual attraction, sexual behavior, sexual fantasies, emotional preference, social preference, lifestyle preference (an outdated phrase referencing a sense of community), and self-identification, each of which are assessed with regard to the past, present, and one’s own sense of what is ideal (allowing for the proxy assessment of internalized stigma and degree of self-acceptance). When under pressure, like many trainees (and their supervisors) are, we may be more likely to inadvertently commit a microaggression because stress can compromise our ability for reflection and perspective-taking.

The nomothetic-idiographic distinction is particularly relevant to this area of challenge in assessment (e.g., see Salvatore & Valsiner, 2010). In scientific research settings, the nomothetic goals of generalizing across samples and coming up with general principles often tend to win out. However, in clinical settings, it
How to Train Professionals in Assessment

behooves us to acknowledge the idiographic nature of our work. After all, we are working with individuals with their own unique experience. A true idiographic approach to assessment of sexuality and gender is open, complex, and inherently more time consuming. Achieving this balance in clinical work can be challenging for trainees as well as seasoned assessors, who must be up-to-date on the constantly evolving understanding of the intricacies of sexuality and gender. For example, as described above, assessing all of the dimensions of sexuality defined by Klein (1993) would be more in line with an idiographic approach. Whereas Western cultures typically view sexual orientation as a relatively unidimensional construct, going into every assessment with the assumption of sexual orientation being just one thing can leave out essential information about any given individual. Similarly, gender consists of multiple aspects of a person’s identity and expression, which may align based on cultural expectations or may not. Disentangling these constructs is important for creating safety and gathering a more accurate, thorough understanding of an individual. Conveying understanding of these intricacies to clients can be incredibly useful at building rapport and conveying openness.

Further decisions lie also in whether self-identification or self-report is supplemented with “objective,” laboratory measures (e.g., sexual arousal based on content of sexually explicit images) or collateral sources of information (e.g., romantic partners, friends, family members). This level of assessment should most often be reserved for research settings, where these factors may be particularly relevant to issues of internal and external validity. It is not recommended, for example, that sexual arousal be measured for the purposes of a clinical assessment (in fact, this would be an unethical practice in the vast majority of cases). In the end, however, it may be useful to acknowledge any limitations of assessment methods, while also taking care not to express disbelief (or disrespect) for a client’s self-identification.

Professional Boundaries

Appropriate personal and professional boundaries are often important to maintain in supervisory relationships. This issue may come up when discussing sexuality and gender in that either or both the supervisor and the supervisee may have personal aspects of their identity that intersect with the subject. Both have to decide if self-disclosure is important, relevant, and safe and whether the clinical work or supervisory relationship may be threatened by either disclosure or lack of disclosure. A further complication arises when considering boundaries between the client and the clinician. What if the client asks the clinician about the clinician’s sexual or gender identity? What if the client and the clinician run into each other, particularly at establishments that suggest a certain identity (e.g., a gay bar, an LGBTQ bookstore, a local Pride celebration)? Sexual orientation and gender identity are important in that they may impact the venues one frequents and “community” in which one is involved. Because the LGBTQ community
is relatively small, the chances of running into clients, supervisors, or trainees and/or having nonsexual multiple relationships may be much greater than with individuals who do not share these aspects of identity (e.g., see Graham & Lid-dle, 2009; Shelton, Winterkorn, Gay, Sabatino, & Brigham, 2011). The trainee, supervisor, and client must decide whether to disclose their sexual orientation or gender identity and how disclosure will enhance the supervisor-supervisee or client-assessor relationship (for a broader review of disclosures, see Henretty & Levitt, 2010). These potential issues should be directly discussed and addressed whenever possible, though the individual factors at play and ultimate choices will likely vary by the particular situations and people involved.

**Possible Solutions**

Given the multitude of potential barriers and challenges in training an assessor to be competent and to assess accurately a client's sexual and gender identity, what can we do as supervisors to help address such challenges? Strategies may include those that (1) increase self-awareness of trainees, (2) clarify the goals of the assessment, (3) enhance motivation of others, and (4) incorporate support from colleagues and other supervisors For general recommendations and resources, see Table 25.1.

**Increasing Awareness**

In order to address any potential explicit or implicit biases, the trainee must first be able to identify them. Identifying bias, as alluded to earlier, can be a sensitive and complex process. If biases are left unacknowledged, however, the potential harm could play out at various levels of assessment and treatment (McHenry & Johnson, 1993). Acknowledging bias as a professional or as a trainee is fraught with challenges beyond social desirability; thus, it is important to frame conversations about bias in a nonjudgmental, inquisitive frame. Bias, especially implicit bias, exists because of external messages. They are not generated spontaneously in a vacuum because of an individual’s personality flaws. For example, even seemingly positive messages about LGBTQ individuals in the media often portray LGBTQ people as attractive, financially affluent, gay white men. Pop culture also talks a lot about the importance of having good “gaydar”—an offensive and narrow idea about how gay and lesbian people present (while also ignoring yet again bisexual identities). We imagine most readers have heard about gay men’s love of Broadway shows or lesbian women’s passion for hiking and sports. These stereotypes have no place in clinical assessments.

What we as supervisors can do is help our trainees (and peers) develop greater metacognitive skills in recognizing biases before acting on them (e.g., see Cooley, Payne, & Phillips, 2014; Yzerbyt & Demoulin, 2012). Supervisors must pay extra attention to establishing a solid and safe supervisor-supervisee relationship in order for the supervisee to feel comfortable exploring these biases
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<th>Domain</th>
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<td>Training and Resources</td>
<td>Directed readings, including:</td>
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<td>• APA Guidelines (2011, 2012)</td>
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<td>• Williams Institute (UCLA) <a href="http://williamsinstitute.law.ucla.edu/">http://williamsinstitute.law.ucla.edu/</a></td>
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<td>• HRC trainings <a href="http://www.hrc.org/">http://www.hrc.org/</a></td>
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<td>Assessment: Initial interview questions</td>
<td>“What is your gender? What was your sex at birth?”</td>
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<td>“How do you describe your sexual orientation or sexual identity?”</td>
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<td>Assessment: Survey or intake items</td>
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<td>- Other (Please specify: __________ )</td>
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<td>Visible signs of LGBTQ-friendly status</td>
<td>Safe space / safe zone images</td>
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<td>Human Rights Campaign logos</td>
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<td>Rainbow flags</td>
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<td>Transgender flag</td>
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<td>LGBTQ-oriented newsletters or magazines (e.g., in the waiting area)</td>
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*Note: Recommended interview questions are from the San Francisco Department of Public Health (2014). Recommended survey item for sexual orientation adapted from Vrangalova and Savin-Williams (2012).*
Kile M. Ortigo & Brandon J. Weiss

in supervision. Otherwise, these biases will be hidden and may be played out in clinical encounters. Part of establishing safety is also acknowledging important professional boundaries that are maintained even when exploring such sensitive material. You do not need to (and often should not) directly ask trainees about their sexual or gender identity out of context or at all. You do, however, want to create the same safety for them to disclose as you would any client or colleague. As a supervisor, given the greater inherent power, one’s own disclosure of lessons learned or other sensitive yet relevant information may help provide the safe space for the trainee to open up and explore his or her own areas of possible growth.

One potentially useful strategy is to encourage trainees to try out the Implicit Association Test (IAT) on their own to see how bias can manifest in less obvious ways. Several versions of the IAT are available at https://implicit.harvard.edu/implicit/takeatest.html, including ones specific to sexual orientation and gender (though at this time no transgender-specific test exists). In the context of training, it is likely best to let trainees keep their results confidential and to themselves while using this exercise as a way to encourage nonjudgmental conversations about biases that we may all have.

In addition, video review or, even better, live supervision are both very effective methods of training, particularly for newer clinicians and assessors, a practice consistent with the recently published APA (2015) Guidelines for Supervision in Health Service Psychology. One guideline calls for live observation of trainees. Benefits include not needing to rely on supervisee-report only, getting to see the verbal and nonverbal communications directly, and in the case of live supervision, being able to demonstrate effective assessment methods in front of the supervisee. In fact, modeling appropriate questioning of sexuality and gender may be a particularly useful first step in training green, or particularly anxious, trainees. In one author’s experience (KO), incorporating interactive exercises into trainings can be particularly helpful, even when live supervision or modeling is not possible. For example, in the VA Safe Space Campaign and other such trainings, attendees are not just passively handed ways to ask about a client’s gender identity or sexual orientation; instead, they are asked to choose possible ways they might ask. By seeing examples and generating their own methods, they can find their own language and are more likely to use it when appropriate. Role plays, where supervisors and supervisees take turns practicing, can also enhance skill acquisition within the context of a collaborative supervision relationship (for a comprehensive overview of supervision processes and approaches, see Falender & Shafranske, 2004b, 2008).

Clarifying Assessment Goals

With the complexities in methods and strategies for assessing sexuality and gender identity, trainees can feel overwhelmed with the myriad options, which are each imperfect in one way or another. To aid in selection of assessment
strategies, as with any area of assessment, the specific referral question and assessment goals are key. If the referral likely has relatively little to do with gender or sexuality, then simple questions about the client’s identity and behavior are probably sufficient. If, however, the evaluation addresses areas more related to sexuality and gender, then one can incorporate more complex and thorough methods (e.g., assessing all domains of Klein’s sexual orientation grid, gathering a developmental history of gender identity and expression). Especially when conducting a more thorough evaluation of these domains, it is important to explain to the client why these factors may be relevant and important. This transparency can go far itself in creating a safe space for the evaluation. One should also be careful to avoid only asking questions about sexual orientation and gender identity when one suspects some difference from the “norm”; that is, only asking about these domains when you suspect someone is not heterosexual or cisgender.

**Enhancing Motivation**

Perhaps the most difficult challenge to face is a lack of motivation to change one’s biased thinking or behaviors. A lack of motivation can come from explicit negative views of certain groups (e.g., sexual or gender minorities) or from a general sense of not having enough time or energy to put in the effort to create positive changes. Motivation problems can be present at all levels of the clinical and training system, from trainee to program or hospital leadership. Strategies for enhancing motivation, thus, differ at each level.

A universal, simple, and effective strategy, however, is to speak to an individual’s personal motivations. Prochaska’s Stages of Change Model (i.e., pre-contemplation, contemplation, preparation, action, and maintenance) may be a useful guide for determining where an individual’s level of motivation lies, for example (Prochaska, Norcross, & DiClemente, 1994). Techniques such as Motivational Interviewing seek to assess and move a person’s motivation from one stage to the next (Miller & Rollnick, 2013). In general, questions like the following may be essential to reflect on or to ask of the trainee (or others):

- Why is the trainee interested in pursuing psychology as a career?
- What values are espoused by the individual or the system?
- Even if money or less altruistic motivations are primary, how might culturally competent, effective assessment and treatment address these alternative motivations?
- What could help the trainee feel more motivated to ask about sexuality and gender?
- What would help him or her feel more confident in doing so?

Fortunately, most psychology trainees have some prosocial desires that can be employed to motivate growth in the area of positive sexuality and gender
assessment. In the event that a trainee is neither competent nor willing to gain competency in working with diverse sexual and gender populations, then our supervisory roles as gatekeepers may come to bear in order to protect the public’s interest (APA, 2015).

For institutions, however, there may be other priorities or demands on resources. Enhancing the motivation of a system is inherently trickier and more complex. However, one effective strategy, seen at VA medical centers and other hospital systems, is pursuing leadership status as part of the Healthcare Equality Index (HEI; Human Rights Campaign, 2014). The HEI is an indicator developed by the Human Rights Campaign to rate hospital policies, practices, and trainings that create an LGBTQ-friendly environment for patients and for their providers (for more information, see http://www.hrc.org/hei).¹ To gain leadership status, local hospital policies must explicitly be LGBTQ-affirming in terms of equal visitation rights, patient nondiscrimination, and employee nondiscrimination. In addition, a number of staff must be trained in LGBTQ patient-centered health care. Even more traditionally conservative institutions like the VA Healthcare System, being a federal organization, have encouraged their hospitals to participate in this process. Being considered a leader, in any area, is certainly a good carrot to dangle in front of administrators who may or may not be engaged in the overarching mission of providing a safe space for underserved populations.

Gaining Support

Last but certainly of no less importance is the necessity of feeling supported by peers and, if possible, institutions to which the supervisor and/or the supervisee belong. Feeling like the lone advocate charging the way can be exhilarating but also exhausting, particularly in a system or social context that is less supportive. When working with trainees who have less willingness to learn, we as supervisors can experience a range of feelings from frustration to a sense of hopelessness, depending on our own emotional proclivities. These feelings are normal, but they may be helpful to discuss with others outside of the dyad. Supervisors can gain support from people in their work context or in their own personal social network. Ideally, the values and competencies espoused by the supervisor are supported by the larger system and training environment.

There may even be times when bringing up these feelings can be productive inside the supervisory dyad. As with clients, unspoken emotions and ruptures can still play out in unproductive ways in the supervisor-supervisee relationship. Effectively sharing and working through these roadblocks may strengthen the training experience for all parties involved (Falender & Shafranske, 2004a). Whether and how to do so depends on the particulars of each situation. As with transference and countertransference, self-reflection on the factors involved is of paramount importance, and repairing a rupture in the supervisory relationship can lead to a stronger, more effective training experience for all involved.
Conclusions and Future Steps

In sum, as has been explored in various ways throughout this handbook, sexuality and gender are complex topics that deserve greater attention in psychological assessment. Training others to be competent and effective in working within these domains is accordingly also complex. Sexuality and gender are moving targets in the larger sociocultural context and are multifaceted within each individual. These qualities require us to continue to adapt, learn, and grow to maintain our own competency and the competency of our trainees and colleagues. Our roles as psychologists also allow us to help systems as they develop programming and update practices to (a) address better the potential barriers to access to care and to providing effective care and (b) acknowledge the benefits of offering more comprehensive and inclusive services.

Creating change requires a combination of top-down and bottom-up strategies, in which psychologists can play a crucial role. We are capable of creating and evaluating effective training programs, and we are equipped to help translate the needs of underserved populations to other disciplines, such as medicine and administration. Recently, one author (KO) was facilitating an interaction between a transgender veteran and a medical doctor new to transgender health care. The physician expressed concern about directly asking about the gender identity of her clients and knowing which words to use. The veteran eloquently stated, “A silent mouth does more harm.” It is by ignoring or failing to ask about sexuality and gender that one can do the most damage to the care of clients. Getting past our own anxiety and discomfort with breaching the topic is an important step in providing competent care of all clients, as well as in providing appropriate training to other current and future providers. The influential AIDS activist group AIDS Coalition to Unleash Power (ACT-UP) used the slogan “Silence = Death.” We believe a similar message is relevant to clinicians providing assessment and clinical care that is unbiased, comprehensive, and—perhaps most importantly—affirming. Where silence can harm, direct communication, inquiry, and support can mend.

Practical Points

• Sexual orientation and gender identity are multifaceted, complex, and vital areas for trainees to understand and learn to incorporate in clinical assessment. Unfortunately, clinical training programs often provide little, if any, specific training and supervision in this area.

• Just as one should not assume clients’ sexual orientation or gender identity without specifically assessing them in a culturally competent manner, supervisors should not assume that their trainees already have a sophisticated understanding of the nuances of sexual orientation and gender identity. Nevertheless, at times, the trainee may be more knowledgeable in some areas and even have to educate the supervisor.
Specific challenges in assessment of sexual orientation and gender identity include implicit and explicit attitudes and discomfort, biased assumptions, difficult choices in assessment strategies, and negotiation of boundaries.

Increasing self-awareness of trainees, clarifying the goals of the assessment, enhancing motivation of trainees and others, and incorporating support from colleagues and other supervisors are vital components of training in the culturally competent assessment of sexuality and gender.

Annotated Bibliography


*Comment:* These guidelines are essential for guiding ethical clinical work, including assessment, with sexual minority clients. Attitudes toward sexual orientation (e.g., nonheterosexual sexual orientations are not mental illnesses; psychologists should strive to distinguish sexual orientation from gender identity), workplace issues, education and training, and research considerations are just a few of the areas covered. Each guideline is supported by descriptions of its rationale and application, as well as a review of the literature supporting the particular guideline. These guidelines should inform the practice of every psychologist, and it would be particularly beneficial for these guidelines to be initially reviewed early in training.


*Comment:* This book provides a helpful overview of clinical work with sexual minority clients. The authors are researchers and clinicians who are experts in the field of culturally competent mental health care of sexual minority clients. Assessment, case conceptualization, and treatment planning are reviewed within a cognitive-behavioral framework. Treating depression and anxiety and conducting couples therapy are particularly highlighted. How the case conceptualization and treatment plan are influenced by the client’s sexual orientation (or not) is described and illustrated with detailed examples that clinicians will find interesting and applicable.


*Comment:* This seminal article describes the Minority Stress Model, which is a useful framework for understanding how prejudice and stigma can impact the mental health of sexual minorities. Meyer details how external, objective stressful events (e.g., discrimination), expectation of such events and the associated (sometimes adaptive) hypervigilance, and internalized negative societal attitudes can result in mental health disparities among sexual minorities, as well as other marginalized groups. The role of coping and social support in attenuating the negative impact of proximal and distal stressors is also highlighted. These concepts are essential for assessment, case conceptualization, and treatment planning. While the articles focuses primarily on theory, the clinical applications will be readily apparent to both experienced clinicians and trainees.

Note

1 Note that psychologists should be aware that HRC’s inclusion of gender diversity and transgender advocacy has been traditionally lacking. However, recent efforts by HRC
have started addressing these issues. Any trainings or advocacy done in educational or treatment programs should not be limited to what is done or emphasized by any organization, including HRC.

References


Sex, Gender, and Psychological Assessment: Integrating Principle and Feminist Ethics

Patria J. Alvelo, Nancy Maguire, and Linda K. Knauss

Psychologists practice assessment in accordance with the American Psychological Association’s (APA, 2010) Ethical Principles of Psychologists and Code of Conduct, which reflects both the core values and enforceable standards of the profession. Because the APA ethics code is necessarily broad in order to cover all activities of psychologists, it cannot possibly capture in detail all aspects of all clinical situations. Therefore, many supplemental guidelines and alternate ethical codes have been introduced to highlight particular ethical facets of practice situations. Those that apply to gender and sexuality include the Guidelines for Psychological Practice With Girls and Women (APA, 2007), Guidelines for Practice With Lesbian, Gay, and Bisexual Clients (APA, 2011), and The Feminist Therapy Code of Ethics (Feminist Therapy Institute [FTI], 2000). Adding a feminist ethical perspective to the practice of psychological assessment can help clinicians engage in a process of mindful self-monitoring to achieve a more thorough understanding of the complex interplay of issues of sex, gender, and power, thereby preventing more subtle ethical violations from occurring.

While definitions of feminist therapy vary greatly, most feminist therapists would likely agree that empowerment of clients is central to feminist praxis. Through a systematic analysis and unpacking of societal inequities and social location, feminist therapists seek to help clients uncover sources of disempowerment in their lives, reframe their distress and dysfunction as attempts to reclaim power, and implement new strategies to move toward empowerment. The formation of an egalitarian relationship is central to feminist clinical practice. While the relationship between therapist and client (or tester and testee) is inherently unbalanced, feminist therapists/assessors attempt to actively acknowledge and
overcome this power differential. Rather than focusing on the therapist or assessor as expert, feminist clinicians value and privilege the unique experience and knowledge of their clients (Brown, 2010). As Hill (1990) observed, “In both therapy and politics, transformation means finding a way to give voice to the unheard, to embody the invisible” (p. 57). The feminist therapy relationship strives to cultivate and enhance a sense of power within rather than power over (Smith & Douglas, 1990).

In an effort to illuminate the spaces left unaddressed by the APA ethics code, members of the Feminist Therapy Institute began the process of developing The Feminist Therapy Code of Ethics in the 1980s (Rave & Larsen, 1990). The Feminist Therapy Code of Ethics (FTI, 2000) is meant to add to, rather than replace, compliance with the APA ethics code. Consistent with General Principle E: Respect for People’s Rights and Dignity of the APA Ethics Code (APA, 2010), The Feminist Therapy Code of Ethics urges practitioners to recognize the equal worth of all human beings. The Feminist Therapy Code of Ethics also encourages practitioners to be aware of the impact of disempowering societal and cultural forces, such as sexism, racism, classism, and homophobia, to name a few. The code is subdivided into five areas: cultural diversities and oppression; power differentials; overlapping relationships; therapist accountability; and social change (refer to Appendix to Chapter 26 for the full text of the code).

An ethical feminist assessment is dimensional, not categorical, in either the view of the individual, sex, gender, or any other identity, such as race or ethnicity. It confers respect as in a quality of looking up at people, versus looking across, as in an empathic view, or looking down, in a power-over view. Applying feminist principles to psychological assessment leads to an ethic of care, which prioritizes the impact on the relationship between provider and client when making ethical decisions (Black, 2005). This approach is consistent with the principles of collaborative assessment, pioneered by Fischer. Fischer writes that “exploring contexts allows us to reach people in their worlds, from which they extend, grow, and change. Indeed, we are reminded that just as we are not static as we engage our clients, so too are they in lively flux—they are not an assemblage of traits or even of set patterns and dynamics” (Fischer, 2000, p. 5). Feminist and principle ethics work in a complementary manner to create the fullest possible view of an individual, including all identity dimensions, such as gender and sexual orientation.

Intersectionality (Crenshaw, 1991), which is itself feminist, creates a dimensional understanding of the multiple identities an individual brings to an assessment, while also allowing for the identities to be temporally mobile. The intersection of gender and sexual orientation creates a dimensional understanding of both identities. Sex and gender can be understood as identities ranging from male to female and masculine to feminine, while sexual orientation includes gay, lesbian, heterosexual, and bisexual identities. An individual can therefore be at an intersecting point of these dimensions. The feminine, gay man or the androgynous, asexual woman can be understood from the concept
Integrating Principle and Feminist Ethics of intersectionality as two points on intersecting dimensions (see Chapter 2 of this volume for a more in-depth discussion of intersectionality).

The intersection of feminist theory and multicultural therapy creates a postmodern view of real people having real struggles without imposing the vertical response inherent to power hierarchies, wherein authority lies in a “higher” power and outside of the individual (Rodis & Strehorn, 1997). This opens up the view from the interior individual to include culture and society. This knowing and integration of the individual into a contextual, mobile knowing becomes an essential ingredient in assessment. This is more simply stated by Brabeck and Ting (2000), who assert that “when one attends lovingly to others by entering into their perspectives and examining the contexts of their lives, one is engaging in feminist ethics” (p. 27). This assertion would support the entire process of psychological assessment, from the development of an intention for the assessment through to report writing and feedback, from a collaborative, feminist perspective.

This chapter will present three case vignettes describing psychological assessments that highlight issues related to gender identity and sexual orientation. Each vignette will be followed by ethical commentary that incorporates the principles contained in the APA ethics code, feminist ethics, and special attention to issues related to sex and gender. Analyses of each vignette will illustrate how The Feminist Therapy Code of Ethics can be used in conjunction with APA’s Ethical Principles of Psychologists and Code of Conduct.

Vignette 1

Maria, 15 years old, was brought by her mother for a psychological assessment at the suggestion of her pediatrician. Before seeing the pediatrician and while alone with the nurse, Maria complained about feeling anxious. She described it as a “nothing is going to be okay feeling” and asked that her mother not be told. The pediatrician then asked some follow-up questions, which Maria struggled to answer. She had a vague sense of negativity regarding the future and was having trouble getting to sleep. Maria had a group of friends at school, enjoyed playing lacrosse, and got along well with everyone on her team. Her grades were mostly A’s and B’s and were very consistent. The pediatrician was reluctant to begin medication for anxiety without a clearer sense of Maria’s difficulties. Maria’s mother was concerned that something more negative was beginning, as her sister was diagnosed with bipolar disorder as an adolescent.

The goals of the assessment were to determine the nature of Maria’s anxiety, to screen for mania, and to suggest a course of treatment if one was warranted. Maria also expressed curiosity about her intelligence and wanted to know if she could succeed in college. Maria expressed concern about her mother’s reaction to the evaluation, and she wanted to make sure the content would be private. The assessor explained to Maria that they would discuss the content of the assessment and what would be communicated to her pediatrician, school
counselor, and family. The assessor discussed the limits of confidentiality with both Maria and her mother. Maria’s mother agreed that privacy was acceptable, unless Maria was in danger.

Testing began with the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV; Wechsler, 2003), which revealed a full-scale IQ at the 85th percentile. Maria’s strengths were in the nonverbal realm, especially with analysis and synthesis and math. Maria had been reluctant to take calculus in her junior year. Upon further inquiry, Maria revealed that none of her girlfriends were advancing in math, and she was thus concerned about seeming boyish. This was a theme that would arise throughout the assessment sessions.

The Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996), a self-report measure, showed elevations only on those questions concerning the future. On question 2, Maria endorsed “I feel I have nothing to look forward to.” On question 7, Maria endorsed “I am disappointed in myself.” Otherwise, her scores were zero. These responses were consistent with the report made in the pediatrician’s office.

The assessor administered the Measures of Psychosocial Development (MPD; Hawley, 1988) to ascertain difficulties in development underlying Maria’s reported distress. The MPD revealed high negative scores on Shame/Self-Doubt and Identity Confusion, with low positive scores in the corresponding Autonomy and Identity scores. Maria endorsed as “Not At All Like Me” items related to the Identity score, such as:

- Have worked out my basic beliefs about such matters as occupation, sex, family, politics, and religion
- Clear vision of what I want out of life
- Stand up for what I believe, even in the face of adversity
- Found my place in the world
- Others see me pretty much as I see myself

On the autonomy score, Maria endorsed the following items as “Very Much Like Me”:

- Easily embarrassed
- Can’t be myself
- Very self-conscious
- Uncertain; doubting

While Autonomy versus Shame and Doubt is a stage typically related to early childhood (ages 2–3), when a sense of personal control, including regulation of affect, is not developed, shame and anger are likely to be evident, as is difficulty with persistence (Roberts, Strayer, & Denham, 2014). The current stage of development for Maria was Identity versus Identity Confusion,
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which seemed to underlie the struggle with a sense of herself in the future, and within that were feelings of shame and doubt. This was evidenced by her reluctance to take a math class her friends were not opting for, even while having the ability to master the material.

On card 2 of the Thematic Apperception Test (TAT; Murray, 1943), Maria described the young woman standing in the foreground as a tomboy who felt uncertain and who was daydreaming. The daydream was about her best friend at school, whom she loved. This was contrasted with the boy in the background of the picture, who Maria described as in love with the girl. Themes of uncertainty and descriptions of the degrees of femininity or boyishness of the figures in the cards predominated in Maria’s responses to the TAT.

Following test administration, the assessor adopted an approach consistent with Fischer’s Collaborative Assessment (Fischer, 2000) and Finn’s Therapeutic Assessment (Finn & Tonsager, 1997) and constructed a clinical interview focused on exploring the content of the testing material, asking Maria to elaborate upon or be curious about the results. The assessor described the developmental issues as revealed by the MPD, while separating such issues from the mood changes related to depression. Maria readily agreed that she was not sad but that she did not have a clear sense of herself. The assessor experienced Maria as inclined toward shame, and was thus careful to use nonpejorative language and to, instead, ask Maria to contextualize her own experience (Santos de Barona & Dutton, 1997). Maria reported feeling different from her family for as long as she could remember. The difference was not acknowledged, and so Maria felt very isolated in the experience. Maria was raised Roman Catholic by her biological parents, who identified as Puerto Rican and would spend holidays and vacations with family in Puerto Rico.

When asked about the dominant themes in the TAT, Maria responded by saying “I kissed my girlfriend when we were playing a game.” Maria said that when she kissed her girlfriend, she realized the strong feelings she had, and simultaneously realized that her friend did not share those feelings. Maria said, “She really was practicing for boys and I wasn’t.” Using a nomological network of sexual orientation (Mustanski, Kuper, & Greene, 2014), the assessor asked Maria a series of questions regarding her sexual behavior, romantic feelings, and sexual thoughts. A nomological network of sexual orientation refers to the observable manifestations, constructs, measurable and theoretical aspects, and the interrelatedness of them. In the case of sexual orientation, an observable manifestation would be sexual behavior, a construct would be identity labels, a measurable aspect would be gay marriage, and a theoretical aspect would be romantic feelings. Other factors that can make up the network are sexual fantasies, sexual attraction, lifestyle, and community participation. An assessment of a person’s thoughts, feelings, and behaviors can be used to understand the individual’s sexual orientation when the nomological network is employed.
The recommendations provided to Maria, her parents, pediatrician, and school counselor were as follows:

1. Maria should meet with the physics teacher at her high school about taking advanced math. The physics teacher, Mrs. Burch, could act as a mentor for Maria for advanced math and science classes in her junior and senior years at high school.

2. There is no evidence that warrants a diagnosis of an affective disorder, including bipolar disorder and major depression, or an anxiety disorder. Maria could benefit from psychotherapy focused on a positive identity formation. This treatment may include Maria’s parents at times. A specific therapist, who was familiar with the coming-out process and had worked with many families of LGBT adolescents, was recommended for treatment.

3. Maria has the intellectual capacity to attend college. Her school counselor can be of assistance in guiding Maria through the process.

4. The robotics program sponsored by Maria’s school district would be a positive resource for Maria, both academically and socially.

**Ethical Commentary**

Several ethical issues in this vignette warrant careful consideration. The APA’s *Ethical Principles of Psychologists and Code of Conduct* begins with five overarching General Principles that express aspirational values and reflect the highest ideals of the profession. In providing an evaluation of Maria, the evaluator first needed to attend to the relevant General Principles before turning to specific standards. General Principles B and C are relevant in Maria’s case. Principle B: Fidelity and Responsibility reflects faithfulness or loyalty to the client and means placing the client’s interests first. This includes keeping one’s promises, maintaining high standards of competence, and accepting fiduciary responsibilities. Psychologists also seek to meet their responsibilities by avoiding conflicts of interest that would jeopardize trust or lead to exploitation or harm, and by consulting with other professionals when necessary. The assessor in this vignette appeared to embrace this aspirational principle by placing Maria’s interests first and discussing the limits of confidentiality. General Principle C: Integrity stresses honesty, keeping one’s promises, and accuracy in science, teaching, and practice. It also includes not making professional commitments that cannot be kept (Fisher, 2013). Standards relevant to this vignette include informed consent, confidentiality, and bases for assessments.

Informed consent is both a legal and ethical obligation to provide information to clients before they participate in assessment or treatment. Telling clients what to expect before committing to treatment or assessment demonstrates respect for their autonomy. In most cases, clients will be able to make decisions in their best interests when they have been given the relevant information (Knapp & VandeCreek, 2012). When performing an assessment, the assessor...
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engages the client in informed consent, including an explanation of the nature and purpose of the assessment, fees, involvement of third parties, the limits of confidentiality, and an opportunity to ask questions and receive answers (APA, 2010). The nature of the assessment refers to the type of assessment (e.g., cognitive, academic, personality), the procedures and testing format, such as interview, self-report, or skills assessment, and the duration of the assessment. The purpose of the assessment refers to the use of the assessment, such as for treatment planning. Clients should also know in advance the expected cost of the assessment and whether it will be covered by their health plan. It is also extremely important to clarify the involvement of third parties in assessment situations. This refers to anyone who has requested and will receive the assessment report. Ethical standards, state laws, and federal regulations govern the release of assessment information to third parties, so it is important to be knowledgeable in these areas. Informed consent must also include a clear explanation of the limits of confidentiality (Fisher, 2013).

Confidentiality is an ethical principle prohibiting the treating professional from disclosing information about a client to a third party without the client’s consent. According to standard 4.02 of the APA Ethics Code, psychologists are expected to discuss with their clients the relevant limits of confidentiality and any foreseeable uses of the information generated through their psychological activities. Several legal, institutional, or professional obligations place limits on the extent to which information acquired during assessment can be kept confidential. For example, psychologists are legally responsible to report child abuse, or they may need to contact a family member to protect an individual from self-harm. Thus, promising confidentiality without also discussing its limitations is a misrepresentation of professional obligations. The release of confidential information can have serious consequences for clients and their families.

Early in this vignette, Maria asked the nurse at her pediatrician’s office not to tell her mother about her “nothing is going to be okay feeling.” The nurse appears to have kept this information confidential, but the pediatrician was concerned enough about Maria to suggest an evaluation. Before the evaluation began, Maria expressed concern about her mother’s reaction to the evaluation and probably to the results as well, and wanted the content to be private. The evaluator, who explained to Maria that they would discuss the content of the evaluation and what would be communicated to her pediatrician, school counselor, and family, appropriately handled this request. Thus, the evaluator was able to respect Maria’s concerns without promising anything that could not be delivered (as indicated in General Principle C: Integrity).

From a feminist viewpoint, through the development of an egalitarian relationship, the assessor and Maria were able to talk about what to share, with whom, and when. In accordance with The Feminist Therapy Code of Ethics, the assessor attended to the power dynamics at play, aware of the power that adults hold over children’s lives as well as the dependency that exists concurrently with the separation and identity formation of adolescence. The evaluator then
openly discussed the limits of confidentiality with Maria’s mother, who agreed
that unless Maria were in danger, she would respect Maria’s privacy. This prac-
tice is consistent with an Agreement of Confidentiality, which is permitted by
the Health Insurance Portability and Accountability Act (HIPAA; Department
of Health and Human Services, 2002) and limits the information a clinician
will tell parents without the consent of their child. This is included in HIPAA
to encourage children to be more forthcoming in both therapy and assessment.

In discussing the results of the evaluation with Maria, the evaluator was
sensitive to Maria’s anxiety about her mother’s potentially negative reaction to
her nonheterosexual feelings and the context of her religion and cultural back-
ground. Clearly, the evaluator adhered to Guideline 1 of the APA’s Guidelines
for Practice With Lesbian, Gay, and Bisexual Clients, which states that psychologists
attempt to understand the stigma and discrimination inherent in the lives of
LGB clients. The evaluator also reflected an adherence to Guideline 10, which
urges psychologists to consider how a client’s sexual orientation can impact his
or her familial relationships.

Finally, it is important to note that the evaluator provided opinions of Maria
that were based only on information and techniques sufficient to substantiate
the findings consistent with Standard 9.01 of the APA Ethics Code. Assessment
provides information to guide decisions affecting individuals and their families,
so it is important that this information is based on techniques that use scientific
and professional knowledge. This standard prohibits written or oral opinions
that cannot be substantiated by the information obtained or the techniques used
(Fisher, 2013). This standard is also an example of General Principle C: Integrity.
The evaluator used measures that were reliable and valid for the purpose of test-
ing and the referral question. In addition, the evaluator’s conclusions included
findings from a clinical interview following testing. The collaborative method
employed by the assessor was in accordance with feminist therapy principles.
Use of this method demonstrated the assessor’s willingness to question the data
obtained as well as an effort to contextualize fully Maria’s subjective experi-
ences. Through this process, the evaluator was able to describe developmental
issues revealed by the MPD that were separate from mood changes related to
depression. The assessor was aware of the intersection between gender identity
and sexual orientation. The assessor was further aware that the intersubjectivity
of complex identity formation that transgresses the heterocentric narrative cre-
ates distress for individuals navigating this process (Cox, Dewaele, van Houtte, &
Vincke, 2011; Page, Lindahl, & Malik, 2013). Maria was in just this position.

Thus, being afraid of appearing boyish could be understood differently in the
context of Maria’s realizing she was actually kissing her girlfriend, not keeping
to the heterocentric norm of “practicing for boys.” The assessor was able to
shift from the anxious, depressed question to include Maria’s anxiety about her
mother’s reaction to her feelings for her girlfriend and the context of a Catholic
and Puerto Rican family potentially holding a negative view of Maria’s non-
heterosexual sexual behavior.
Together, Maria and the assessor discovered that Maria was developing a personal identity that may include being attracted to women. While stage models for sexual orientation exist (see Chapter 1, this volume), the importance of understanding the intersection of developmental lines—in Maria’s case, her psychosocial development, cultural identity, and sexual orientation (Bilodeau & Renn, 2005)—allows for a fluid process and varied understanding of Maria, her behaviors, thoughts, and feelings. This nuanced, nonbinary approach created the space for Maria to come to her own self-understanding.

The evaluator was able to shift from the initial referral question related to anxiety and depression and a possible diagnosis of bipolar disorder to a recognition of the likelihood that Maria’s anxiety was founded on her mother’s reaction to her developing personal identity that possibly included being attracted to women. Thus, the evaluator concluded that no evidence to warrant a formal psychiatric diagnosis existed. It was recommended that Maria could benefit from psychotherapy focused on a positive identity formation, potentially with a therapist who was familiar with the coming-out process and had worked with LGBT adolescents and their families. In this case, feminism informed the psychological view by transcending a focus on the intrapsychic to one that includes culture, society, and power. This integration of the individual into a context is an essential part of assessment (Fischer, 2000; Rodis & Strehorn, 1997).

Vignette 2

Samantha, a college student, sought an evaluation after having a panic attack. She went to the hospital believing that she had a life-threatening illness. The emergency room physician suggested she be evaluated for anxiety and possibly depression after Samantha reported sleeping for extended periods of time, not feeling motivated to change her clothes, and missing classes. On the first day of testing, Samantha presented with very poor eye contact, wearing a torn sweatshirt, blue jeans, and sneakers. She reported the experience of the panic attack, along with a long history of mild to moderate anxiety. She self-identified as Albanian American from New York City and one of two children in an intact, heterosexual family.

The Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV; Wechsler, 2008) revealed a full-scale IQ at the 92nd percentile and a working memory index score at the 77th percentile as the most remarkable findings. Samantha reported that she worked very hard in school and that her parents’ expectation was that she would enter a prestigious college and receive a degree in math. Samantha believed it was with considerable effort that she achieved academically.

The Trauma Symptom Inventory (TSI; Briere, 1995) showed clinically significant elevations on the Anxious Arousal (AA) scale, largely from the Anxiety (AA-A) subscale. The Somatic Preoccupations (SOM) Scale was at the 64th percentile, while the General (SOM-G) was at the 79th percentile. Samantha corroborated this finding with reports of anxiety about eating enough food.
or getting enough sleep. Inquiry revealed a history of child sexual abuse by a paternally uncle. Samantha described her mother as highly anxious and a heavy cigarette smoker. Her father worked several jobs and was often absent from the home.

While formulating her testing questions, Samantha raised the question of being transgender. She pointed out her masculine clothing, the fact that she was wearing a binder over her breasts, and a general discomfort with her body. Later, Samantha revealed that the sweatshirt was originally her mother’s, and she described her mother as “butch” in appearance. Exploration of a potential transgender identity revealed a traumatic history regarding coming out as gay to her family of origin. Samantha had written a letter to her high school girlfriend, including overtly sexual content. Samantha’s mother then read the letter without her knowledge or permission and became angry and threatening toward her. Samantha became distraught and suicidal. No subsequent clinical intervention was made.

On moving away to college, Samantha sought out the lesbian community on campus and within the faculty. She struggled to find lesbians who “looked like me” or supported her masculine appearance. There was an unspoken pressure on campus to “pass” as heterosexual. The university was generally conservative, so the lesbian-identified faculty often cautioned students about their self-presentation, positioning their advice within a feminist framework of using patriarchal rules concerning the appearance of women to subversively afford lesbian and queer-identified students a degree of safety and power. This use of feminism to corral nonheterosexual women went unexamined, while Samantha found herself increasingly anxious and isolated. Simultaneously, Samantha developed a connection to a community of transwomen through a local bookstore in the months leading up to her visit to the emergency room. When the assessor asked Samantha to self-identify on a scale from masculine to feminine, from male to female, and from gay to straight, Samantha crafted an identity as a masculine, gay female.

Samantha believed her anxiety arose from both the pathology attached to her masculine appearance within the context of the university and her uncertainty that the transgender community was really where she belonged. This type of identity confusion can result in immobilizing anxiety and isolation. Samantha’s symptoms of depression were a result of social isolation, and a panic attack followed a period of moderate anxiety. Samantha also believed that the panic attack was a means to get help.

Recommendations made to Samantha were for psychotherapy that was both trauma-informed and feminist. Samantha was referred to a local women’s social service agency that was feminist in approach and also offered a range of services for trauma treatment. The second recommendation was for Samantha to join a women’s group. The objective here was for Samantha to break her social isolation and find a range of women with whom she could connect in varied ways. Samantha joined an ongoing psychotherapy group for women who
identified as queer. The third recommendation was for further testing to assess for Attention-Deficit/Hyperactivity Disorder once the symptoms of depression and anxiety were reduced by treatment. A follow-up evaluation showed a mild impairment in attention, especially sustained attention and shifting attention. Samantha subsequently sought out neurofeedback treatment to address these issues.

**Ethical Commentary**

The assessor’s actions in this vignette reflect adherence to both *The Feminist Therapy Code of Ethics* and the *APA Ethical Principles of Psychologists and Code of Conduct*. This assessor has done an excellent job of incorporating feminist principles into her professional standards. Principal A: Beneficence and Nonmaleficence from the *APA Ethical Principles of Psychologists and Code of Conduct* reflects the obligation to do good while avoiding harm. Doing good includes promoting the welfare of others, treating people humanely, increasing scientific and professional knowledge of behavior and people’s understanding of themselves, and improving the condition of individuals, organizations, and society (Fisher, 2013). The vignette states that the assessor took a feminist approach to assessment and did not marginalize Samantha into dichotomies. Thus, the assessor promoted Samantha’s welfare, sought to increase her understanding of herself, and helped to improve her condition through making useful recommendations.

In addition, psychologists are expected to avoid harm by maintaining competence, guarding against behaviors that would lead to exploitation of those with whom they work, minimizing intrusions on personal information in reports, and providing opinions and reports based only on information or techniques sufficient to substantiate findings (Fisher, 2013). In this vignette, the assessor appeared to avoid harm by being conscientious about guarding against behaviors that would result in Samantha’s exploitation, and provided conclusions based on reliable and valid assessment measures. Even within these guidelines, Samantha could have been diagnosed, and treatment recommended, for gender dysphoria (American Psychiatric Association, 2013). As a masculine woman, or as a transgender person, the diagnosis of gender dysphoria privileges the heteronormative socially dominant view of gender and sexuality, not the nondichotomous fluid view of gender and sexuality reflected in a feminist viewpoint (Lev, 2013). The assessor took a feminist approach to assessment, and so operated from an ethic that did not marginalize Samantha into dichotomies, such as male/female or homosexual/heterosexual.

Principal E: Respect for People’s Rights and Dignity is also important to this vignette. This principle highlights the need to be aware of and to respect cultural, individual, and role differences, which play a central role in this vignette. This is consistent with the first Ethical Guideline for Feminist Therapists, Cultural Diversities and Oppressions. Assessors must be familiar with the scientific and professional knowledge relevant to these differences and have the competencies
necessary to perform their role effectively. They must also strive to be aware of
and eliminate from their work their own and others’ prejudices. In addition to
the assessor’s sensitivity to Samantha’s gender and sexual orientation, the rec-
ommendations were described as both trauma-informed and feminist. Saman-
tha was referred to a local women’s social service agency that was feminist in
approach. She was also recommended to join a women’s group to find women
who represented her various diversities. These recommendations reflect princi-
ples contained in The Feminist Therapy Code of Ethics, including assisting clients
in obtaining additional services; uncovering and respecting cultural differences
between the assessor and client; evaluating interactions between the assessor and
client for evidence of biases, discriminatory attitudes, or practices; and seeking
multiple ways of enacting change (FTI, 2000).

Consistent with the fifth Ethical Guideline for Feminist Therapists, Social
Change, the assessor took into consideration Samantha’s relationship to her
broader context (her relationship to her university environment) in her case
conceptualization. This ethical guideline states, “A feminist therapist, teacher,
or researcher is alert to the control of information dissemination and questions
pressures to conform to and use dominant mainstream standards” (FTI, 2000).
Samantha indicated that within her university community was an unspoken
pressure to pass as heterosexual, resulting in Samantha feeling increasingly anx-
ious and isolated in the months leading up to her panic attack. Samantha was
also uncertain that the transgender community was really where she belonged.
This ambivalence regarding identity can also result in anxiety and isolation.
The assessor concluded that Samantha’s symptoms of depression were a result
of social isolation, and the panic attack followed a period of moderate anxiety.
Her depression may also have been rooted in a sense of loss; she briefly found
a sense of belonging in the transgender community, but once again found that
she did not fit in.

In addition to the General Principles, several additional standards relate to
this vignette. The standard of competence is related to Principal A: Beneficence
and Nonmaleficence. The key concept is, “Psychologists provide services, teach,
and conduct research with populations and in areas only within the boundaries
of their competence, based on their education, training, supervised experience,
consultation, study, or professional experience” (APA, 2010). This standard also
requires that psychologists have or obtain special understanding and skill when
an understanding of individual differences is needed for competent work (Fisher,
2013), a directive especially relevant to this vignette. The competencies required
to work with any particular population are determined by the current scientific
and professional knowledge in the field. This standard is echoed by The Femi-
nist Therapy Code of Ethics’ emphasis on Therapist Accountability, which is the
fourth Ethical Guideline for Feminist Therapists. This guideline also stresses that
a feminist therapist works with clients and issues within the realm of her com-
petencies. Having appropriate skill to deliver knowledge and knowing when to
refer are also essential components of competence. Similarly, feminist therapists
utilize consultation and available resources if issues develop beyond their areas of competence (FTI, 2000). Working competently with LGBT clients requires the clinician to have knowledge of the population and the unique stressors they face, knowledge of LGBT issues, understanding of how to handle emotional reactions of and to LGBT clients, and comfort dealing with sexual issues (Knapp & VandeCreeke, 2012).

The standard related to nonmaleficence states, “Psychologists take reasonable steps to avoid harming their clients/patients, students supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm when it is foreseeable and unavoidable” (APA, 2010). Unfortunately, harm is not always unethical or avoidable, such as violating confidentiality to protect the client or a third party. Providing an appropriate diagnosis through assessment could also be harmful, although ethical and necessary. This could have been the result of an assessment such as Samantha’s; however, the assessor’s competence resulted in both providing benefit and avoiding harm to Samantha.

Samantha was well served by the assessor, and she was given appropriate referrals where this would continue to be the case. The integration of feminism into a broader knowledge of principle ethics, trauma, and assessment allowed a comprehensive, effective, and ethical assessment to take place. This argues for the active use of APA Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients and the Guidelines for Psychological Practice With Girls and Women as an integral part of clinically and ethically sound practice.

Vignette 3

Theo, a 19-year-old Puerto Rican man, sought outpatient therapy complaining of depressed mood, loss of interest in his usual activities, and an inability to focus. A recent high school graduate, Theo reported that he had been an A student until his junior year, when he began to feel depressed and lost his ability to focus on schoolwork. Theo could not identify a stressor that triggered this sudden decline in functioning, but he reported that he began to withdraw from his friends around this time as well. Theo’s grades dropped significantly, but he managed to scrape by with D’s and graduated on time with his classmates. At the time of intake, Theo reported that he had been consistently depressed for the past 2½ years. When asked why he sought help now as opposed to before, Theo replied that he wanted to be the first in his family to go to college and that he would like to get a job in order to help his family pay the bills. Although he once envisioned himself capable of accomplishing these goals, he could not foresee meeting them in his current state.

Additionally, Theo reported that he had been physically assaulted by a group of young men roughly five weeks before. This was the fourth time in his life that Theo had experienced such an assault. This time, however, he was struggling with flashbacks of the face of one of the perpetrators. Theo also reported feeling very afraid when walking alone on the street or when he encountered groups
of young men. Since the attack, he had been staying at home more and avoiding certain places in his neighborhood.

Finally, at the end of the initial intake session, Theo admitted that he should share one more thing: He sometimes imagined himself in a different universe where he was a completely different person. Theo said that he had control over these realities in terms of what happened and what people within them said and did. He did, however, feel that this was a problem because it was taking over his life. Theo said that he was creating new realities daily and that he needed to make it stop so that he could focus on living his life.

Two months into therapy, Theo was referred for a psychological assessment in order to clarify his symptom presentation and definitively rule out the presence of psychosis. Theo was amenable to the assessment and reported that he had always been curious about his intellectual functioning and various aspects of his personality. Measures administered included the WAIS-IV, Personality Assessment Inventory (PAI; Morey & Boggs, 1991), Trauma Symptom Inventory (TSI), Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), Rorschach Inkblot Method (Exner, 2001), TAT, House-Tree-Person Test (Buck, 1964), and Incomplete Sentences Blank (Rotter, 1950).

WAIS-IV results revealed that Theo was performing in the overall High Average range of intellectual functioning, with Verbal Comprehension scores in the Superior range. His lowest scores were on the subtests measuring processing speed, where he performed in the Average range. Theo’s PAI showed significant elevations on the subscales measuring depression (DEP C, A, and P) and traumatic stress (ARD-T). He showed no significant elevation on the schizophrenia (SCZ) scale. On the TSI, Theo reported oscillating between avoidance symptoms and intrusive symptoms. Theo’s responses to the DES indicated that he showed a tendency to become highly absorbed with and preoccupied by his own thoughts, so much so that he became distracted from the world around him at times. He also displayed a tendency to become deeply involved in fantasies and daydreams, to the point of treating them as reality. Theo’s tendency to become absorbed in this way led him to miss part of what others said to him, stare off into space, and lose track of short chunks of time.

Theo’s responses on the Rorschach revealed a positive Suicide Constellation. He demonstrated a tendency to neglect the richness and complexity of information in his environment when under stress. Theo focused on idiosyncratic details, preventing him from seeing the larger picture before him. Theo displayed evidence of some minor difficulties in reality testing and misinterpretation of social and environmental cues in conventional situations (level one DVs and DRs) but no gross distortions (no level two special scores or cognitive special scores). His Rorschach responses also revealed that he evaluated himself and others negatively.

Theo’s responses on the projective measures reinforced the presence of depressive and post-traumatic symptomatology and contained a considerable amount of content related to gender and sexuality. On the Incomplete
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Sentences Blank, Theo completed item number four ("I want to know") with "what it feels like for women." In response to item number nine ("Men"), he wrote "do not get to live as fully as women because they have to conceal things." He completed item 16 ("When I see a man and a woman together") with "I feel sad and envious." Several of Theo’s TAT stories contained references to confusion and low self-esteem and described women in positive, even idealized, ways.

Perhaps most revealing in this regard were Theo’s House-Tree-Person drawings. When asked to draw a person like him, Theo drew an androgynous figure with slumped shoulders, hands in pockets, and downcast eyes. The figure was concealed in baggy clothing and had an overall morose quality. When asked to describe this figure, Theo described someone who was socially awkward, confused, and sad. When asked to draw a person of another gender, Theo drew another androgynous figure. This figure was thinner, stood upright, and wore more stylish clothing. When describing this person, Theo notably used the pronoun “they,” leaving the gender of the person in the drawing ambiguous. He said this person “knew who they were, had a lot of friends, and was not held back by negative feelings.” Theo’s tree was old and gnarled. He reported that it stood tall and firm, though it was full of scars and deformities and had a large hole in the middle. Theo said that the tree had no leaves and appeared dead to the naked eye, but he was sure to note that the tree was, in fact, alive and deeply rooted. He also mentioned that several small animals lived in the tree, and it provided them a secure haven.

The examiner concluded that Theo was currently overwhelmed by post-traumatic stress symptomatology and using his fantasy world as a means of coping with and escaping from what he perceived to be an unpredictable, dangerous environment. She further concluded that Theo had a persistently negative view of himself and his abilities, which directly contradicted his high potential for achievement. Theo also appeared to be confused about his sexuality and ruminated on this topic a great deal. While Theo craved closeness and connection, he tended to avoid social interactions for fear of being endangered or rejected. Integrating data from the self-report and performance measures as well as the clinical interview, the examiner concluded that Theo was traumatized and depressed without psychotic features.

When conducting feedback, the assessor focused on the areas about which Theo had questions, most notably his intellectual abilities and personality traits. She noted the content related to sexuality and gender, but, as it was not one of Theo’s or the therapist’s referral questions, the assessor did not make this a central focus of the feedback session. Following the assessment, the therapist processed the feedback with Theo. Theo resonated with the assessor’s feedback regarding his IQ and his emotional difficulties. He did not comment on the sexual and gender-related material and shifted uncomfortably in his chair when the therapist gently brought it up. The therapist verbally acknowledged that this content appeared to make Theo uncomfortable and let him know that they did
not have to discuss it at the present time, but that she would be happy to discuss it in the future if he so desired.

After six additional months of outpatient therapy, Theo reported that his PTSD symptoms had remitted and that, while he occasionally slipped into patterns of negative thinking and experienced sadness, he now felt in control of his thoughts, feelings, and behaviors. Theo began taking college courses, working part-time, and entered into a romantic relationship with a woman. Theo thus decided to terminate therapy because he had accomplished his treatment goals. One year later, Theo returned to his therapist’s office and revealed that he had once more become absorbed in his fantasy world and that his characters within the fantasies were now female. He said that he felt like a woman on the inside and that he had begun making small changes, such as wearing his hair longer, painting his nails, and wearing some articles of women’s clothing beneath his own. Theo said that he would like to discuss what these things meant and how to proceed.

**Ethical Commentary**

Assessing an individual who reveals a question of gender identity outside of the binary view of male and female creates both a challenge and an opportunity for the psychologist to consider ethical implications from multiple perspectives. Principle ethics will guide the psychologist to act responsibly and to consider carefully the principle of justice. Feminist ethics will ask the evaluator to understand the social and institutional power structures that continue to hold a binary view of gender.

In addition to the General Principles discussed in the previous vignettes, this vignette is also relevant to General Principle D: Justice. This principle encourages clinicians to strive to provide to all clients fair, equitable, and appropriate access to treatment informed by scientific knowledge. In addition, findings should be presented objectively, the accomplishment of which requires that one is aware of and guards against one’s own biases and the prejudice of others that may lead to unjust practices. Assessors must also select procedures and services that meet clients’ needs and recognize that diverse clients may need different but comparable scientific and professional interventions (Fisher, 2013). From a feminist perspective, the integration of Theo’s multiple identities, as a Latino/a, as the first person in his family to attend college, as a survivor of assault, and as a person with a nonbinary gender identity, means finding the point of integration by the evaluator (Sparks & Park, 2000) in order that the full person can be seen.

The value of justice is reflected in the standard related to unfair discrimination. According to this standard, “In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law” (APA, 2010). Thus, it is important to respect the dignity and worth of all clients and consider the relevance of personal characteristics based on diversity factors. Much of assessors’
work requires making valid discriminating judgments that best serve the individuals with whom they work. This is appropriate as long as their work does not reflect personal or organizational biases or prejudices that can lead to injustice. What is inappropriate is making unfair discriminations based on job-irrelevant diversity factors.

The evaluator in this vignette recognized Theo’s confusion about his sexuality without pathologizing it and concluded that Theo was traumatized and depressed without psychotic features. Consistent with General Principle D: Justice (APA, 2010), the evaluator presented the evaluation results objectively and ensured that her work did not reflect personal bias or prejudice. This is also consistent with The Feminist Therapy Code of Ethics: The assessor took Theo’s social context into consideration and ensured that the assessment was a helpful experience rather than a damaging one.

Another standard that is relevant to this vignette has to do with cooperation with other professionals. Individuals such as Theo who seek counseling or therapy may benefit from assessment services as well and vice versa. Clients may also need medical, legal, educational, or social services. Thus, it is often necessary to collaborate and consult with or refer to other professionals to serve clients’ best interests. It is important to cooperate with other professionals when it will serve clients most effectively. In many settings, clinicians may have joint responsibilities with other professionals for the assessment and treatment of clients. In these settings, clinicians should develop a clear agreement with the other professionals regarding overlapping and distinct role responsibilities. It should also be clear how confidential information will be handled, and clients should be aware of the content of these collaborative agreements (Fisher, 2013). For example, the assessor may discover that a client is gay or transgender during the course of the assessment and must obtain permission from the client before disclosing this to another healthcare provider.

In this vignette, Theo’s therapist and evaluator clearly collaborated well together. After two months of therapy, Theo’s therapist wanted clarification of his symptoms and wanted to rule out the presence of psychosis, so Theo was referred for a psychological assessment. The evaluator provided feedback to Theo and then, following the assessment, the therapist processed the feedback with Theo. The assessment uncovered sexual and gender-related information that the therapist indicated she would be happy to discuss with Theo in the future if he did not want to do so presently. Theo was patently reluctant to fully engage in the process of exploring his gender identity. He was uncomfortable with even the evaluator’s tentative exploration of gender and sexuality, and he did not raise it as a primary issue. The evaluator therefore operated from the ethic of respect for an individual’s rights and dignity (APA, 2010). The feedback session respected this boundary, while also acknowledging it and offering future conversation should Theo desire it. This collaboration and respect provided the opportunity for Theo to return to therapy a year after termination to discuss these issues.
This vignette highlights the importance of competence and sensitivity in interpreting assessment results. Accurate interpretations of assessment results are critical to ensure appropriate decisions, such as diagnosis and treatment planning. Accuracy necessitates that assessors must take into consideration the purpose of the test and the client’s characteristics and indicate any significant limitations of their interpretations. The purpose of the assessment must be carefully considered when interpreting test scores. Assessors must also resist allowing test interpretations to be biased by pressures from others with a vested interest in a particular interpretation.

When making recommendations, evaluators need to differentiate between recommendations based on test results and those based on professional judgment, which incorporates background information, behavioral observations, and information from others. Theo’s evaluator carefully considered all of the relevant factors in interpreting his test results. The evaluator interviewed Theo and gathered data from his therapist. She also asked Theo about what he wanted to learn from the assessment and used reliable and valid instruments that were directly related to the purpose of testing. No departures from standardized testing conditions or other significant limitations that needed to be considered in interpreting Theo’s test results were evident. The evaluator considered the test data in context and did not make an interpretation based on a single piece of data, such as the suicide constellation of the Rorschach. The active consideration of Theo’s position as a racial/ethnic minority and as a gender minority both adds to the understanding of Theo and places the experience of depression into a context that can act to empower Theo, rather than pathologize him. As Rosewater (1985) indicates, feminist interpretation of test results assumes that a client’s behavior is reactive rather than pathological.

Psychologists who administer tests are also responsible to give feedback to participants on the testing results (Fisher, 2013; Knapp & VandeCreek, 2012). The feedback process is designed to enable the client to understand the meaning of the test scores and interpretation in relation to the referral question, recommendations, and potential consequences. The Standards for Educational and Psychological Testing state that psychologists should deliver feedback in simple, understandable language, describing what test scores mean and how they are used (AERA, APA, & NCME, 2014). Feedback is a very important component of this vignette. When the evaluator provided feedback, she focused on the areas about which Theo had questions, specifically his intellectual abilities and personality traits. Theo was able to agree with the evaluator’s feedback in these areas. As indicated in the vignette, the evaluator noted the content related to sexuality and gender; however, as it was not related to Theo’s or the therapist’s referral questions, the evaluator did not make this a central focus of the feedback session. Similarly, when Theo’s therapist processed the feedback with him, he seemed uncomfortable when the therapist brought up the sexual and gender-related material. The therapist acknowledged that Theo seemed uncomfortable with this information and let him know that he did not have to discuss it, but he
could bring it up at any time in the future if he so desired. This informative yet sensitive feedback process helped Theo identify the source of his confusion and opened the door for him to discuss issues of sexuality when he was ready.

Principle II: Power Differentials of The Feminist Therapy Code of Ethics is also important with feedback sessions. By focusing on the information in which Theo expressed interest, the evaluator is focusing on facilitating a therapeutic process for Theo. When Theo is uncomfortable with the material about gender and sexuality, the assessor empowers Theo by giving him the opportunity to come back and talk about it later.

An assessment of Theo’s views of trans identity, gender identity, and gender ideology would have usefully informed this evaluation. An assessment of transphobia, such as the Genderism and Transphobia Scale (Hill & Willoughby, 2005), could have created the avenue for furthering the assessment and identifying both the traumatic events and how those events were subjectively traumatic for Theo. This measure could also have created a clearer view of Theo as relates to identity, self-esteem, suicidal risk, and his own unique psychological makeup.

The awareness of a transgressive identity, in this case as a transgender individual, is one that a psychological evaluation, including the use of projective techniques, is uniquely able to assess and understand. The ethical principles of fidelity, integrity, and justice converge with the feminist ethics of cultural diversity, oppression, power, and therapist accountability to create a unique opportunity for psychology to rise above the prejudice, pathologizing, and oppression scattered across the histories of psychology and humanity.

**Practical Points**

- When used in combination, principle ethics and feminist ethics enable the assessor to achieve a full, individualized view of the client.
- The synthesis of feminist ethics with principle ethics in psychological assessment naturally creates an integrated ethic of care and justice.
- In a feminist-informed ethical assessment, the focus is on what is right for the client.
- Assessment training and supervision from a feminist perspective creates an environment where an ethical approach is discussed as an inherent part of the process from the beginning of the assessment through to feedback.
- The integration of data from various assessment tools and from the client shift the assessment from being about the client to a collaborative process with the client.
- Through an integration of feminist ethics with principle ethics, organizational, social, and personal biases regarding gender, sexual orientation, and sex can be addressed to the client’s benefit.
- Within a feminist ethical framework, population knowledge regarding all minority statuses becomes a matter of ethics, and so the assessor will naturally be informed.
Annotated Bibliography


Comment: Part of the APA’s Theories of Psychotherapy Series, this concise volume provides an excellent introduction to—or refresher on—feminist therapy. Brown traces the developmental trajectory of feminist therapy, from its roots in the women’s liberation movements of the 1970s to its integration with multicultural counseling in current clinical practice. It includes sections on history, theory, practice, and future directions.


Comment: Though somewhat outdated, this volume traces the development and evolution of the Feminist Therapy Code of Ethics. It offers numerous vignettes with ethical commentaries from a variety of clinicians, focused on issues such as diagnosis, overlapping relationships, and therapist self-care.

References


Appendix to Chapter 26
FEMINIST THERAPY CODE OF ETHICS* (REVISED, 1999)

Preamble

Feminist therapy evolved from feminist philosophy, psychological theory and practice, and political theory. In particular feminists recognize the impact of society in creating and maintaining the problems and issues brought into therapy.

Briefly, feminists believe the personal is political. Basic tenets of feminism include a belief in the equal worth of all human beings, a recognition that each individual’s personal experiences and situations are reflective of and an influence on society’s institutionalized attitudes and values, and a commitment to political and social change that equalizes power among people. Feminists are committed to recognizing and reducing the pervasive influences and insidious effects of oppressive societal attitudes and society.

Thus, a feminist analysis addresses the understanding of power and its interconnections among gender, race, culture, class, physical ability, sexual orientation, age, and anti-Semitism as well as all forms of oppression based on religion, ethnicity, and heritage. Feminist therapists also live in and are subject to those same influences and effects and consistently monitor their beliefs and behaviors as a result of those influences.

Feminist therapists adhere to and integrate feminist analyses in all spheres of their work as therapists, educators, consultants, administrators, writers, editors,
and/or researchers. Feminist therapists are accountable for the management of the power differential within these roles and accept responsibility for that power. Because of the limitations of a purely intra-psychic model of human functioning, feminist therapists facilitate the understanding of the interactive effects of the client’s internal and external worlds. Feminist therapists possess knowledge about the psychology of women and girls and utilize feminist scholarship to revise theories and practices, incorporating new knowledge as it is generated.

Feminist therapists are trained in a variety of disciplines, theoretical orientations, and degrees of structure. They come from different cultural, economic, ethnic, and racial backgrounds. They work in many types of settings with a diversity of clients and practice different modalities of therapy, training, and research. Feminist therapy theory integrates feminist principles into other theories of human development and change.

The ethical guidelines that follow are additive to, rather than a replacement for, the ethical principles of the profession in which a feminist therapist practices. Amid this diversity, feminist therapists are joined together by their feminist analyses and perspectives. Additionally, they work toward incorporating feminist principles into existing professional standards when appropriate.

Feminist therapists live with and practice in competing forces and complex controlling interests. When mental health care involves third-party payers, it is feminist therapists’ responsibility to advocate for the best possible therapeutic process for the client, including short or long term therapy. Care and compassion for clients include protection of confidentiality and awareness of the impacts of economic and political considerations, including the increasing disparity between the quality of therapeutic care available for those with or without third-party payers.

Feminist therapists assume a proactive stance toward the eradication of oppression in their lives and work toward empowering women and girls. They are respectful of individual differences, examining oppressive aspects of both their own and clients’ value systems. Feminist therapists engage in social change activities, broadly defined, outside of and apart from their work in their professions. Such activities may vary in scope and content but are an essential aspect of a feminist perspective.

This code is a series of positive statements that provide guidelines for feminist therapy practice, training, and research. Feminist therapists who are members of other professional organizations adhere to the ethical codes of those organizations. Feminist therapists who are not members of such organizations are guided by the ethical standards of the organization closest to their mode of practice.

These statements provide more specific guidelines within the context of and as an extension of most ethical codes. When ethical guidelines are in conflict, the feminist therapist is accountable for how she prioritizes her choices.
Integrating Principle and Feminist Ethics

These ethical guidelines, then, are focused on the issues feminist therapists, educators, and researchers have found especially important in their professional settings. As with any code of therapy ethics, the well being of clients is the guiding principle underlying this code. The feminist therapy issues that relate directly to the client’s well being include cultural diversities and oppressions, power differentials, overlapping relationships, therapist accountability, and social change. Even though the principles are stated separately, each interfaces with the others to form an interdependent whole. In addition, the code is a living document and thus is continually in the process of change.

The Feminist Therapy Institute’s Code of Ethics is shaped by economic and cultural forces in North America and by the experiences of its members. Members encourage an ongoing international dialogue about feminist and ethical issues. It recognizes that ethical codes are aspirational and ethical behaviors are on a continuum rather than reflecting dichotomies. Additionally, ethical guidelines and legal requirements may differ. The Feminist Therapy Institute provides educational interventions for its members rather than disciplinary activity.

**Ethical Guidelines for Feminist Therapists**

**I. Cultural Diversities and Oppressions**

A. A feminist therapist increases her accessibility to and for a wide range of clients from her own and other identified groups through flexible delivery of services. When appropriate, the feminist therapist assists clients in accessing other services and intervenes when a client’s rights are violated.

B. A feminist therapist is aware of the meaning and impact of her own ethnic and cultural background, gender, class, age, and sexual orientation, and actively attempts to become knowledgeable about alternatives from sources other than her clients. She is actively engaged in broadening her knowledge of ethnic and cultural experiences, non-dominant and dominant.

C. Recognizing that the dominant culture determines the norm, the therapist’s goal is to uncover and respect cultural and experiential differences, including those based on long term or recent immigration and/or refugee status.

D. A feminist therapist evaluates her ongoing interactions with her clientele for any evidence of her biases or discriminatory attitudes and practices. She also monitors her other interactions, including service delivery, teaching, writing, and all professional activities. The feminist therapist accepts responsibility for taking action to confront and change any interfering, oppressing, or devaluing biases she has.
II. Power Differentials

A A feminist therapist acknowledges the inherent power differentials between client and therapist and models effective use of personal, structural, or institutional power. In using the power differential to the benefit of the client, she does not take control or power that rightfully belongs to her client.

B A feminist therapist discloses information to the client that facilitates the therapeutic process, including information communicated to others. The therapist is responsible for using self-disclosure only with purpose and discretion and in the interest of the client.

C A feminist therapist negotiates and renegotiates formal and/or informal contacts with clients in an ongoing mutual process. As part of the decision-making process, she makes explicit the therapeutic issues involved.

D A feminist therapist educates her clients regarding power relationships. She informs clients of their rights as consumers of therapy, including procedures for resolving differences and filing grievances. She clarifies power in its various forms, as it exists within other areas of her life, including professional roles, social/governmental structures, and interpersonal relationships. She assists her clients in finding ways to protect themselves and, if requested, to seek redress.

III. Overlapping Relationships

A A feminist therapist recognizes the complexity and conflicting priorities inherent in multiple or overlapping relationships. The therapist accepts responsibility for monitoring such relationships to prevent potential abuse of or harm to the client.

B A feminist therapist is actively involved in her community. As a result, she is aware of the need for confidentiality in all settings. Recognizing that her client’s concerns and general well-being are primary, she self-monitors both public and private statements and comments. Situations may develop through community involvement where power dynamics shift, including a client having equal or more authority than the therapist. In all such situations a feminist therapist maintains accountability.

C When accepting third party payments, a feminist therapist is especially cognizant of and clearly communicates to her client the multiple obligations, roles, and responsibilities of the therapist. When working in institutional settings, she clarifies to all involved parties where her allegiances lie. She also monitors multiple and conflicting expectations between clients and caregivers, especially when working with children and elders.

D A feminist therapist does not engage in sexual intimacies nor any overtly or covertly sexualized behaviors with a client or former client.
A feminist therapist is accountable to herself, to colleagues, and especially to her clients.

A feminist therapist will contract to work with clients and issues within the realm of her competencies. If problems beyond her competencies surface, the feminist therapist utilizes consultation and available resources. She respects the integrity of the relationship by stating the limits of her training and providing the client with the possibilities of continuing with her or changing therapists.

A feminist therapist recognizes her personal and professional needs and utilizes ongoing self-evaluation, peer support, consultation, supervision, continuing education, and/or personal therapy. She evaluates, maintains, and seeks to improve her competencies, as well as her emotional, physical, mental, and spiritual well-being. When the feminist therapist has experienced a similar stressful or damaging event as her client, she seeks consultation.

A feminist therapist continues to re-evaluate her training, theoretical background, and research to include developments in feminist knowledge. She integrates feminism into psychological theory, receives ongoing therapy training, and acknowledges the limits of her competencies.

A feminist therapist engages in self-care activities in an ongoing manner outside the work setting. She recognizes her own needs and vulnerabilities as well as the unique stresses inherent in this work. She demonstrates an ability to establish boundaries with the client that are healthy for both of them. She also is willing to self-nurture in appropriate and self-empowering ways.

A feminist therapist seeks multiple avenues for impacting change, including public education and advocacy within professional organizations, lobbying for legislative actions, and other appropriate activities.

A feminist therapist actively questions practices in her community that appear harmful to clients or therapists. She assists clients in intervening on their own behalf. As appropriate, the feminist therapist herself intervenes, especially when other practitioners appear to be engaging in harmful, unethical, or illegal behaviors.

When appropriate, a feminist therapist encourages a client’s recognition of criminal behaviors and also facilitates the client’s navigation of the criminal justice system.

A feminist therapist, teacher, or researcher is alert to the control of information dissemination and questions pressures to conform to and use dominant mainstream standards. As technological methods of communication change
and increase, the feminist therapist recognizes the socioeconomic aspects of these developments and communicates according to clients’ access to technology.

A feminist therapist, teacher, or researcher recognizes the political is personal in a world where social change is a constant.
SEX, GENDER, AND SEXUALITY IN PSYCHOLOGICAL ASSESSMENT: WHERE DO WE GO FROM HERE?

Joni L. Mihura and Virginia M. Brabender

The more the assessor belongs to a socially advantaged group, the more that writing the identifying information section of a psychological report (i.e., name, age, sex, ethnicity, etc.) can seem easy and straightforward, the part to which one gives the least thought. However, thinking back to the first time we are introduced to the client through the referral and then to our first personal encounter, this identifying information shapes how we perceive the client, the implicit schemas we follow in our interpersonal interactions, and our assumptions about the client that affect our clinical decisions and recommendations. But just how does the client’s identifying information affect the assessment relationship and the eventual psychological report?

Our handbook has focused on sex, gender, and sexuality as part of the client’s identity to help us begin answering such questions. Gender is a lens through which all people are seen throughout their entire lives. As noted by Whitehead (Chapter 3, this book), “Gender has been termed ‘omnirelevant’ to human interactions, dictating some of our most fundamental understandings of people and our uses of language” (Klein, 2011) (p. 82). Although biological sex has been a topic of psychology research for many years, its psychological component, gender, is a relative newcomer, and gender identity is newer still. This differential was reflected in the limited amount of literature available for our chapters on these topics.

In our final chapter, we discuss key areas of focus for the future regarding sex, gender, and sexuality in psychological assessment. Due to the wide range of sex, gender, and sexuality areas and the limited psychological assessment literature in most of these areas, our chapter authors were faced with a
challenging task. For many of the areas our chapters reviewed, the status of the literature could be summed up as “More work needs to be done.” In this final chapter, we describe and discuss key chapter themes and their implications, which we group in sections on the client, the assessor, the assessment proper, and the assessment research. Subsequently, we make suggestions to go beyond the boundaries of the psychological assessment literature and its nomenclature to further understand the implications of sex, gender, and sexuality in psychological assessment.

The Client

**Stigma, Discrimination, and Psychological Health**

The assessor must realize that everyone’s psychological health has been affected in some way by his or her sex, gender, and sexuality. There are a myriad of ways that not understanding this fact can result in an assessment failure, including a misinterpretation of the assessment results, a rift in the assessment alliance, or the client’s disengagement in the assessment. These can all culminate in clients not obtaining the services they need, along with having yet another disconnected experience with someone with whom they risked being vulnerable in the hope of being understood. From what we have gleaned from the chapters, we describe key assessment considerations in regard to stigma, discrimination, and psychological health.

Research indicates that sexual minorities are disproportionally affected by psychopathology, including, but not limited to, anxiety disorders, depressive (not bipolar) disorders, and psychosis (Berg, Mimiaga, & Safren, 2008; Bostwick, Boyd, Hughes, West, & McCabe, 2010; Chakraborty, McManus, Brugha, Bebbington, & King, 2011; Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003; Gevonden et al., 2013; Gilman et al., 2001; King et al., 2008). As addressed in many of the chapters, the stress associated with sex, gender, and sexuality and the related stigma or discrimination can result in various health problems (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Lewis, Kholodkov, & Derlega, 2012; Lick, Durso, & Johnson, 2013; Meyer, 2003; Schmitt, Branscombe, Postmes, & Garcia, 2014), as can having an incongruence between felt gender and biological sex (Rieger & Savin-Williams, 2012; Sandfort, Melendez, & Diaz, 2007). Recent studies have also found significantly higher mortality, or shortened lifespan, for LGBT persons living in high-prejudice communities. Hatzenbuehler and colleagues (2014) found that gay men living in a high-prejudice community had a shorter lifespan of about 12 years, in particular from suicide, homicide/violence, and cardiovascular diseases. The two general types of psychopathology that disproportionally affect nonheterosexual persons compared to heterosexual persons are internalizing psychopathology and substance use (Hatzenbuehler, 2009; Meyer, 2003). Nonheterosexual persons are also much more likely to attempt suicide than are heterosexual, cisgender

Psychological assessment would benefit from incorporating information from a growing body of literature on the negative effects of stigma and discrimination related to sex, gender, and sexuality on psychological and physical health. For example, Hatzenbuehler (2009) has developed a psychological mediation framework for sexual minority stress, which includes the distal stigma-related stressors (e.g., prejudice events such as discrimination or violence), mediating psychological processes (e.g., rumination, social isolation, hopelessness, coping), and resulting psychopathology (e.g., depression, anxiety, and substance disorders). Pachankis (2014) has developed a model for working with gay and bisexual men in the context of minority stress. When conducting a psychological assessment with a nonheterosexual client, the assessor should be familiar with basic sexual minority stress frameworks (e.g., Meyer, 2003) to guide conceptualization.

**Intersectionality Considerations**

As discussed in our chapters, the assessor should remember that sexual minority stress may manifest differently per gender. Women and persons with a more feminine gender identity are more likely to respond to stress with internalizing symptoms; men and persons with a more masculine gender identity are more likely to respond to stress with externalizing disorders and drug use (Markon, 2010; Rosenfield, 2000). Age should also be a consideration. Blagov and Goodman (Chapter 11) cite research showing a significant narrowing of sex differences in recent cohorts (consistent with the variation in gender role traditionality) for major depressive disorder, intermittent explosive disorders, and substance use but not for other disorders (Seedat et al., 2009). That is, sex differences for these internalizing and externalizing disorders appear to be particularly influenced by societal gender roles.

**Avoidance Coping**

Broadly speaking, one of the more maladaptive ways to cope with stress is avoidance (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Hayes et al., 2004). For sex-, gender-, and sexuality-related stress, the stress to be avoided would be related to revealing one’s sexual orientation or gender identity or one’s beliefs or emotions that are incongruent with societal norms (e.g., a woman showing her anger or a man crying). For understandable reasons, there is evidence that LGBTQ individuals use avoidant coping more than their heterosexual, cisgender peers (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009). The stigma literature refers to this type of avoidance coping as “concealing” a stigma (Frable et al., 1998; Pachankis, 2007). Pachankis (2007) has written an excellent article on the specific negative psychological implications of concealing a stigma, which
include vigilance and self-monitoring, the shame of keeping a secret, social avoidance and isolation, problems forming close relationships, identity ambivalence, and a negative self-view.

One consideration in understanding how a client with a stigmatized attribute copes is how “concealable” the attribute is. For example, it is generally easier to conceal one’s sexual orientation than one’s biological sex or race. The concealability of the stigma affects the person’s coping methods and the psychological implications. For example, although one might think that a trans client’s “success” in passing would resolve the minority stress, as noted by Bockting and colleagues (2013), “successful passing” is confounded with concealment, which can itself be a source of stress.

**Stress Buffer: Interpersonal Connectedness**

The predominant protection against mental health problems discussed in the chapters centered on interpersonal connections and belonging, which makes intuitive sense given the psychological pain caused by being stigmatized and rejected by society. In general, support by like-minded persons was a protective factor against sexual minority stress, whether the support came from individual peers or a community (Frable, Hoey, & Platt, 1998; Herek & Garnets, 2007). For transgender persons, peer support (from other trans persons) has unique implications, as they experience even higher levels of rejection compared to nonheterosexual groups (Bockting et al., 2013; Simons, Schrager, Clark, Belzer, & Olson, 2013). For trans youth, parental support has been shown to be particularly important for psychological well-being (Drescher & Byne, 2012). The relationship with the assessor can also provide support and connection to alleviate sex-, gender, and sexuality-related stress, especially for the client who feels rejected and dehumanized by society. As noted by Burks and Cramer (Chapter 14, this book), best practices suggest that the alliance with the clinician is vital in the assessment of suicide risk (Jobes, 2012).

Group identification can also be a buffer against the stress related to stigma and discrimination. For example, actively participating in a sexual minority community can help buffer psychological stress for nonheterosexuals (Herek & Garnets, 2007). Regarding gender, Schmitt, Branscombe, Kobrynowicz, and Owen (2002) found that increasing group identification in the face of perceived discrimination significantly improved psychological well-being for women (but not for men). These findings have important implications for assessors’ recommendations, and the assessor should be familiar with sex, gender, and sexuality groups in both the online and offline community. Assessors should remember that the Internet is a valid mode of social connection and include it in their assessments, especially for young people, since it provides the ability to explore one’s identity and place in the world (DeHaan, Kuper, Magee, Bigelow, & Mustanski, 2013).
Intersectionality Considerations

Our chapters highlighted two subgroups as having unique sexual minority vulnerabilities: the young and the old. For example, children and adolescents have fewer options for changing their environment and are less skilled in navigating complex social waters. As Wright and Nickelberry noted (Chapter 23, this book), adolescence is an important stage in identity development, including gender identity and sexual orientation. Sexual minority individuals are becoming more likely to come out in adolescence rather than adulthood (Riley, 2010). Therefore, the adolescent’s task of identity development is accelerated during puberty.

Regarding the other end of the age continuum, as noted by Languirand (Chapter 24, this book), nonheterosexual elders are much more likely than heterosexual elders to live alone and much less likely to have adult children to call upon for help (Espinoza, 2011; Hillman & Hinrichsen, 2014). LGBTQ persons who lose partners often face “disenfranchised grief,” as their partners are seen as less important and their losses less profound than those of heterosexual couples (Jenkins, Edmundson, Averett, & Yoon, 2014).

A Caveat

Although we have highlighted the negative psychological implications of concealing sex-, gender, and sexuality-related stigmas, the assessor must be aware that disclosure in a hostile or dangerous environment (e.g., parental hostilities or religious sanctions) can require strategic planning. In these cases, it may be in the client’s best interest to continue to use concealment or to limit disclosure to very circumscribed spaces (e.g., an online community or a friend in another city). In these cases in particular, the relationship with the assessor can be an important social connection allowing the client to express suppressed emotions in a safe place.

The Assessor

The Assessor’s Person

As seen in the cases described in our chapters, the assessor as a person impacts the assessment in many ways. These can include the physical manifestations of the assessor’s biological sex; the behavioral expressions of the assessor’s masculinity-femininity, gender identity, or sexual orientation; as well as the implications of the assessor’s beliefs, expectations, and stereotypes. All of these can affect the assessment in ways of which the assessor may not be (and perhaps never will be) aware. As noted by Rourke and Bartolini (Chapter 5, this book), “An assessor’s expectations, perhaps subtly or implicitly cued by the presentation of the client, could easily activate a script that brings gender expectations into the room” (p. 119).
The Assessor’s Role

Yalof (Chapter 15, this book) discusses the four roles evoked by the interpersonal nature of the testing situation, as described in Roy Schafer’s (1954) classic writings: (a) voyeuristic, (b) autocratic, (c) oracular, and (d) saintly. As suggested by Schafer, the more that assessors are conflicted in any of these four areas, the more likely they are to step into that role.

The assessor should think about what these common roles could mean for sex-, gender-, and sexuality-related interpersonal dynamics. For example, the very nature of the assessment that gives assessors access to private parts of the client’s life—especially without the typical getting-to-know-you phase—can lead to a feeling of voyeurism on both the client’s and assessor’s part, especially for those aspects society considers taboo. The more assessors treat these characteristics as taboo in their own life, the more likely they are to be influenced by voyeurism. As a result, for personal reasons, the assessor might pruriently pursue private information about the client’s sex life or, conversely, avoid these private areas of the client’s life in the guise of protecting the client.

The assessor’s role as an expert authority pulls for an oracular role. The more assessors unwittingly step into the oracular role, the more clients may be silenced from expressing their own views, thoughts, and experiences. The oracular role may be particularly problematic when clients are feeling the most conflicted about their gender identity or sexual orientation, which could be especially pronounced with adolescent clients. The pull to step into the oracular role may be particularly strong when the assessor is conducting an assessment with a gatekeeping function, such as assessments that are conducted as a condition of sex reassignment surgery (see Finn, Chapter 21, this book).

The role of telling clients what to do in an assessment (e.g., sit here, do this, don’t do that) pulls for an autocratic role, which, in the context of this chapter, can result in clients’ experience of the assessor as more masculine/dominant and themselves as more feminine/passive. Finally, the assessor’s pull to step into the saintly role—all-caring, nonjudgmental, self-sacrificing—can be more insidious when assessors are blind to their own sex, gender, and sexuality prejudices and can result, for example, in reaction formation. Clients may, therefore, feel pulled to help the assessor deny their homophobia instead of the assessor helping the clients feel safe to express their own feelings, beliefs, and conflicts.

The Proactive Assessor

Know Thyself

Several chapters have highlighted the importance of assessors’ awareness of their own sex, gender, and sexuality identities and the ways these can shape their interactions with clients. To foster this awareness, Whitehead (Chapter 3, this book) suggests that clinicians conduct their own cultural self-assessment utilizing Hays’ (2008) ADDRESSING framework, which includes Age, Developmental
and acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender. The sex, gender, and sexuality component of this self-assessment can begin by asking oneself questions such as, “What if my sense of my gender were different? How would I feel about that?” or “When I was born, what were the social expectations for a person of my identity?” The assessor could also take the tests mentioned in Appendix to Chapter 27, which follows this chapter, such as the Conformity to Feminine [or Masculine] Norms Inventory (Mahalik et al., 2003, 2005).

Other chapter authors (Bullock & Wood [Chapter 20, this book]; Ortigo & Weiss [Chapter 25, this book]) recommend that assessors take Implicit Association Tests (IATs) to learn about their own interpersonal biases, such as those at Project Implicit®. Another resource is the gender version of the Implicit Association Test at the Understanding Prejudice website (Understanding Prejudice, 2015). However, we caution the assessor (or anyone) against concluding that IAT results indicate a truly unconscious attitude or belief. Common sense and knowledge of how the IAT works suggest that how fast one responds to paired associates can simply reflect an overlearned association of which the respondent can be aware—and research also supports this view (Hahn, Judd, Hirsh, & Blair, 2014). Regardless, assessors whose IAT results indicate social biases should be aware of these tendencies and attempt to change them (see next section).

Further Reduce Your Prejudice and Ignorance

Consult the Relevant Literature. The mere presence of our handbook suggests we believe it is important for the assessor to consult relevant literature on sex, gender, and sexuality issues, which you are clearly already doing by consulting our handbook. Each of our handbook’s chapters also provides bibliographies for future reading on the topic, and Ortigo and Weiss’s chapter on training (Chapter 25, this book) provides a table of very basic, helpful resources. In the bibliography for this chapter, we list general readings on the assessment of men, women, and LGBTQ clients (Cochran, 2005; Moe, Finnerty, Sparkman, & Yates, 2015; Worell & Robinson, 2009). At the same time, a study by Boysen and Vogel (2008) suggests that purely intellectual learning is unlikely to change an assessor’s sex, gender, and sexuality biases. Specifically, they found that training reduced counseling trainees’ level of self-reported bias against lesbians and gay men, but it did not affect the bias shown on IATs. Therefore, read on.

Engage With Others Unlike Yourself. Meta-analyses suggest that one of the most effective ways to reduce prejudice—especially sexual prejudice—is intergroup contact (Barto, Berger, & Hegarty, 2014; Pettigrew & Tropp, 2006). Although not required, intergroup contact particularly reduces prejudice if Allport’s (1954) optimal conditions of (a) equal status between the groups, (b) common goals, and (c) intergroup cooperation are present in the contact situation (Pettigrew & Tropp, 2006). Therefore, the assessor might capitalize on social or professional opportunities such as campaigning for LGBTQ rights.
(e.g., through The Human Rights Campaign®) or simply attending a sex-, gender-, or sexuality-focused panel (vs. lecture) presentation (Walch et al., 2012).

At the same time, there is also good evidence that imaginal intergroup contact can help reduce prejudice (Crisp & Turner, 2009; Stathi, Tsantila, & Crisp, 2012). Husnu and Crisp (2010) found that enhancing the vividness of the imagined intergroup scenario can help create a more accessible script to actualize one’s intentions in the future.

Get Involved on a Broader Scale. The Human Rights Campaign (HRC) website (http://www.hrc.org/) and HRC’s associated social media (i.e., Facebook and Twitter) provide excellent, up-to-date information and ways to get involved in promoting LGBTQ rights. You can also become involved in existing professional divisions or special interest groups. The American Psychological Association has specific divisions for Women (Division 35), Men and Masculinity (Division 51), and LGBTQ issues (Division 44). Check to see if your current professional societies have any sex-, gender-, and sexuality-related special interest groups. If not, you might contact the appropriate representative in their governance structure to make this suggestion (or initiate the special interest group yourself). More locally, you can review your workplace policies and procedures for areas that might need improvements. By being an advocate for marginalized groups, you are also better able to help your clients advocate for themselves.

Make You and Your Space Safe

Meeting with a psychologist for a psychological assessment can be anxiety-provoking for anyone but especially for people who already feel stigmatized or marginalized by society. The chapter authors varied in their views, both explicitly and implicitly, regarding how the assessor should handle this situation. For example, Whitehead (Chapter 3, this book) specifically recommends that assessors explicitly convey their affirmative stance when interviewing LGBTQ clients. While other chapter authors did not make explicit recommendations to the contrary, the most common implicit stance was for assessors to take their cues from their clients. There are two challenges to using this method: (a) the concealability of sexual orientation and gender identity, which means the assessor might not know to whom to express an affirmative stance, and (b) the assessor’s ability to read the client’s cues accurately. To address this problem, Ortigo and Weiss (Chapter 25, this book) give general suggestions to help make assessors and their space safer for sexual minority clients. For example, including a range of sexual orientation and gender identity choices on intake forms sends an implicit message of awareness and acceptance (e.g., St. Pierre, 2012). In fact, to help reduce LGBTQ health disparities, there are efforts underway in the U.S. to include sexual orientation and gender identity in electronic health records, with initial positive results (Cahill et al., 2014; Cahill & Makadon, 2014; Callahan et al., 2015; Deutsch & Buchholz, 2015). Ortigo and Weiss also suggest that the assessor display LGBTQ safe space signs in the office. Whether one also
expresses an affirmative stance explicitly, the assessor has many options for making his or her space safer for LGBTQ clients (also see St. Pierre, 2012).

The Assessment

The Necessity of Multi-method Assessment

Across the chapters, we have seen the absolute necessity of the multi-method approach because self-report tests and performance tests yield different findings and each contains a legitimate perspective. For example, the self-report method of assessment—self-report questionnaires as well as self-report in the clinical interview—appears to be more influenced by gender role concepts than performance instruments. When responding to a self-report test, clients’ responses are consciously and unconsciously influenced by how they wish to appear, given their sex, gender, and sexuality. Clients may also be inclined to conceal or distort sex-, gender-, or sexuality-related information that may interfere with health services.

The clinical interview involves several different methods of assessment, including the client’s self-report but also behavioral observations and clinical judgment. The information from the clinical interview can be skewed due to subtle cues from the assessor that shape and alter what the client says and does. In general, substantial evidence shows that clinicians’ own sex, gender, and sexuality biases or stereotypes can influence their judgment. Bornstein and McLeod (Chapter 9, this book) report research indicating that clinicians may exaggerate sex differences for certain forms of personality pathology, particularly antisocial, histrionic, and borderline (Corbitt & Widiger, 1995; Cosgrove & Riddle, 2004; Crosby & Sprock, 2004; Samuel & Widiger, 2009; Woodward, Taft, Gordon, & Meis, 2009; see also Narrow, First, Sirovatka, & Regier, 2007). In regard to cognitive assessment, Rourke and Bartolini (Chapter 5, this book) note a gender bias favoring males when teachers make decisions about whether to place students in gifted programs (Bianco, Harris, Garrison-Wade, & Leech, 2011) and gender disparities favoring boys in special education placements (Coutinho & Oswald, 2005). Intelligence testing can also be influenced when a client is affected by stereotype threat, particularly for females’ math performance (Franceschini, Galli, Chiesi, & Priml, 2014; Galdi, Cadinu, & Tomasetto, 2014; Ganley, Mingle, Ryan, Ryan, & Vasilyeva, 2013).

Performance tests may be more immune to the influences of gender roles when assessing personality characteristics. By far, there are significantly fewer sex differences on the Rorschach compared to self-report methods. Krishnamurthy (Chapter 4, this book) reports numerous sex differences on the popular broadband self-report tests (i.e., the MMPI-2 or MMPI-2-RF), but Tuber, Boesch, Gagnon, and Harrison (Chapter 6, this book) report very few sex differences on Rorschach. Tuber and colleagues report differences on the Rorschach Texture score (Cassella & Viglione, 2009; Ivanouw, 2007), a measure of
attachment, with women scoring higher than men. The direction of this difference is consistent with expected sex differences. However, these findings should be viewed with caution since they were not replicated by Meyer, Giromini, Viglione, Reese, and Mihura (2015). However, Silverstein (Chapter 7, this book) also reported research showing higher TAT affiliation and intimacy scores for women than for men. When assessing dependency, Bornstein (1995) found the expected male/female difference on a self-report measure but not on a well-validated Rorschach measure of dependency (Bornstein, 1999); in fact, men scored slightly higher than women. A review of potential affiliation and intimacy—or close relationship—sex differences on the Rorschach and TAT seems warranted. Otherwise, there were no obvious sex differences in regard to personality on these tests.

Performance methods’ relative immunity to sex and gender bias compared to self-report methods may not be due to self-report versus performance per se but, rather, due to its “face validity” (i.e., the degree to which what the test is measuring is obvious). The more unaware clients are regarding what is being assessed, the less they should be influenced by sex and gender bias. In comparison to most self-report tests, it is not obvious to the examinee what most Rorschach scores are designed to measure. In contrast, intelligence tests are performance tests, yet they are face valid tests (i.e., they are clearly assessing intelligence) and, thus, can be affected by gender stereotype threat (Schmader, Johns, & Forbes, 2008).

**Interpretation**

One question that has arisen across chapters is to what degree the meaning of a test score depends on the client’s identity or self-representation. For example, both Kleiger (Chapter 10, this book) and Bullock and Wood (Chapter 20, this book) note instances in which the thought distortion coding on the Rorschach may not be indicative of a primary thought disorder but, rather, discontinuities in self-experience. In other words, when the physical self that one shows to the world is incongruent with one’s internal sense of self, these incongruent self-experiences may manifest as incongruous representations on the Rorschach. Although intuitively a very appealing interpretation, the assessor may be on safer ground applying this interpretation only to Rorschach responses that more concretely represent the client’s own ideographic sex, gender, and sexuality experience. Either way, research is needed to test this interesting hypothesis. In the interim, the assessor may wish to consider this alternative interpretation if a sexual minority client has incongruous combinations on the Rorschach.

**Norms**

Many chapters in this handbook address the challenge of using norms in regard to gender, including (a) the lack of gendered norms for psychological tests,
Where Do We Go From Here?

Whether or not to use gendered norms when they are available, and (c) the lack of norms for most sex-, gender-, or sexuality-focused tests. Most of the current versions of psychological tests do not use gendered norms; the MMPI-2 and intelligence tests are key exceptions. Most chapter authors recommend using gendered norms in addition to combined gender norms with self-report and cognitive performance tests when they are available, although Krishnamurthy (Chapter 4, this book) describes relevant legal and diagnostic considerations. If using a test with gendered norms with transgender clients, the research is not yet clear which (if any) norms the assessor should use. None of the major personality and cognitive tests have transgender norms. The Rorschach seems less influenced by sex and gender bias, so gendered norms may not be warranted. Finally, most of the available sex-, gender-, and sexuality-focused tests (described next) do not have norms.

**Sex-, Gender-, and Sexuality-Related Tests**

Depending on the case, the assessor may find it helpful to add a minority stress or other sex-, gender-, and sexuality-specific scale to the assessment. Whitehead (Chapter 3, this book) recommends that during the clinical interview the assessor ask LGBTQ clients about experiences of discrimination, harassment, or bullying. In addition to using the clinical interview to address such experiences, relevant self-report scales are also available. For example, Testa, Habarth, Peta, Balsam, and Bockting (2014) developed the Gender Minority Stress and Resilience (GMSR) measure. The GMSR also includes subscales to assess gender-related discrimination, rejection, and victimization; nonaffirmation of gender identity; internalized transphobia; pride; negative expectations for the future; nondisclosure; and community connectedness.

As a quick reference, we have compiled the sex-, gender-, and sexuality-related scales discussed in our handbook’s chapters into Appendix to Chapter 27, which follows this chapter. The scales in the Appendix are separated into categories of sex-, gender-, or sexuality-related (a) attitudes and identity and (b) negative experiences, distress, and coping. For your reference, we have also included the chapter in which the scale is cited. Many of these scales are also reviewed in chapters by Moradi and Parent (2013) and Smiler and Epstein (2010). As an important note, however, most sex-, gender-, and sexuality-focused tests do not have norms.

**Underrepresented Areas in the Assessment Literature**

**Culture as Context**

With few exceptions, most of our chapters focused on the U.S. literature. Bornstein and McLeod (Chapter 9, this book), whose personality disorder chapter included cross-cultural issues, discussed the problem of generalizing from U.S. samples. For example, the authors note that borderline personality disorder is
diagnosed more frequently in women than in men in the U.S. but is diagnosed in equal rates in women and men in Japan (Calliess et al., 2008). It is important to note, however, that the underrepresentation of international research is not a problem limited to the topics of sex, gender, and sexuality. Arnett (2008), in his *American Psychologist* article “The Neglected 95%” (referring to everyone, other than Americans, who constitute 5% of the population), reviewed APA journals from 2003 to 2007. Of the samples, 68% were from the U.S., 14% were from other English-speaking countries, and 13% were from Europe; therefore, only 5% of the samples in the APA journals came from countries other than these. Focusing on young, educated Americans can be especially problematic in sexual prejudice research since the U.S. is among the least sexually prejudiced nations. According to the World Values Survey (http://www.worldvaluessurvey.org/wvs.jsp), 31% of Americans stated that “homosexuality is never justifiable,” as opposed to 90% of Georgians and 99% of Jordanians (while only 4% of Swedes agreed with this statement).

**Areas of Focus and Lack of Focus**

Across the various topics in this handbook, a few sex, gender, and sexuality areas appear to be particularly underrepresented in the literature. Transgender individuals have been notably underrepresented in research assessing the prevalence of psychological problems in LGBTQ populations (Institute of Medicine of the National Academies, 2011). Another area in need of more research is the use of a bidimensional versus unidimensional approach to assessing sexual orientation (i.e., heterosexual, mostly heterosexual, bisexual, mostly gay/lesbian, gay/lesbian). Although the “mostly” categories seem to peak in adolescence and young adulthood, they do not disappear in adulthood (Savin-William & Vrangalova, 2013; Vrangalova & Savin-William, 2012). Far less studied, and mentioned in only one chapter, is asexuality. Whitehead (Chapter 3, this book) recommends Chasin (2011) for a theoretical and conceptual understanding of asexuality. Clients, and perhaps assessors, may find the popular press book *The Invisible Orientation: An Introduction to Asexuality* (Decker, 2014) to be a helpful introduction. Yule, Brotto, and Gorzalka (2015) have also developed the 12-item Asexuality Identification Scale.

With a few exceptions, most of the sex-, gender-, and sexuality-related research conducted with psychological tests has focused on biological sex but not sexual orientation or gender identity. A lack of LGBTQ inclusion in psychological testing research can obviously limit generalizability, but it can also result in the omission of LGBTQ experiences in the item content. For example, a study by Garrett, Waehler, and Rogers (2010) suggests that the research finding that LGB participants have fewer reasons to live may be an artifact of the lack of LGB experiences in the scale (i.e., Reasons for Living Inventory; Linehan, Goodstein, Nielsen, & Chiles, 1983). A broader lack of sex, gender, and sexuality focus was found in the didactic literature on clinical interviewing. To provide perspective,
Whitehead (Chapter 3, this book) noted that most of the clinical interviewing literature is written for training purposes and, therefore, largely provides broad, basic overviews of formats and styles of interviewing. As exceptions, Whitehead notes Brown’s (1986, 1990) articles on gender in the clinical interview and Silverstein’s, C (2011) edited volume *The Initial Interview: A Gay Man Seeks Treatment*.

**Sex-, Gender-, and Sexuality-Related Strengths**

Historically, clinical psychologists have been accustomed to focusing on pathology, but an emerging body of literature focuses on the humanistic or positive psychology contributions to mental health (e.g., Seligman & Csikszentmihalyi, 2001). Two areas relevant to our handbook are stress-related growth and LBGT strengths. Stress-related growth is the development of a sense of personal strength in response to a difficult and stressful experience (Folkman & Moskowitz, 2004), which Cox, Dewaele, van Houtte, and Vincke (2011) applied to the coming-out experience. In the positive psychology literature, LBGT strengths have recently been thoughtfully integrated into the “three pillars” of positive psychology: (a) positive social institutions, (b) positive subjective experiences, and (c) character strengths. Vaughan and Rodriguez (2014) and Lytle, Vaughan, Rodriguez, and Shmerler (2014) provide some guidance in incorporating LGBTQ strengths into clinical research, training, and practice. We believe it is important for assessors not just to focus on pathological experiences but also to value sex-, gender-, and sexuality-related personal strengths and growth, which can help the client feel seen and understood and may help heal stigma experiences that have left the client feeling defective.

**Research on Intersectionalities**

As discussed in Chapter 2, we believe that intersectionalities—the space shared by two or more social identities—should receive more focus in clinical research, training, and practice. In Chapter 2, we provide a discussion of how each of Hays’ (2008) ADDRESSING framework components can interact with sex, gender, and sexuality. Here, we simply note that research on intersectionalities exists (Ghavami et al., 2011; Ghavami & Peplau, 2012; Johnson & Ghavami, 2011), but conducting such research is challenging. Including several intersectionalities in a research study requires very large sample sizes and complicated statistical analyses. A further challenge is expecting the researcher to possess or obtain expertise in each of the intersecting areas, as well as access to the populations. One solution is to include several authors who each have expertise in at least one of the intersecting areas. Benefits to the authors are their inclusion in more research publications, and the resulting intersectional multi-authored publications should have better specificity and value (the whole should be greater than the sum of its parts).
Going Beyond the Boundaries in Research and Practice

In many ways, the psychological assessment literature could be greatly enhanced by going beyond its boundaries, both internally and externally, since the topic of sex, gender, and sexuality has been explored more extensively in the broader nonclinical personality literature (e.g., Else-Quest, Hyde, Goldsmith, & Van Hulle, 2006; Feingold, 1994; Lippa, 2008; Marsh, Nagengast, & Morin, 2013). Since the self-report method is ubiquitous in gathering research data, one can roughly generalize from the broader research on sex, gender, and sexuality and apply these findings to formal psychological instruments like the PAI and MMPI-2. For example, the broader literature consistently shows that females are more likely to report internalizing symptoms, and males are more likely to report externalizing symptoms (Markon, 2010; Rosenfield, 2000). These findings are consistent with the research on individual MMPI-2 and MMPI-2-RF scales reported by Krishnamurthy (Chapter 5, this book). In contrast to self-report tests, however, it is more difficult to generalize from the broader literature to tests that use other assessment methods (e.g., Rorschach, TAT, WAIS).

The field of psychological assessment could also benefit from integrating sex-, gender-, and sexuality-related literature from other areas of psychology (e.g., developmental, social, industrial/organizational [I/O]) as well as areas beyond psychology (e.g., health, educational, business). For example, ostracism and bullying have been studied more broadly in the areas of social, I/O, developmental, and school psychology, and many of these publications have addressed sex, gender, and sexuality dynamics (Benenson, Hodgson, Heath, & Welch, 2008; Hawes et al., 2012; Siyahhan, 2014; Williams & Sommer, 1997; Wittenbaum, Shulman, & Braz, 2010). There are also psychotherapy-oriented publications for working with gender and LGBTQ groups that contain assessment-relevant information (e.g., Pachankis & Goldfried, 2004). In the I/O literature, Petriglieri (2011) has developed a Theoretical Model of Identity Threat Processes and Responses that is highly relevant to the sexual minority stress literature. The literature on the effects of sexuality biases in job interviews (Hebl, Foster, Mannix, & Dovidio, 2002) should also be integrated with the literature in which biases affect decision making when psychological assessment is used to give people access to resources—for example, when cognitive assessment is used to place students in gifted programs or to allow people to receive valued services (e.g., disability benefits). Relevant research with sexual minority populations in primary healthcare settings (e.g., St. Pierre, 2012) should also be integrated into the psychological assessment literature. Finally, psychological assessment would also benefit from incorporating research on the broader study of stigma and related health inequities (Fredriksen-Goldsen et al., 2014; Hatzenbuehler, Phelan, & Link, 2013; Mayer et al., 2008).
Where Do We Go From Here?

**A Final Note**

Throughout this handbook, chapter authors have emphasized many different areas that need improvement in the treatment of sex, gender, and sexuality in psychological assessment. To move forward, we must remember that there is always something in our world that can be improved. A hundred years from now, people will look back and clearly see many social injustices and inequalities about which we are not currently aware. On a broader social scale, it has been only during the past 100 years that significant strides have been made in recognizing and reducing sex, gender, and sexuality discrimination and inequality. In 1920, women’s legal right to vote was established in the U.S. In 2000, the first state in the U.S. (Virginia) gave full marriage rights to same-sex couples, and the first country in the world (the Netherlands) signed into law a same-sex marriage bill. In the history of human beings, all of this is within the blink of an eye. Yet still, many sex-, gender, and sexuality-related injustices and inhumane treatment continue to occur in the world at a much higher frequency and level of cruelty than one might expect. We will always have plenty of work to do to improve the human condition.

**Practical Points**

- Psychological assessment would benefit from incorporating information from a growing body of literature on the negative effects of stigma and discrimination on psychological and physical health.
- We recommend that assessors be aware of how their own sex-, gender-, and sexuality-related physical and psychological characteristics, as well as the interpersonal dynamics of their role (e.g., Schafer’s voyeuristic, autocratic, oracular, and saintly roles), affect the assessment.
- We recommend that assessors be proactive in their self-awareness (e.g., conduct a cultural self-assessment; take sex-, gender-, and sexuality-related IATs and self-report instruments) and work to reduce prejudice and ignorance (e.g., consult the relevant literature, engage with others unlike yourself, become an advocate of LGBTQ rights).
- We recommend that assessors make their space safe by using nonbinary intake forms, displaying LGBTQ safe space signs in the office, and depending on the situation, explicitly stating their LGBTQ affirmative stance.
- The assessor should use multi-method assessments and be aware of the challenges, biases, and benefits of each method (e.g., gender role affecting self-report, the Rorschach’s more relative immunity to the influences of sex and gender stereotypes and stigmas).
- The assessor should be aware of the considerations of using nongendered or gendered norms, and research should more actively address this issue. The reader can consult each of the relevant chapters in our handbook to see how the authors addressed the problem.
We have provided Appendix to Chapter 27 of the sex-, gender, and sexuality-related scales discussed in this handbook. The lack of norms for these scales, however, is a concern.

There is a particular need for more research in the assessment literature in the following areas: (a) sex-, gender-, and sexuality-related cross-cultural research, (b) gender-related and LGBTQ issues (compared to biological sex), (c) the specific topics of transgenderism, asexuality, and the sexual orientation continuum, (d) sex-, gender-, and sexuality-related strengths, and (e) sex-, gender-, and sexuality-related intersectionalities.

Finally, we encourage assessment researchers to go beyond the boundaries of psychological assessment and integrate the research from other areas of psychology (e.g., developmental, social, I/O), as well as areas beyond psychology (e.g., health, educational, business).

Annotated Bibliography

Additional Readings on the Assessment of Men, Women, and LGBT Clients


Comment: Written for working with men who have traditional, Western masculine values, Cochran’s article discusses the most common expressions of psychodynamic conflicts and DSM disorders with a case example.


Comment: Based on a review of literature, the authors provide guidance in avoiding hetero-normative and cisgender biases when conducting an assessment with LGBTQ clients.


Comment: Discusses potential areas of biases when conducting assessments with women, as well as suggests potentially relevant topics and concerns to address.

Sex-, Gender-, and Sexuality-Focused Scales


Comment: This chapter provides descriptions of various gender-related scales to assess identity, attitudes, ideologies, perceived discrimination, and gender-related stress and inner conflicts.
Broader Considerations on Sexuality and Gender in Assessment and Diagnosis


Comment: A two-volume set by the American Psychological Association on a broad range of topics on sexuality and psychology. There are chapters on topics such as sexual diversity, theories of sexual orientation, gender and same-sex sexuality, as well as broader cultural topics such as sexuality and culture, sexual social movements and communities, sexual rights, sexuality and social policy, and more.

Notes

1. In particular, the assessor should consult Hays’ (2008) chapter “Looking into the Clinician’s Mirror.”

2. For example, in Chapter 5 of this volume, Krishnamurthy states:

   Several MMPI-2 content and supplementary scales scores are found to be slightly higher for women than men in clinical settings, including Anxiety, Fears, Depression, Health Concerns, Low Self-Esteem, Work Interference, Welsh’s Anxiety, College Maladjustment, Post-Traumatic Stress Disorder–Keane, and Overcontrolled-Hostility. Men are found to score slightly higher than women on Cynicism, Antisocial Practices, Type A, Hostility, and the alcohol/drug problem scales MacAndrew Alcoholism-Revised, Addiction Admission, and Addiction Potential.

References


Where Do We Go From Here?


Where Do We Go From Here?


Appendix to Chapter 27
SEX-, GENDER-, AND SEXUALITY-RELATED SCALES DISCUSSED IN CHAPTERS
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<tr>
<td>Bem (1981)</td>
<td>Bem Sex Role Inventory</td>
<td>60-item scale widely used for the measurement of the masculinity–femininity construct; 30-item short form available</td>
<td>18+</td>
<td>7, 9</td>
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<tr>
<td>Drewlo (2011)</td>
<td>The Riddle Scale Adapted for Transphobia</td>
<td>16-item scale helps the user to assess his or her own attitudes toward transgender people on a continuum ranging from Repulsion to Nurturance</td>
<td>18+</td>
<td>20</td>
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<tr>
<td>Ehrhardt &amp; Meyer-Bahlburg (1984)</td>
<td>Gender-Role Assessment Schedule—Adult</td>
<td>33-item semi-structured interview</td>
<td>18+</td>
<td>23</td>
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<tr>
<td>Mahalik et al. (2005)</td>
<td>Conformity to Feminine Norms Inventory</td>
<td>84-item scale assesses a woman’s conformity to feminine norms found in the U.S.</td>
<td>18+</td>
<td>27</td>
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<tr>
<td>Mahalik et al. (2003)</td>
<td>Conformity to Masculine Norms Inventory</td>
<td>94-item scale assesses a man’s adherence to masculine norms found in the U.S.</td>
<td>18+</td>
<td>27</td>
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<tr>
<td>Mohr &amp; Fassinger (2000)</td>
<td>Outness Inventory</td>
<td>11-item scale examines the degree to which LGB people are public about their sexual identity (e.g., at home, at work, in the community)</td>
<td>18+</td>
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<tr>
<td>Mohr &amp; Kendra (2011)</td>
<td>The Lesbian, Gay, and Bisexual Identity Scale</td>
<td>27-item scale of sexual identity based on the various experiences (e.g., disclosure of one’s sexual identity, acceptance, concealment)</td>
<td>18+</td>
<td>14</td>
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<tr>
<td>Yule, Brotto, &amp; Gorzalka (2015)</td>
<td>The Asexuality Identification Scale</td>
<td>12-item scale for assessing asexuality</td>
<td>18+</td>
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**Negative Experiences and Coping**

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<tr>
<td>Balsam, Molina, Beadnell, Simoni, &amp; Walters (2011)</td>
<td>LGBT People of Color Microaggressions Scale</td>
<td>18+</td>
<td>1, 2, 20</td>
<td></td>
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<tr>
<td>Cohen-Kettenis &amp; van Goozen (1997)</td>
<td>Utrecht Gender Dysphoria Scale</td>
<td>11+</td>
<td>23</td>
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<tr>
<td>Deogracias et al. (2007)</td>
<td>Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults</td>
<td>13+</td>
<td>23</td>
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<tr>
<td>Fitzgerald, Magley, Drasgow, &amp; Waldo (1999)</td>
<td>Sexual Experiences Questionnaire</td>
<td>18+</td>
<td>2, 19</td>
<td></td>
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<tr>
<td>Klonoff &amp; Landrine (1995)</td>
<td>Schedule of Sexist Events</td>
<td>18+</td>
<td>2</td>
<td></td>
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<tr>
<td>Testa, Habarth, Peta, Balsam, &amp; Bockting (2015)</td>
<td>Gender Minority Stress and Resilience Measure</td>
<td>18+</td>
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