

Patients Who Request a Female Psychotherapist

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Abstract

Upon arriving at an outpatient clinic, many patients request to see a female psychotherapist. Yet little has been written on this topic. The aim of this study was to explore the demographic and clinical characteristics of such patients. We compared patients who voiced a preference for a female therapist with controls on the demographic variables of age, sex, race, marital and financial status and the clinical characteristics of diagnosis, history of sexual abuse, sexual preference, overt presence of sexual or social difficulties, history of prior treatment, gender of the previous therapist, and treatment drop out rate. A chi square analysis for categorical data was used to measure differences between the two populations. We found that patients who voiced a request for a female therapist were more often white, young, or had voiced sexual or social difficulties in their chief complaint. The treatment drop out rate of study patients whose request was granted was greater than control patients who received a female therapist. The request for a female therapist may be reflective of an age or race based comfort in expressing preference, or related to specific presenting complaints in the realm of sexual or social relationships. Granting such a request without an understanding of its significance may result in premature termination of treatment.

INTRODUCTION

While much has been written about the potential effects of a therapist's gender upon the process and outcome of psychotherapy (1-6), a patient's request for a specific gender therapist has received little attention. A review of the literature revealed few papers on this topic (7,8). Such inattention to a frequently encountered clinical occurrence prompted us to undertake our investigation. Our aim was to study the demographic and clinical characteristics of individuals who request a female therapist. Through this data we sought to explore the potentially significant therapeutic issues involved in treating such patients.

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METHODS

This study was conducted at a resident run, university hospital outpatient psychiatric clinic. In a fifteen month period, 222 intake evaluations were performed. Thirteen male and eleven female residents worked in the clinic over the course of our study. Study subjects were selected by their having spontaneously requested a female therapist before or during intake. A control population was generated by using the next intake in which no such request was made. The two samples were then compared on the demographic variables of age, sex, race, marital and financial status and on the clinical characteristics of diagnosis, history of sexual abuse, sexual preference, overt presence of sexual or social difficulties, history of prior treatment, the gender of the previous therapist, and the drop-out rate. A chi square analysis for categorical data was used to measure differences between the two populations. Dropping out of treatment was defined as attending therapy for less than two months or seven sessions.

RESULTS

Twenty-two out of 222 new patients (10%) requested a female therapist at the time of initial evaluation. Patients who requested a female therapist were more often younger ($p < .06$, $\chi^2 = 7.61$), white ($p < .005$, $\chi^2 = 7.50$) (Table 1), and likely to voice concerns regarding sexual and/or social relationships ($p < .05$, $\chi^2 = 3.03$) as their presenting complaint (Table 2). Diagnosis, sexual orientation, history of sexual abuse, socio-economic status, and marital status did not differentiate the control from the experimental group. Previous psychotherapy with either a male or female therapist was also not noted to distinguish the two groups. While seventeen of the twenty two (77%) patients requesting a female therapist were themselves female, this percentage was not significantly different from the control group.

Fifteen of the twenty two (68%) patients requesting a female therapist were indeed assigned to a female therapist. Two patients who voiced a preference for a female therapist later changed their minds as a result of the intake interviewer's exploring the origin of their requests. The requests of the remaining five could not be granted due to the lack of availability of female therapists; these patient did accept male therapists.

Nine of the fifteen patients (60%) requesting and receiving female therapists dropped out of treatment prematurely. This value was significantly higher ($p < .05$, $\chi = 7.67$) than control patients receiving female therapists (Table 2).

DISCUSSION

Attempts to study patient preference of therapist gender have been inconsistent. Studies have revealed same gender preference (1,2,9,10), opposite gender preference (11), preference for male therapists by both sexes (3) and preference for female therapists by both sexes (4). Methodologic differences between these studies

TABLE 1.

Patients Requesting a Female Therapist: Demographic Characteristics

Characteristics	Subjects (n = 22)	Controls (n = 22)
Age		
< 20	0	1
20-29	1*	4
30-39	4	11
> 40	7	6
Sex		
Male	5	9
Female	17	13
Race		
Black	1	8
White	20**	14
Other	1	0
Marital Status		
Single	17	12
Married/Widow	3	5
Separated/Divorced	2	5
Socioeconomic Status		
Medical Assistance	6	7
Hospital Subsidy	12	9
Private Pay	4	6

*p < .06; **p < .005

further complicate their interpretation. A more important discrepancy to our purpose is the fact that these studies refer to patients already engaged in treatment. Our investigation, in contrast, deals with the patient's request for a female therapist before or during the initial evaluation.

In comparing such patients with controls (Tables 1 and 2), we found four positive findings. First, the explicitly stated preference of younger patients in our sample may reflect a consumer-oriented mentality in which asking for what one wants is valued. Second, a similar reasoning may apply to the race-related differences in our study. White patients in our sample may have a greater sense of empowerment than black patients. An important consideration is that black patients were in the minority, both in the patient sample and the clinic staff. Our third and fourth findings confirm our intuitive prediction, that patients requesting a female therapist voice concerns with sexual or social relationships. This finding may be due to the widespread belief that women are more sensitive and gentle than men (12) and hence less threatening when patients reveal such concerns.

We were surprised by our negative findings. We had expected more female patients, especially those who has been sexually abused, to have requested a female therapist. Our hypothesis was based upon clinical impressions and the feminist perspective of a female to female therapist-patient dyad being preferable (3). Clearly, neither belief was borne out by the data.

TABLE 2.

Patients Requesting a Female Therapist: Clinical Characteristics

Characteristics	Subjects	Controls
Diagnosis		
Schizophrenia	1	4
Affective Disorder/Depr.	11	13
Affective Disorder/Manic	4	3
Anxiety Disorder	10	7
Organic Disorder	2	1
Adjustment Disorder	8	7
Personality Disorder	14	10
History of Sexual Abuse		
Yes	4	3
No	18	19
Sexual Preference		
Heterosexual	16	18
Homosexual	5	3
Bisexual	1	1
Sexual/Social Chief Complaints		
Yes	8*	3
No	14	19
History of Prior Treatment		
By Male & Female	3	3
By Female	9	3
By Male	2	4
No Prior Treatment	6	10
Not Obtained at Intake	2	2
Drop Out Rate		
Total Number of Drop Outs	11	8
Assigned to Female	9*	2
Assigned to Male	2	6

* $p < .05$

Our drop out rate data, while reflective of a relatively small sample, reveals interesting findings. The high drop out rate (41%) of female study patients whose request was granted may, at first glance, be surprising. A patient's request at the onset of treatment may be a harbinger of future requests which at some point will not be able to be granted.

In light of the positive and negative findings of our study, it seems that the request for a female therapist is either reflective of an age and/or race based comfort in expressing preference and/or specific presenting complaints in the realm of sexual or social relationships. These findings dictate that each request be explored on an individual basis. Merely granting the request does not necessarily imply that treatment will be more likely to be successful or longer-lasting. The interviewer must inquire as to why the patient has made such a request or risk incorrect assumptions about its origin, thus colluding with factors which might have led to such a request. The importance of exploring the patient's request for a specific gender therapist is

underscored by the literature of the past thirty years which has focused on what gender therapist should treat a particular gender patient rather than addressing the significance of a patient having made such a choice. We expect that such a choice presents an opportunity to examine how the patient perceives the therapeutic community into which he or she is about to enter.

The decision to grant a patient's request for a female therapist rests upon the tension between adding to a resistance to therapy versus fostering a comfortable treatment relationship. In several of the cases where a patient was able to explore the nature of their request for a female therapist, irrational beliefs towards males were unbelievable and indeed the patients were able to continue working with a male therapist. Such cases lend support to the adage that a patient's choice of therapist may complicate the treatment, but need not prevent optimal outcome.

Clearly our findings and their interpretations are tentative. Further study needs to be done to assess the importance of a patient's initial request for a specific gender therapist. Just as we found surprising results in our preliminary study, long term follow up may reveal unsuspected effects on outcome, drop out rates, and satisfaction with care.

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