**Clinicians' Diagnostic Practices with
Senior Survivors of Childhood Trauma**

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Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of
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Abstract

In a postal survey, 111 psychologists (47.7% female) and 119 psychiatrists (44.5% female) were presented a case history depicting a senior female or male survivor of childhood sexual abuse (vs. the Holocaust) whose symptoms fulfilled criteria Posttraumatic Stress Disorder, Borderline Personality Disorder (BPD), depression and dementia. Although there were no effects due trauma type, data analyses suggested age-related biases, including high dementia ratings, more medical therapy recommendations, and less favourable client evaluations. There was also evidence of gender bias because female trauma survivors were given higher rates of BPD than males. Moreover, clinicians assigned the client higher diagnostic ratings for depression than dementia and for dementia than PTSD. Finally, the variations in clinicians' diagnoses added to existing evidence regarding the unreliability of the diagnostic enterprise. The validity of the findings, particularly in view of the 24.5% response rate, and the implications for future research and clinical training, are discussed.

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Clinicians' Diagnostic Practices with Senior Survivors of Childhood Trauma

Aging, for most people, is associated with a number of challenges, including mandatory job loss, loss of social supports, and declines in physical health. Because women outlive men, senior women are also likely to experience the consequences of widowhood, chronic health problems and poverty (Perkins, 1992). In addition, while men may encounter the challenges posed by their earlier war-related experiences, women may be faced with realities of their earlier experiences of physical and sexual assault. These realities, and in particular clinicians' diagnostic responses to these realities, comprise the focus of this research.

It is estimated that one in three women have been sexually abused before the age of 18 (Russell, 1986; Silverman, Reinherz, & Giaconia, 1996), a rate that is at least twice as high as that among boys (Silverman et al., 1996). In a national U.S. survey, for example, 27% of adult women and 16% of adult men reported childhood experiences of sexual abuse involving physical contact (Finkelhor, Hotaling, Lewis & Smith, 1990). In addition, approximately 20% of women are sexually assaulted as adults and 30% are battered by their partners (Koss et al., 1994). Interestingly, women who were sexually abused as children are twice as likely to be sexually assaulted or battered by their partners (van der Kolk, 1996; see also Browne & Finkelhor; Green, 1993a).

The increasing numbers of seniors in society, the majority of whom are women (Statistics Canada, 2001), creates a pressing need to examine the long-term aftereffects of violence toward women and children. This need is all the more urgent because, as will become evident, the lack of insight into how senior women manifest their earlier experiences of trauma leaves room for sexism and ageism in clinical practice.

Aftereffects of Trauma Across the Lifespan

As defined by the American Psychiatric Association (1994, p. 424), a traumatic event is one that “involves direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person.” Many events have the potential to meet these criteria, some of which are more common in the lives of men (e.g., those associated with war) and others in the lives of women (e.g., child sexual abuse, adult sexual assault and partner abuse).

One psychological response to trauma is Posttraumatic Stress Disorder (PTSD). Originally observed during World War II, when it was called “survivor syndrome,” PTSD is characterized by three sets of symptoms (APA, 1994). The first set of symptoms involves persistent re-experiencing of the event in the form of nightmares, intrusive recollections, hallucinations, dissociative episodes, or intense psychological and physical arousal when exposed to situations similar to the traumatic event. The second set of symptoms involves persistent avoidance of stimuli associated with the trauma in the form of efforts to avoid thoughts, feelings, conversation, places or people reminiscent of the trauma. It can also manifest itself in the inability to express a normal range of affect, decreased interest in activities, a sense of doom and estrangement from others. The final set of symptoms characterizing PTSD involves persistent symptoms of increased arousal, including insomnia, irritability, anger, difficulty concentrating, hypervigilance and an exaggerated startle response. According to the DSM-IV (APA, 1994), additional symptoms are associated with interpersonal traumas such as childhood sexual abuse, battering, surviving a concentration camp, being incarcerated as a prisoner

of war, and being taken hostage. Sometimes referred to as complex PTSD (e.g., Herman, 1992), these symptoms include difficulty modulating affect, self-destructive and impulsive behaviour, somatic complaints, feelings of ineffectiveness, shame, hopelessness and threat, hostility, social withdrawal, impaired relationships, and changes in personality.

PTSD rates in adults. Although estimates vary, largely as a result of differences in assessment procedures, the characteristics of the sample (e.g., clinical vs. nonclinical) and the intensity of trauma across studies, it is clear that a sizeable number of people experience PTSD in the wake of interpersonal trauma, be it combat experience, confinement in concentration camps, child sexual abuse, rape or battering.

The documented rates of PTSD associated with combat experience are high. The National Vietnam Veterans Readjustment Study (Weiss et al., 1992), in which PTSD prevalence rates were assessed in a nationally representative community sample of Vietnam veterans, revealed lifetime PTSD prevalence rates of 30.9% for men and 26% for women. Lifetime prevalence rates for partial PTSD included a further 22.5% of men and 21.2% of women. In total, 53.4% of men and 48.1% of women had at some point experienced clinically significant symptoms of PTSD. Similar findings were observed in Solomon's (1993) longitudinal study of Israeli soldiers who fought in the 1982 Lebanon War. The prevalence of PTSD among 382 men who had suffered a psychiatric breakdown on the battlefield (i.e., Combat Stress Reaction) was high: 62% after the first year, 56% after the second year, and 43% after the third year. Even soldiers who had managed to cope successfully with the immediate stress of combat ($n = 334$) were vulnerable to PTSD after the war, as indicated by PTSD prevalence rates of 14%, 17%

and 10%, respectively. Eighteen years after the war, 13.4% of those who had Combat Stress Reaction and 3.3% of those who did not, satisfied the criteria for PTSD.

Other research has examined the factors moderating the likelihood of PTSD following combat. This research indicates that PTSD was more likely among soldiers who were younger (Green et al., 1990), whose combat experiences involved chronic high-risk (Weisaeth & Eitinger, 1993) and who were physically injured (Orner, 1993). In addition, several studies have documented higher PTSD rates among Vietnam veterans who had been physically or sexually abused during childhood, suggesting that trauma predisposes people to more extreme reactions to subsequent trauma (Bremner et al., 1993; for a review see Breslau, Chilcoat, Kessler & Davis, 1999).

People interned in concentration camps also experience PTSD. In Drozdek's (1997) study of 120 concentration camp survivors from Bosnia-Herzegovina (aged 27 to 41 years), 44% had full-blown PTSD and 22% satisfied most, but not all, of the criteria for PTSD. Interestingly, 83% of those who received therapeutic treatment maintained their diagnosis of PTSD three years later. The presence of PTSD after three years was higher for married men and parents. Furthermore, with increasing age, the survivors had more PTSD symptoms, suggesting that aging affects the course and severity of PTSD.

Comparable rates of PTSD have been observed among survivors of violence toward women and children. After a comprehensive review of 45 studies, Kendall-Tackett, Williams, and Finkelhor (1993) concluded that PTSD is likely to occur in 30 to 50% of sexually abused children. Similar rates of PTSD have been noted during adolescence and adulthood. In an ongoing longitudinal study of 375 young adults, Silverman et al. (1996) found that the diagnostic criteria for PTSD were met by 35% of

young women who had experienced childhood sexual abuse and 42% who had experienced childhood physical abuse. Similarly, Rowan and Foy (1993) reported PTSD rates ranging from 40 to 90% across seven studies of adult survivors of childhood sexual abuse. Indeed, in a meta-analysis of 37 studies, Paolucci, Genuis, and Violato (2001) found at least a 143% increase in the risk of developing PTSD for adults who had been sexually abused as children versus those who had not.

Both the likelihood of PTSD following child sexual abuse and its severity are affected by a number of factors, including the intrusiveness of the abuse (i.e., penetration; Briggs & Joyce, 1997; Kendall-Tackett et al., 1993), age of onset (Berliner & Elliot, 1996; Kendall-Tackett et al., 1993), duration (Berliner & Elliot, 1996), the relationship of the perpetrator (i.e., family vs. non-family member; Berliner & Elliot, 1996; Kendall-Tackett et al., 1993; Rowan & Foy, 1993), and the use of force or violence (Berliner & Elliot, 1996; Kendall-Tackett et al., 1993).

Studies of women who were sexually or physically assaulted as adults yield comparable PTSD rates, ranging from 31 to 63% following rape (Breslau et al., 1997; Foa, 1997; National Victims Center, 1992) and 43 to 84% following partner abuse (Houskamp & Foy, 1991; Kemp et al., 1991). As observed for other traumas, the onset of PTSD following such traumatization is moderated by previous exposure to trauma, whether the trauma involved violence, and pre-existing anxiety or depression (Breslau et al., 1999).

In view of the above findings, it is clear that the interpersonal traumas common to men and women have the potential to evoke PTSD. Moreover, men and women manifest PTSD in comparable ways. In a unique study that compared the clinical presentation of

PTSD following different traumas, Elhai and his colleagues (2000) examined data provided by 122 combat veterans (M age = 47 years) from a Veterans' Affairs Medical Center and 64 sexual abuse survivors (M age = 31 years) from an outpatient treatment program. Both groups were diagnosed with PTSD and had completed the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) as part of a standard intake evaluation. Sexual abuse survivors scored higher on hostility and impulsivity, anxiety, difficulty thinking and concentrating, and elevated mood and energy whereas veterans scored higher on fears, health concerns and social discomfort. Although these group differences were statistically reliable, Elhai et al. (2000) described them as clinically insignificant because all of the participants received relatively high scores on these variables. Moreover, most group differences disappeared when age was controlled.

While adult women and men may manifest PTSD in comparable ways, women may be more likely to develop PTSD in response to trauma. Breslau, Davis, Andreski and Peterson (1991) interviewed 1007 people (62% female) about their traumatic experiences and current psychological functioning. After controlling for the type of trauma and previous exposure to trauma, they found that the risk of PTSD was twice as high for women than men. This finding was subsequently replicated by Breslau et al. (1999). Although the reason for this gender difference is largely speculative, some researchers contend that it may be due to the increased risk of physical injury for women during trauma and the presence of pre-existing disorders such as depression or anxiety (Seedat & Stein, 2000).

PTSD rates in seniors. Studies of aging war veterans and Holocaust survivors yield findings that pose a serious challenge to the notion that 'time heals all wounds.'

Although the National Center for PTSD (1998) estimates that about five percent of senior WW II veterans are at risk for PTSD, studies of aging prisoners of war (POWs) and Holocaust survivors report substantially higher rates. In Engdahl, Dikel, Eberly and Blank's (1997) study of 262 community-based nontreatment-seeking men who had been POWs in Japan, Korea or Europe (*Mdn* age = 71 years) the prevalence of current and lifetime PTSD was 29% and 53%, respectively. Predictors that collectively explained 33% of the variance in POW's PTSD were, in order of magnitude, more weight loss during captivity, more combat exposure, experiencing or witnessing torture or beatings, lack of social support and being younger at the time of capture.

Kuch and Cox (1992) observed even higher rates of PTSD in their sample of 123 Holocaust survivors (*M* age = 62 years), of whom 78 had been in concentration camps, 20 had been tattooed and in Auschwitz (an extermination camp) and 45 in labour camps, ghettos or in hiding. Of the entire sample, 46.8% satisfied the criteria for PTSD. Among the concentration camp survivors in general, and the Auschwitz survivors in particular, this rate rose to 51.3% and 65%, respectively. Yehuda, Kahana, Southwick and Giller (1994) reported similar findings in their study of 23 Holocaust survivors aged 62 to 80 years. Despite the fact that these survivors were physically healthy and free of major psychiatric disorders (e.g., schizophrenia, dementia, and substance abuse), 48% currently had PTSD and 78.3% had experienced PTSD at some point in their lives. In a subsequent study, Yehuda et al. (1995) observed PTSD in 55.6% of 72 nontreatment-seeking Holocaust survivors (*M* age = 66.4 years).

As observed among aging POWs, the likelihood of PTSD for senior Holocaust survivors varies as a function of factors such as age at time of internment (Yehuda et al.,

1997), intensity of the atrocities experienced (Kuch & Cox, 1992) and the strength of social supports and self-disclosure (Harel, Kahana & Kahana, 1993). Interestingly, in Yehuda et al.'s (1995) study the 40 Holocaust survivors with PTSD reported more cumulative trauma and recent stress than those without PTSD. Moreover, severity of PTSD symptoms, cumulative trauma and recent stress were correlated, suggesting that the presence and severity of current PTSD were related to having experienced stressful events in addition to the Holocaust and that current stress exacerbated ongoing PTSD.

That aging itself may be a risk factor for PTSD (Aarts & Op den Velde, 1996) is apparent from studies documenting the re-emergence and delayed-onset of PTSD as war veterans enter their so-called 'golden years.' In a study of 179 POWs from the Korean War and WW II, Zeiss, Dickman and Nichols (1985) found that 22% had continuous symptoms of PTSD, 20% experienced symptoms that had remitted but re-emerged, and 36% had late-onset PTSD. In another study of 147 senior Dutch resistance fighters (*M* age = 64) who were socially stigmatized in much the same way as child sexual abuse survivors (Op den Velde, et al., 1993), 55.8% displayed ongoing PTSD, 12% had PTSD that became more severe with age, and 56% had delayed-onset PTSD. Moreover, almost half (46.6%) of these resistance fighters did not manifest any symptoms of PTSD until at least 20 years after the war.

At this point there are, unfortunately, no systematic studies of the prevalence of PTSD in senior survivors of violence toward women and children. The case studies that have appeared in the literature, however, suggest that these women, like their male counterparts, are at risk for chronic, re-emergent or delayed-onset PTSD. Allers, Benjack and Allers (1992) described three elderly women with psychological problems stemming

from childhood sexual abuse. One case involved a 69 year-old woman living in a seniors' housing facility. This woman entered therapy for sleep problems, poor appetite, disorientation, general fatigue, and an inability to maintain personal hygiene. These symptoms had become worse following her husband's death six years earlier. During therapy, she disclosed sexual abuse by her grandfather that went on until she married at age 14. Therapy consisted of music and art therapy, bibliotherapy, and discussions of the impact of the abuse on her life. After eleven months of therapy, she was eating, sleeping and caring for herself, felt more energetic, and had more satisfying peer relationships.

A second case involved an 81 year-old woman living independently in an adult housing facility who was referred for therapy because of incapacitation and social withdrawal following an 'incident' in her home. In therapy, she disclosed that the 'incident' was an attempted assault by a male resident that she had been reluctant to disclose for fear that she would be blamed. As therapy continued and she began to trust the therapist, she revealed a history of both father-daughter incest and spousal abuse. After several months of individual counseling, art therapy, and assertiveness training, her confusion and disorientation abated, she reported feeling less depressed and socially more active.

McInnis-Dittrich (1996) presented four case studies of senior women who had varying problems with depression, dissociation and self-mutilation associated with their undisclosed experiences of childhood sexual abuse. In the first case, a 76 year old woman was experiencing anxiety, depression and mild dissociation. She appeared disoriented and confused when in the presence of her husband. During her therapy, she disclosed sexual abuse from the age of 11 to 16 years by her father, during which time

she had contracted a sexually transmitted disease. Her husband, aware of the abuse, often reminded her about the abuse and made her feel ashamed. In subsequent life review therapy, this woman expressed her anger toward her father, anger that she had previously projected on to her husband.

The second case involved an 82 year old women who was severely depressed and suffering from bleeding ulcers. Notably, this woman refused to let anyone help her care for her middle-aged handicapped daughter because she was afraid someone would sexually molest her. In therapy, this woman had no memory of her childhood between the ages of four and ten. However, she eventually recovered her memory of being violently sexually abused by her older brother at which point she realized that her unreasonable fear regarding care for her daughter stemmed from her own traumatic experiences.

A third case involved a 68 year old woman who was depressed with suicidal ideation, engaged in self-mutilation and had difficulty concentrating on even simple tasks. In therapy, she expressed rage about her sexual abuse by her father and grandfather. She was infertile due to the abuse and never married. In her later years, she fixated more on her abuse because she was alone and this left her bitter, agitated and depressed.

McInnis-Dittrich's final case involved an 83 year old widow who had lived alone for 20 years. She was generally a happy person but experienced frequent depressive episodes that confined her to bed. In therapy she disclosed sexual abuse by her father that she was unwilling to discuss.

In sum, PTSD following interpersonal trauma is far from rare, regardless of the type of trauma. It has also become apparent that senior war veterans and Holocaust survivors frequently continue to suffer from PTSD, be it chronic, re-emergent or delayed-onset PTSD. In contrast to this research, there is a distinct lack of research examining the aftereffects of violence toward women and children in senior women. However, existing case studies, together with the possibility that women are more likely than men to experience PTSD in the wake of trauma (Breslau et al., 1991, 1999), suggest that senior women may well experience PTSD.¹

Sexism and Ageism in Diagnostic Practice

Reich (1996) contends that senior women's experiences of childhood abuse are often neglected because senior women are members of two disadvantaged groups: women and older adults. From this perspective, one might speculate that the lack of

¹The resurgence or delayed-onset of PTSD in trauma survivors has been attributed to a variety of situational factors and psychological processes associated with aging. Situational factors contributing to the distress of aging war veterans and concentration camp survivors include the loss of family and work roles that served as distractors, the loss of family and friends, isolation, and loneliness (Aarts & Op den Velde, 1996; Danieli, 1995; Krystal, 1995; see also Krystal, 1981; Ornstein, 1981), especially if accompanied by a lack of social support (Nichols & Czirr, 1986). Such stressors may be especially difficult for trauma survivors. Solomon and Prager (1992), for example, found that 61 Holocaust survivors perceived more danger and experienced more stress and anxiety in response to the Persian Gulf war relative to 131 seniors who did not live through the Holocaust. Thus, rather than having an inoculating effect, the Holocaust made these seniors more vulnerable to stress. In addition, the life review process and reminiscence associated with aging may be involved. This seems especially likely because the stages underlying both successful aging and recovery from trauma involve mourning and accepting losses and establishing a coherent, positive sense of self. Similar factors may contribute to the distress encountered by aging survivors of violence toward women and children. In addition, Kristiansen and Hay (2000; see also Reich, 1996) suggest that aging is likely to replicate the traumagenic dynamics underlying such trauma (Finkelhor & Browne, 1986), including powerlessness (e.g., via the staff-senior power differential in senior care facilities), stigmatization (e.g., via sexism and ageism), betrayal

research with senior survivors of child abuse is an example of sexist biases in the topics deemed worthy of investigation. Reich (1996) also argues that sexism and ageism contribute to the misdiagnosis of senior survivors of child abuse. Consistent with Reich's claim, there is evidence that clinicians' diagnostic and treatment practices are often riddled with sexist and ageist biases.

Sexism in clinical practice. Widiger and Spitzer (1991) outlined three types of gender bias that affect the diagnostic process, namely etiological bias, sampling bias and diagnostic biases. Etiological gender bias refers to the differential distribution of sociocultural factors that result in differential rates of psychological disorders among men and women. These sociocultural factors include gender disparities in educational and occupational opportunities, childrearing practices and gender-specific traumas such as violence against women and children. Sampling bias refers to the over-representation of women in our mental health system, which may result from women's greater willingness to acknowledge symptomatology or the tendency of women to engage in more help-seeking behaviour than men. For example, the APA (1994, p. 667) notes that the rates of Histrionic Personality Disorder (HPD) and Dependent Personality Disorder (DPD) are “not significantly different from the sex ratio of females within the respective clinical setting.” Thus, Widiger (1998) contends that it is not particularly meaningful to find high rates of HPD or DPD in a population if that population is comprised primarily of women.

Finally, and most relevant here, diagnostic gender bias involves both criterion and assessment biases. Criterion bias is said to exist when diagnostic criteria represent role stereotypes of the group most frequently labeled with the disorder (Chodoff, 1982;

(e.g., via neglect and abandonment by children) and retraumatization (e.g., via sexual and other abuse).

Kaplan, 1983). Assessment bias, on the other hand, involves the biased application of diagnostic labels.

According to Kaplan (1983), gendered criterion biases occur when diagnostic criteria are based on gender stereotypes and caricatures of femininity that depict healthy women as unhealthy. For example, the diagnostic criteria for HPD and DPD include ‘exaggerated expression of emotions,’ ‘overreaction to minor events,’ ‘being vain and demanding,’ and being ‘dependent, helpless, constantly seeking reassurance,’ all of which are consistent with female sex-role stereotypes. Rather than being signs of pathology, then, such behaviours may be displayed by any healthy woman.

That gender biased criterion biases exist is evident from studies of gender stereotypes regarding mental health. Landrine (1989) presented 23 psychology undergraduates (14 were female) with descriptions of eight personality disorders from the DSM-III (APA, 1980) and asked them to predict the characteristics (e.g., age, gender) of a person with these attributes. The students typified the histrionic personality as a young, single, white middle-class woman and the antisocial personality as a 26 year-old, lower class male. The dependent personality was perceived as a middle class, middle aged white woman and the paranoid personality was perceived as a male in his mid-30s. To the extent that the diagnostic criteria for these disorders are based on gender stereotypes, it is not surprising that women are over-represented within certain disorders and men in others (Hamilton & Dawes, 1986).

Gender diagnostic assessment biases are also well documented, especially for the so-called “personality disorders.” Consistent with the criterion biases noted by Kaplan (1983), a meta-analysis of 18 studies examining the prevalence rates of DPD revealed

that women are 40% more likely to receive a diagnosis of DPD than men and that clinicians over-diagnose this disorder in women (Bornstein, 1996). Gender biases in diagnostic assessment were also noted in Ford and Widiger's (1989) study of HPD, which in the DSM-III (APA, 1980, p. 315) is characterized by "behaviour that is overly dramatic, reactive and intensely expressed" and "disturbances in interpersonal relationships," and Antisocial Personality Disorder (APD), which is characterized by delinquent behaviour, lying, criminality, inconsistent work behaviour, irresponsible parenting, failure to accept social norms, aggression, and the inability to maintain enduring relationships (APA, 1980). In a postal survey, Ford and Widiger (1989) presented 354 psychologists with a case history of a female, male or gender neutral client who satisfied the criteria for both HPD and APD. In the 'balanced' case history, the client met an equal number of criteria for both HPD and APD. The 'HPD tilt' and 'APD tilt' case histories included additional criteria for the diagnosis of HPD and BPD, respectively. Analyses of these data revealed that the female (46%) was more likely than the male (15%) to be labeled with HPD even when the female satisfied more APD than HPD criteria. Moreover, the male (44%) was less likely than the female (76%) to be diagnosed with HPD even when the male satisfied more HPD than APD criteria.

Given such gendered criterion and assessment biases, it is not surprising that sexism also affects clinical practice with trauma survivors. Such biases are perhaps especially likely in the case of trauma survivors because the phenomenological presentation of the aftereffects of trauma has, historically, been misconstrued. The PTSD experienced by WW I soldiers, for example, was first attributed to the physical concussive effects of exploding shells and, when it became apparent that soldiers who

had not been exposed to physical trauma also suffered from 'shell shock,' it was attributed to soldiers' moral inferiority, malingering and cowardice (Herman, 1992). Similarly, women's display of PTSD in the form of hysteria was originally attributed to a disease of the uterus and then to malingering. Although in the mid-1800s both Freud and Janet recognized that hysteria was a result of psychological trauma, Freud's subsequent retraction of the 'seduction theory' relegated women's reports of childhood sexual abuse to the realm of unconscious wishes and the Electra complex (Herman, 1992).

Despite increasing awareness of the clinical presentation of the aftereffects of trauma, the diagnoses applied to trauma survivors continue to be problematic, particularly for women (Hartman & Burgess, 1993). One particularly contentious diagnostic label in this regard is Borderline Personality Disorder (BPD), which is characterized by "a pattern of instability in interpersonal relationships, self image, and affects, and marked by impulsivity" (APA, 1994, p. 629).² In an early paper, Rosewater (1985) alerted clinicians to the need to distinguish between the aftereffects of partner abuse and the symptoms of BPD. Consistent with a diagnosis of BPD, battered women may display signs of impulsivity, unstable intense relationships, intense anger, identity disturbance, mood shifts, defensiveness, anger and dependency, all of which are normal reactions within the context of violence. She also noted that battered women display characteristics similar to

² Although BPD "is diagnosed most predominantly (about 75%) in females" (APA, 1994, p. 652; see also Castenada & Franco, 1985), some research suggests this may be inappropriate. For example, Henry and Cohen (1983) had 277 university students complete a 35 item questionnaire in which they rated the extent to which they displayed the DSM-III criteria for BPD. Examining these students' responses revealed that men reported borderline characteristics more often than women, perhaps because these qualities are more acceptable in men. If so, men may be less likely than women to be diagnosed with BPD because the criteria for BPD are regarded as more congruent with male sex role expectations.

schizophrenia, such as delusions of persecution (e.g., fear of their spouse), deterioration of functioning (e.g., missing work to avoid displaying bruises), social withdrawal (e.g., not disclosing her abuse out of fear), flat affect (e.g., avoiding potential conflict), and paranoia (e.g., claiming that their batterer is stalking them). Indeed, citing her dissertation research, Rosewater presented evidence that battered and schizophrenic women share similar MMPI profiles. Because the treatment of battered women is very different from that for BPD or schizophrenia, Rosewater urged therapists to become familiar with the aftereffects of such trauma.

The diagnosis of BPD is also contentious in view of research documenting child abuse in the lives of people diagnosed with BPD (e.g., Green, 1993a; Herman, Perry & van der Kolk, 1997; Jordon, Schlenger, Caddell & Fairbank, 1997; Perry & Herman, 1993; Westen, et al., 1990; Zanarini, Dubo, Lewis & Williams, 1997). Further, as Perry and Herman (1993) explained, “many of the most troubling and difficult features of BPD become more comprehensible in the light of a history of early, prolonged, severe childhood trauma. The psychopathology becomes an understandable adaptation to an environment of fear, secrecy, and betrayal rather than an innate defect in the self” (p. 135). In addition, the diagnostic criteria for BPD are similar to those for PTSD in that both are characterized by dissociative episodes, avoidance behaviours such as substance abuse, and increased arousal in the form of uncontrollable anger. As a result, a number of clinicians have argued that BPD would be more accurately and empathetically described as complex PTSD (e.g., Herman, 1992; van der Kolk, 1996).³

³Interestingly, based on their study of adult Vietnam veterans Weiss et al. (1992) suggested that “long-term chronic lifetime partial PTSD may also begin to be understood as the development of a Post-Traumatic Character Disorder” (p. 373) in which “the

Despite the fact that men and women manifest PTSD in comparable ways (Elhai et al., 2000), research suggests that there are sexist biases in the diagnosis of BPD and PTSD. In a postal survey, Becker and Lamb (1994) had 311 social workers, psychologists and psychiatrists respond to a case history of a male or female survivor of childhood sexual abuse whose behaviour satisfied the criteria for both BPD and PTSD. Participants were asked to rate the extent to which the person described in the case study satisfied the criteria for seven Axis I and Axis II disorders, to indicate their familiarity with the disorder, and to list three questions they would ask the client. Overall, BPD was given the highest diagnostic rating, followed by dysthymia, self-defeating personality disorder and PTSD. Participants' diagnostic ratings were independent of their familiarity ratings. In addition, while gender had no effect on PTSD ratings, the female was given higher BPD and HPD ratings while the male was given higher APD ratings. Further, clinicians who rated the case lower on PTSD asked fewer questions about the client's situation, whereas clinicians who gave higher PTSD ratings expressed more interest in the clients' situation and the relationship of their abuse to attitudes, feelings and behaviour. Finally, Becker and Lamb also noted effects associated with the clinicians' characteristics. Specifically, female clinicians found the PTSD significantly more applicable to both the male and female case histories than did male clinicians. Those clinicians who were younger psychologists or psychiatrists, and who spent a minimum of 50% of their time in psychotherapy rated cases significantly higher for BPD (for a critique and response see Garb, 1995 and Becker & Lamb, 1995, respectively).

behavioral avoidance seen in full PTSD has been manifest as a substance abuse problem" (p. 374).

In view of Becker and Lamb's (1994) findings it is clear that BPD is a person-centered diagnosis while PTSD is a situational diagnosis (e.g., Herman, 1992). As a result, being labeled with BPD is likely to be more blaming and socially stigmatizing than being labeled with PTSD. Indeed, because BPD is often used to refer to difficult clients (Herman, 1992; Reiser & Levenson, 1984), women trauma survivors diagnosed with BPD may face considerable disparagement by clinicians, disparagement that may be reminiscent of their earlier abuse.⁴

Ageism in clinical practice. Ageism, which involves devaluative attitudes and stereotypes of elderly people (Gatz & Pearson, 1988; Perkins, 1992), is found in both psychological research and clinical practice. In research, many gerontological studies fail to discriminate between disease and normal aging, studies often have design flaws (e.g., comparing inappropriate cohorts), research reporting age differences and age changes may be mistakenly interpreted as universal and characteristic of a particular age group, and personality inventories are often normed on young adults (Schaie, 1988).

In practice, clinicians have been found to regard elderly people as less ideal patients, less suitable for psychotherapy and having poorer prognoses than younger people (Ford & Sbordone, 1980; James & Haley, 1995; Meeks, 1990). In a study by Ford and Sbordone (1980), for example, 179 psychiatrists were presented with four case histories of a person who varied in age (65 years and older vs. 45 years old vs. younger) and presenting problem (agoraphobia, alcohol abuse, mania and neurotic depression).

⁴The misdiagnosis of survivors of violence toward women and children is likely to be an ongoing problem in view of Barnard-Thompson and Leichner's (1999) finding that, although psychiatric residents were aware of the magnitude of childhood sexual abuse and its relation to BPD, PTSD and dissociative disorders, they believed their training in this area was insufficient.

Participants were asked to rate the extent to which the person would be an ideal patient and their likely prognosis and to choose one of four possible treatment plans: psychotherapy alone; psychotherapy and pharmacotherapy; primarily pharmacotherapy; or no treatment. The analyses revealed that, regardless of the presenting problem, younger clients were rated as more ideal than those 65 or older. Younger patients were also given better prognoses than older clients, although this effect did not reach significance for patients with agoraphobia and mania. In addition, psychiatrists' treatment recommendations for neurotic depression varied as a function of age. For example, although almost 30% of the psychiatrists recommended psychotherapy for the 32 year old neurotic, only 8% recommended it for the 72 year old female neurotic.

Clinicians may also display a health bias against seniors. James and Haley (1995) presented 371 clinicians with a case history of a client who varied in age (35 or 70 years old) and health status. Health status was presented as either unremarkable or remarkable for congenital health disease (frequent hospitalization, shortness of breath). The clinicians consistently rated people in poor health more negatively than their healthy counterparts. Clients in poor health were also perceived as significantly older than healthy clients. In addition, older clients were rated as being less appropriate for psychotherapy, having a poorer prognosis and were also more likely to have their condition related to an organic brain disorder. Furthermore, psychologists rated themselves as less competent and comfortable in treating clients in poor health.

In addition to devaluing senior clients and viewing them as unsuitable for psychotherapy, stereotypes that depict aging as rife with physical and psychological dysfunction (Schmid, 1991), coupled with ignorance regarding seniors' presentation of

mental health problems, contribute to the misdiagnosis of seniors. The diagnosis of depression, for example, is problematic because depression manifests itself differently in older and younger people. In particular, symptoms of depressed mood and guilt often become less prominent with age while somatic complaints such as weight loss and insomnia become more apparent (Gintner, 1995). As a result, clinicians may misattribute signs of depression to the physical decline associated with aging. The diagnosis of depression in seniors is also difficult because depression may have adverse effects on their cognitive functioning and therefore mimic dementia. Indeed, after conducting extensive neuroimaging and psychological and cognitive testing, Moller (cited in Goodman, 1999) found that depression underlay the difficulties of 12% of 232 men and 15% of 222 women who had been diagnosed with dementia. In such cases, depression has come to be known as 'pseudodementia.' Consistent with the misattribution of seniors' manifestation of depression to dementia, Gatz and Pearson (1988) argue that Alzheimer's disease may represent a new form of ageism because its prevalence is overestimated and it is over diagnosed.

Ageism has also been noted in the diagnosis of personality disorders. Molinari, Ames and Essa (1994) observed that clinicians were less likely to assign a diagnosis of personality disorder, especially Cluster B diagnoses such as BPD, to older patients. Moreover, this occurred despite the fact that up to two thirds of depressed seniors suffer from a comorbid personality disorder (Hillman et al., 1997). This reluctance may, in part, stem from the belief that people with such disorders get better with age. In regard to BPD, for example, a clinical maxim has been "Help the borderline stay alive to the age of 30 or 35" (Kroll, 1993, p. 23).

More recent research, however, suggests that this reluctance is on the decline. In a postal survey Hillman, et al. (1997) presented 186 psychologists with a case history of a male who varied in age (46 vs. 66 vs. 86 years) and symptomatology (i.e., indicative of major depression or major depression with comorbid BPD). Participants were asked to provide a diagnosis, a Global Assessment of Functioning (GAF) score, and make treatment recommendations. Contrary to previous findings, there was no age-related bias in the diagnosis of BPD or any other AXIS II personality disorder. Nevertheless, only 14% made the appropriate diagnosis of comorbid BPD and those who did were more prejudicial and less optimistic, as indicated by their GAF scores, their assessment of the suitability of the client for their practice, and their ratings of the likelihood of a favourable outcome following treatment. Importantly, while clinicians' personal (i.e., age and gender) and professional characteristics (e.g., theoretical orientation) were independent of their responses, those with more gerontological training made more informed diagnostic and treatment decisions, including recommending medical exams to rule out aged related-diagnoses of dementia and organic brain disorder.

Clinicians' ageist biases and their diagnostic difficulties with seniors are also evident in their practices with senior trauma survivors. The diagnosis of senior Holocaust survivors, for example, has been problematic because they often manifest PTSD in the form of physical complaints. Holocaust survivors report remarkably higher levels of psychosomatic complaints such as unremitting headaches, generalized musculoskeletal pain, dizziness, tremors, gastrointestinal pain, ulcers, colitis, and respiratory and cardiovascular disturbances than non-traumatized seniors (Honigman-Cooper, 1979; Kuch & Cox, 1992). Because many of these complaints are incorrectly attributed to the

natural process of aging, these seniors' PTSD remains untreated. Such physical complaints may also elicit the health bias noted by James and Haley (1995). Similarly, based on their review senior war veterans and PTSD Nichols and Czirr (1986) contend that senior war veterans' symptoms of PTSD are often misdiagnosed as other disorders such as depression, schizophrenia, APD and alcoholism. They also caution that the diagnosis of PTSD may be difficult because the elderly may be unwilling to divulge a traumatic past.

PTSD in Holocaust survivors has also been misdiagnosed as organic brain disorder and dementia. Aarts and Op den Velde (1996) described an 83 year old Holocaust survivor who reported no emotional problems in the years after the war and functioned well into her retirement. At the age of 81, when she had outlived her friends and acquaintances and was moved into a home for the elderly, she became tense, irritable, lost weight, experienced horrific nightmares and insomnia, and isolated herself from the other residents. She was eventually referred to a clinician with suspected organic brain disorder. Upon physical examination, however, there were no signs of cognitive impairment and she was diagnosed with late-onset PTSD. Krystal (1995) also noted that some elderly Holocaust survivors "retreated into a sullen state ... similar to pseudodementia, in which individuals are so hurt, so deeply wounded beyond the possibility of recovery through grieving, that they constrict their mental functions and function as if they were partly demented" (p. 92).

In view of the above, it seems likely that the symptoms of PTSD displayed by senior survivors of violence toward women and children may also be misattributed to physical or cognitive decline (Reich, 1996; Somer, 2000). Indeed, this may be

particularly likely because senior women may be especially reluctant to disclose their abuse because they grew up in a time when the subject of sex, let alone sexual abuse, was taboo (McInnis-Dittrich, 1996). Therapists may also be reluctant to broach the possibility of sexual abuse out of respect for the elderly or their own discomfort talking about sex with an older adult (Somer, 2000).

Consistent with these speculations, Allers et al. (1992) described a 66 year old woman diagnosed with manic depression who sought counselling for problems that were not improving despite being on lithium. Because of memory and coordination problems, she was also suspected of being in the early stage of Alzheimer's. As counselling progressed she disclosed a history of incest and, after referral to a therapist familiar with child abuse issues, was subsequently diagnosed with PTSD rather than manic depression. After psychotherapy, she reported that she was happier and more socially orientated, her memory improved, and follow-up testing revealed no evidence of early stage dementia.

In another case study, McCartney and Severson (1997) described an 82 year-old woman who was diagnosed with Alzheimer's dementia, glaucoma, and arthritis. After being transferred to a nursing home facility, this woman began to display various problematic behaviours, including being inconsolably agitated, pacing restlessly, being easily alarmed, showing great fear and having difficulty concentrating. After her daughter divulged that a male resident in the previous nursing home had sexually assaulted her, the woman was diagnosed with PTSD.

Research Purpose

Taken together, the sexism of the 'double standard of aging' (Palmore, 1997) and ageism put senior women, including those who are trauma survivors, at risk for

misdiagnosis and inappropriate treatment for their psychological distress. The present study was therefore designed to examine clinical practice in the diagnosis of senior women who experienced trauma during childhood. Of special interest was whether clinicians would show a bias toward the person-focused diagnosis of BPD in the case of women and those who survived childhood sexual abuse and a bias in favour of the situation-focused diagnosis of PTSD in the case of both men and survivors of the Holocaust. In addition, this study was designed to assess the extent to which trauma survivors' symptoms of PTSD were misconstrued as those of dementia or depression.

Method

Procedure

Questionnaires with prepaid return envelopes were mailed to 500 psychologists and 500 psychiatrists ($N = 1000$), half female, randomly selected from the professional directories of the Ontario College of Psychologists and the Royal College of Physicians and Surgeons of Ontario. Only clinicians doing psychotherapy and those working with adults were included in the sample. To facilitate the response rate, another survey package was sent to those participants who failed to return a prepaid response card indicating that they had either returned the survey or did not wish to participate. The response card was also used to provide participants with the opportunity to indicate whether they wished to receive a summary of the findings.

Survey Materials

Participants were asked to read and respond to one of four randomly assigned case histories describing a 71 year old resident of a medium-level seniors' care facility. (Copies of the survey materials appear in Appendix A.)

Case histories. As shown in Table 1, there is marked overlap in the diagnostic criteria and associated features of BPD, PTSD, dementia and depression (see Appendix B for the diagnostic criteria and associated features for each of these diagnoses). For example, the four diagnostic entities share anxiety and agitation, anger, irritability and hostility. To the extent that dissociative experiences are construed as episodes of disorientation or as hallucinations, they also share hallucinations, dissociation and disorientation. In view of these and other similarities, each case history described a resident whose behaviour could be construed as fulfilling the DSM-IV (APA, 1994)

criteria for BPD, PTSD, dementia and depression.⁵ However, the client's gender (i.e., Judith vs. Jerry) and the type of childhood trauma they experienced (i.e., internment in a children's camp during the Holocaust vs. sexual abuse perpetrated by the father) were manipulated within the case history.

Measures. After reading the case history, participants were asked about their diagnosis of the client, any additional information they would like, their treatment recommendations and their evaluations of the client. Using scales ranging from 'meets none of the criteria' (0) to 'meets all of the required criteria' (6), the participants rated the extent to which the client met DSM-IV criteria for 12 Axis I disorders (cyclothymia, dysthymia, intermittent explosive disorder, major depressive disorder, posttraumatic stress disorder, adjustment disorder with mixed emotional features, delirium, generalized anxiety disorder, delusional disorder, dementia, schizophrenia with paranoia, and schizophreniform disorder), and ten Axis II personality disorders (narcissistic, schizoid, dependent, histrionic, obsessive compulsive, antisocial, borderline, schizotypal, avoidant and paranoid). A variety of disorders were included to minimize the participants' awareness of the purpose of the study as well to provide them with the opportunity for multiple diagnoses. Participants were also asked to rate their familiarity with these disorders using scales ranging from 'not at all' (0) to 'extremely familiar' (4).

Using open-ended questions, participants were given the opportunity to list three questions they would ask if the senior presented in the case history was their client and to list any additional information they would like from or about the client. They were then asked to outline their treatment plan and treatment recommendations.

⁵The content of the case history and the measures were developed with the assistance of 12 registered clinical psychologists.

To gain insight into their evaluative responses to the client, participants were asked to provide a Global Assessment of Functioning (GAF) score (APA, 1994; which could range from 0 to 100) and used seven-point scales to rate both the suitability of the client for treatment in their practice and the likelihood that the client would respond positively to treatment.

Finally, after completing measures of their demographic characteristics (i.e., age, gender, whether they were psychologists vs. psychiatrists), respondents were asked a number of questions about their professional background and activities. Specifically, they indicated their number of years in practice, their practice setting (private practice, inpatient setting, institution, hospital or other), the percentage of time devoted to doing psychotherapy, their theoretical orientation (cognitive-behavioural, eclectic, feminist, humanistic, interpersonal, psychobiological, psychodynamic/psychoanalytic, other). They also answered questions about the nature of their clientele, including the percentage of their clients that were female and the percentage 65 or older, and used five-point scales ranging from 'none' (0) to 'a great deal' (4) to rate the extent of their specialized gerontological training.

Results

The initial analyses examined the demographic and professional characteristics of the sample, the descriptive statistics and intercorrelations of the conceptual variables of the study, and the correlations between participants' characteristics and their scores on the criterion variables. The main analyses examined the effects of client gender, type of trauma (child sexual abuse vs. Holocaust), participant gender and participant profession on participants' responses to the criterion variables and their diagnostic ratings for PTSD relative to dementia and depression. The final analyses assessed whether any variables were systematically confounded with both the predictor and criterion variables in a way that might provide alternative explanations for the findings.

The Sample

Response rate. A total of 234 completed questionnaires were returned, as well as 232 response cards indicating nonparticipation. Reasons for non-response included statements that participants did not use the DSM in their practice ($n = 5$) and others did not believe that the survey accurately reflected clinical practice ($n = 3$). Adjusting for 33 questionnaires that were returned as undeliverable and 10 questionnaires that were insufficiently completed yielded a response rate of 24.5%. The number of participants who responded to the four case histories were 70 and 56 for the female and male child sexual abuse survivors, respectively, and 67 and 41 for the female and male Holocaust survivors, respectively, and the response rate for female and male case histories was independent of type of trauma, $\chi^2(1, N = 234) = 0.99, ns$.

Participants. The participants (excluding the 4 respondents who did not specify their gender or profession) consisted of 111 psychologists (47.7% female) and 119

psychiatrists (44.5% female) who were between the ages of 30 and 85 years ($M = 52.2$, $SD = 11.7$ yrs.). Respondents reported an average of 20.4 years of clinical experience ($SD = 12.0$ yrs.), and most were currently working in private practice (75.7%) and/or a hospital (61.3%). Other participants indicated that they were employed in an inpatient setting (40.0%), an institution (26.5%), or another setting (27.0%; e.g., outpatient clinic, community setting, organization).

On average, these respondents reported spending 46.7% of their time doing psychotherapy ($SD = 32.5\%$) and a clear majority ($n = 167$, 72.3%) described their theoretical orientation as eclectic in that they endorsed two or more perspectives. The remaining respondents described themselves as cognitive-behaviourally orientated ($n = 29$, 12.6%), psychoanalytic/psychodynamic ($n = 16$, 6.9%), psychobiological ($n = 6$, 2.6%), humanistic ($n = 3$, 1.3%), and interpersonal ($n = 1$, 0.4%). Although most participants (53.7%) did not specify a particular area of competence, some did specify areas relevant to this research, specifically mood/anxiety (25.0%), geriatrics (8.7%), trauma/PTSD (7.0%) and neuropsychology (5.6%).

Respondents typically reported working with somewhat more females than males ($M = 58.2$, $SD = 19.7\%$). They also reported working with relatively few clients aged 65 years or older ($M = 13.2$, $SD = 22.7\%$) and had little specialized gerontological training ($M = 1.28$, $SD = 1.21$).

Although participants' gender was independent of their profession (i.e., psychologist vs. psychiatrist), $\chi^2(1, N = 230) = 0.72$, ns , as shown in Table 2 there were some significant relations between respondents' personal and professional characteristics. As one would expect, older participants had more years of clinical experience. Older

participants also spent moderately more of their time conducting psychotherapy. In addition, respondents who devoted more time to psychotherapy reported moderately more female clients and fewer senior clients. Of special interest, older participants, those with more clinical experience and those who spent more of their time conducting psychotherapy reported somewhat less specialized gerontological training while those with more senior clients reported substantially more gerontological training.

Criterion Variable Scores

Descriptive statistics for the criterion variables. The descriptive statistics for participants' diagnostic ratings, shown in Tables 3 and 4, indicate that the case history content reflected the intended diagnostic criteria for Major Depressive Disorder (MDD), dementia, PTSD and BPD. In regard to the Axis I disorders, the senior trauma survivors were, on average, seen as fulfilling almost all of the diagnostic criteria for MDD and at least half of the criteria for dementia and PTSD. Similarly, BPD was, on average, regarded as the most plausible Axis II disorder.

In addition, the trauma survivors were seen as meeting almost half of the criteria for adjustment disorder, which is characterized by "the development of [excessive] emotional or behavioral symptoms in response to an identifiable stressor" that results in "significant impairment in social or occupational ... functioning" (APA, 1994, p. 626). This diagnosis is reasonable given that the case history described the client as having recently entered a seniors' home. The diagnosis of adjustment disorder may also explain why respondents did not give higher diagnostic ratings for PTSD and BPD in that the criteria for adjustment disorder require that "the stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting

Axis I or Axis II disorder" (APA, 1994, p. 626). The diagnosis of adjustment disorder, then, suggests that some respondents did not attribute the client's difficulties to the exacerbation of pre-existing PTSD or BPD. In view of these findings, and to maintain statistical power, some of the subsequent analyses of participants' diagnostic ratings were limited to those assigned to PTSD, BPD, and adjustment disorder. PTSD and BPD were selected for analysis because this research was designed to examine the factors affecting clinicians' diagnoses of these disorders. Adjustment disorder was selected due to its relatively high rating by participants and because its diagnosis precludes other diagnoses. Other analyses were limited to comparisons of respondents' diagnostic ratings for depression and dementia.

As listed in Tables 5 and 6, respondents' ratings of their familiarity with the various diagnoses indicated that they were between 'very' and 'extremely familiar' with MDD, and 'very familiar' with generalized anxiety disorder, PTSD, adjustment disorder and BPD. By comparison, participants were, on average, only 'moderately familiar' with dementia and, relative to MDD, there was twice as much variability in their familiarity with dementia. On the whole, and as displayed in Tables 7 and 8, clinicians' diagnostic ratings were largely independent of their familiarity with the various disorders in that only eight of the 22 correlations were statistically reliable and those that achieved significance were small in magnitude ($M_r = .19$, range = .15 to .25). In view of this, participants' familiarity ratings were not considered further.

Not surprisingly in view of the client's symptoms in the case history, on average the respondents assigned a relatively low Global Assessment of Functioning score to the client ($M = 36.31$, $SD = 10.60$). This score indicates that participants saw the client as

having "some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking or mood" (APA, 1994, p. 32). Although respondents gave low ratings of the client's suitability for their practice ($M = 2.32$, $SD = 2.19$), they did regard the client as likely to respond moderately well to treatment ($M = 3.49$, $SD = 1.21$).

A total of 226 (96.5%) of clinicians completed the open-ended questions regarding desired additional information. Of those responses, a content analysis revealed that, if given the opportunity, most ($n = 139$, 61.8%) would request dementia-related information about the client, particularly information about memory and cognitive functioning. A number of participants ($n = 80$, 35.9%) also indicated that they would like more information about the client's situational experiences, particularly their experiences of trauma ($n = 62$, 27.4%) and their life in the seniors' home ($n = 42$, 18.6%). However, only 5.6% ($n = 13$), indicated a desire for information about both the client's childhood experiences of trauma and their life in the seniors' home. Other respondents ($n = 65$, 28.8%) were interested in learning more about the client's relationships, particularly with the daughter.

A total of 206 (88%) completed the open-ended questions regarding treatment recommendations. In their open-ended responses, participants recommended four types of treatment, most commonly medical treatment ($n = 168$, 82.8%) such as a medical examination or the prescription of antidepressants or antipsychotics, followed by psychotherapy ($n = 109$, 54.2%), efforts to rule out and/or treat dementia ($n = 72$, 35.8%), and trauma-related therapy ($n = 29$, 14.4%).

Relations between the criterion variables. As shown in Tables 9 to 11, there were a number of significant relations between respondents' scores on the various criterion variables. In regard to their diagnostic ratings, participants who gave the client higher ratings for dementia gave only slightly higher ratings for MDD. This finding runs contrary to the documented overlap in seniors' symptoms of dementia and depression (Moller, cited in Goodman, 1999). In addition, those who gave the client higher ratings for PTSD gave slightly higher ratings for MDD and adjustment disorder and moderately higher ratings for BPD. The latter finding is consistent with the documented overlap in the symptoms of PTSD and BPD and the suggestion that BPD be characterized as 'complex PTSD' (e.g., Herman, 1992).

As displayed in Table 10, participants' evaluative ratings of the client were generally independent of their diagnostic ratings. The sole exception was a small, negative correlation between respondents' diagnostic ratings for dementia and GAF scores, suggesting that the diagnosis of dementia in itself contributed to a view of the client as slightly more dysfunctional.

A number of the relations between participants' diagnostic ratings and both the additional types of information they desired and their treatment recommendations were statistically reliable, as shown in Table 10. Consistent with the situational etiology of PTSD, participants who gave the client higher diagnostic ratings for PTSD were somewhat more likely to desire additional situational information. Participants who gave higher ratings for BPD, on the other hand, were only slightly more likely to desire situational information. Given that the role of trauma in the lives of persons diagnosed with BPD is well documented (e.g., Green, 1993a; Herman, 1992; Perry & Herman,

1993; Westen, et al., 1990; Zanarini, et al., 1997), the small magnitude of this relation is rather surprising. In addition, participants who gave higher ratings for BPD were only slightly more likely to request information about the client's relationships. That this relation was not stronger is also surprising in view of the interpersonal difficulties associated with BPD (APA, 1994).

Respondents who assigned the client higher diagnostic ratings for dementia evidenced some desire for information that might confirm or disconfirm this diagnosis. Although respondents' diagnostic ratings for depression were independent of their desire for additional dementia-related information about the client, depression ratings were slightly correlated with treatment recommendations that included efforts to rule-out dementia. Ideally, these relations would have been stronger given the overlap in seniors' manifestations of depression and dementia (Moller, as cited in Goodman, 1999).

That the diagnostic label applied to a client has important treatment implications was evident in the observed relations between participants' diagnostic ratings and their treatment recommendations. Although participants who assigned higher diagnostic ratings to both PTSD and BPD were somewhat more likely to recommend psychotherapy, participants who give the client higher PTSD ratings, but not those who gave the client higher BPD ratings, were moderately more likely to recommend trauma-related therapy. Neither participants' PTSD or BPD ratings were related to recommendations of medical intervention. Given that some medications, such as serotonin re-uptake inhibitors (Herman, 1992), are effective in alleviating the symptoms of both PTSD and BPD, this finding is also surprising.

The consequences of diagnostic labels for treatment were also evident in the relations between participants' ratings for depression and dementia and their treatment recommendations. As shown in Table 10, respondents who assigned the client higher depression ratings were at least slightly more likely to recommend psychotherapy. Participants' diagnostic ratings for dementia, on the other hand, were independent of whether or not they recommended psychotherapy. However, both depression and dementia ratings were associated with moderately more medical recommendations. Interestingly, clinicians who gave higher ratings of adjustment disorder, were more likely to recommend treatment that was dementia-related or involved ruling out dementia.

Table 11 presents the correlations between participants' evaluative ratings of the client, the types of additional information they would like and their treatment recommendations. As indicated there, clients who were rated as more likely to respond positively to treatment were viewed as more suitable for participants' clinical practice. These respondents were also slightly more likely to desire situational information and recommend trauma-related therapy for clients deemed more suitable for their practice. In addition, participants were slightly more likely to recommend both psychotherapy and medical interventions for clients deemed more responsive to treatment.

The correlations in Table 11 also indicate that the desire for additional dementia-related information about the client was associated with slightly less desire for relational information and moderately more dementia-related treatment recommendations. Once again, the fact that the latter correlation was not stronger raises some concern in that efforts to distinguish between dementia and depression should ideally accompany any dementia-related treatment recommendations. Moreover, a client's suitability for

practice was moderately associated with a favourable treatment response, slightly correlated with situational information as well as with trauma-related treatment recommendations. Furthermore, as suggested by the slight, positive correlations between a clients treatment response and psychotherapy and medical treatment, clinicians' thought that the client would do well if they received both types of treatment. Finally, and as one would expect, dementia-related treatment recommendations were associated with more medical recommendations, albeit only slightly.

Relations between criterion variable scores and participant characteristics. As shown in Table 12, a number of the correlations between participants' criterion variable scores and their personal and professional characteristics were statistically significant. Both older clinicians and those with more clinical experience saw the client as fulfilling slightly fewer of the criteria for major depressive disorder and moderately fewer of the criteria for BPD. They were also moderately less likely to recommend dementia-related treatment. Older participants were also slightly less likely to recommend a medical intervention, while participants with more experience and those who devoted more time to conducting psychotherapy gave slightly lower diagnostic ratings for adjustment disorder. In addition, those with proportionately more female clients rated the client as slightly more suitable for their clinical practice. Of special interest, however, participants who worked with proportionately more seniors clients and those who had more specialized gerontological training regarded the client as moderately more suitable for their clinical practice and more likely to respond positively to treatment.

Main Analyses

The primary analyses consisted of tests of the effects of client gender, type of trauma (childhood sexual abuse vs. Holocaust), participant gender and participant profession (psychologist vs. psychiatrist) on the criterion variable scores. These analyses also assessed the extent to which these variables affected the extent to which the client was diagnosed with PTSD relative to depression and dementia.

Diagnostic ratings.⁶ A customized Multivariate Analysis of Variance (MANOVA) assessed the effects of client gender, type of trauma, participant gender, participant profession, the client gender by type of trauma interaction, the client gender by type of trauma by clinician gender interaction, and the client gender by type of trauma by profession interaction on respondents' diagnostic ratings for BPD, PTSD and adjustment disorder.⁷ This analysis revealed significant multivariate effects due to client gender, $Wilks' \Lambda = .865$, $F(3,185) = 9.65$, $p < .01$, $\eta^2 = .14$, clinician gender, $Wilks' \Lambda = .944$, $F(3,185) = 3.63$, $p < .05$, $\eta^2 = .06$, and profession, $Wilks' \Lambda = .930$, $F(3,185) = 4.63$, $p < .01$, $\eta^2 = .07$. The univariate analyses revealed that, in each case, the significant multivariate effect was associated solely with respondents' diagnostic ratings of BPD.

⁶Although peripheral to the present study, in view of the findings in previous research (Becker & Lamb, 1994; Ford & Widiger, 1989), a MANOVA was conducted to ascertain the effects of client gender and type of trauma (childhood sexual abuse vs. Holocaust) on the diagnostic ratings associated with Dependent Personality Disorder (DPD), Histrionic Personality Disorder (HPD), Antisocial Personality Disorder (APD) and Paranoid Personality Disorder (PPD). This MANOVA revealed a significant multivariate effect for client gender, $Wilks' \Lambda = .871$; $F(4,196) = 7.27$, $p < .001$, $\eta^2 = .129$, with significant univariate effects for client gender on DPD, $F(1,199) = 4.81$, $p < .05$, $\eta^2 = .024$, PPD, $F(1,199) = 15.67$, $p < .01$, $\eta^2 = .073$, and APD, $F(1,199) = 7.83$, $p < .01$, $\eta^2 = .038$. In each case, women were given lower ratings than men (DPD: $M = 0.94$, $SE = 0.14$ vs. $M = 1.44$, $SE = 0.18$, respectively; PPD: $M = 1.35$, $SE = 0.15$ vs. $M = 2.30$, $SE = 0.18$, respectively; APD: $M = 0.28$, $SE = 0.08$ vs. $M = 0.62$, $SE = 0.09$).

Consistent with previous research (Becker & Lamb, 1994), female trauma survivors ($M = 3.58$, $SE = 0.19$) received higher ratings for the person-focused diagnosis of BPD than male trauma survivors ($M = 2.12$, $SE = 0.23$), $F(1, 187) = 24.06$, $p < .01$, $\eta^2 = .11$.

Unlike previous research (Becker & Lamb, 1994), however, female clinicians gave higher ratings of BPD ($M = 3.32$, $SE = 0.22$) than male clinicians ($M = 2.39$, $SE = 0.21$), $F(1, 187) = 9.65$, $p < .01$, $\eta^2 = .05$, and psychologists gave higher ratings of BPD ($M = 3.40$, $SE = 0.21$) than psychiatrists ($M = 2.31$, $SE = 0.21$), $F(1, 187) = 13.47$, $p < .01$, $\eta^2 = .07$.

Due to the *a priori* nature of the hypotheses, a series of planned comparisons was conducted using Bonferroni's correction ($\alpha/3 = .017$) to assess whether the female childhood sexual abuse survivor was given higher ratings for the person-focused diagnoses of BPD and lower ratings for the situational-focused diagnoses of PTSD and adjustment disorder relative to the female Holocaust survivor and either male trauma survivor. A planned comparison that assessed whether there were any differences in the diagnostic ratings given to the male holocaust survivor and the male sexual abuse survivor was, as hypothesized, nonsignificant, *Wilks' Λ* = .984, $F(3, 197) = 1.07$, *ns*. Contrary to expectations, however, the planned comparison that compared the diagnostic ratings assigned to the female sexual abuse survivor relative to the female Holocaust survivor was also nonsignificant, *Wilks' Λ* = .989, $F(3, 197) = .730$, *ns*. Given this, the third intended comparison of the diagnostic ratings for the female sexual abuse survivor relative to all three other trauma groups was not conducted.

⁷All multivariate assumptions, including independence, normality, and homogeneity of variance, were satisfied.

Another set of comparisons was conducted to examine whether the effects of client gender and type of trauma were qualified by participants' gender. The first comparison, which examined whether female and male clinicians differed in their diagnostic ratings of the male sexual abuse survivor relative to the male Holocaust survivor, was nonsignificant, *Wilks' Λ* = .981, $F(3, 190) = 1.20$, *ns*. A second comparison, which examined whether female and male clinicians differed in their diagnostic ratings of the female sexual abuse survivor relative to the female Holocaust survivor, was also nonsignificant, *Wilks' Λ* = .990, $F(3, 190) = 0.65$, *ns*.

A final set of comparisons was designed to assess whether the effects of client gender and type of trauma were qualified by participants' profession. The first comparison, which examined whether psychologists and psychiatrists differed in their diagnostic ratings of the male sexual abuse survivor relative to the male Holocaust survivor, was nonsignificant, *Wilks' Λ* = .983, $F(3, 190) = 1.10$, *ns*. The second comparison, which assessed whether psychologists and psychiatrists differed in their ratings of the female sexual abuse survivor relative to the female Holocaust survivor, was also nonsignificant, *Wilks' Λ* = .994, $F(3, 190) = 0.38$, *ns*.

Taken together, these analyses indicate that a gender bias underlay the person-focused diagnosis of BPD, but not the situation-focused diagnoses of PTSD and adjustment disorder, and that this bias exists regardless of the type of trauma.⁸

Dementia vs. depression vs. PTSD. In view of the tendency of clinicians to misconstrue seniors' symptoms of PTSD as signs of both depression (Nichols & Czirr, 1986) and dementia (Aarts & Op den Velde, 1996), a mixed factor analysis of variance

was conducted with client gender, type of trauma, participant gender and profession, and the client gender by type of trauma interaction as the between participant factors and diagnosis (depression vs. dementia vs. PTSD) as the within participant factor. This analysis yielded a significant main effect of diagnosis, $F(2, 406) = 43.31, p < .01, \eta^2 = .176$.⁹ Consistent with the findings of earlier research (e.g., Aarts & Op den Velde, 1996; Nichols & Czirr, 1986), respondents gave the senior trauma survivor higher ratings for depression ($M = 4.60, SE = 0.12$) than dementia ($M = 3.45, SE = 0.14$), and higher ratings for dementia than PTSD ($M = 2.95, SE = 0.15$). No other effects or interactions were significant.

Client evaluations. A customized MANOVA¹⁰ that examined the effects of client gender, type of trauma, participant gender, participant profession, the client gender by type of trauma interaction, the client gender by type of trauma by clinician interaction, and the client gender by type of trauma by profession interaction on participants' GAF, suitability and treatment responsiveness scores yielded only a main effect of profession, $Wilks' \Lambda = .942, F(3, 194) = 3.64, p < .01, \eta^2 = .058$. Examining the univariate analyses revealed that this effect was associated with suitability for practice and treatment responsiveness ratings. Specifically, psychiatrists gave higher ratings of the client's suitability for their practice ($M = 2.78, SE = 0.21$) than psychologists ($M = 2.01, SE = 0.22$), $F(1, 196) = 6.39, p < .05, \eta^2 = .032$. Psychiatrists also gave higher ratings of the

⁸In addition, none of the univariate effects associated with these three sets of comparisons were significant.

⁹The assumption of sphericity was not violated.

¹⁰All multivariate assumptions, including independence, normality, and homogeneity of variance, were satisfied.

positivity of the client's treatment responsiveness ($M = 3.76$, $SE = 0.12$) than psychologists ($M = 3.23$, $SE = 0.12$), $F(1, 196) = 10.06$, $p < .01$, $\eta^2 = .049$.

Given the *a priori* nature of the hypotheses, a series of planned comparisons was designed to assess whether the female sexual abuse survivor received less favourable evaluations relative to the female Holocaust and male trauma survivors. The first comparison, which compared participants' evaluations of the male sexual abuse survivor with those of the male Holocaust survivor was, as predicted, nonsignificant, *Wilks' Λ* = .984, $F(3, 204) = 1.10$, *ns*. Contrary to expectations, however, the comparison of the evaluations of the female sexual abuse survivor relative to those of the female Holocaust survivor was also nonsignificant, *Wilks' Λ* = .978, $F(3, 204) = 1.50$, *ns*. In addition, none of the univariate effects underlying these two multivariate comparisons were significant.

The second and third sets of planned comparisons assessed whether respondent gender and profession qualified the effects of client gender and type of trauma on participants' evaluations of the client. In each case, the first comparison, which examined whether female and male clinicians, *Wilks' Λ* = .981, $F(3, 190) = 1.20$, *ns*, and psychologists and psychiatrists, *Wilks' Λ* = .984, $F(3, 199) = 1.10$, *ns*, gave differential evaluations of the male sexual abuse survivor relative to the male Holocaust survivor, was nonsignificant. Similarly, the second pair of comparisons, which assessed whether female and male participants, *Wilks' Λ* = .990, $F(3, 190) = .654$, *ns*, and psychologists and psychiatrists, *Wilks' Λ* = .980, $F(3, 199) = 1.36$, *ns*, gave different evaluations of the female sexual abuse survivor relative to the female Holocaust survivor, were also nonsignificant.

Taken together, these analyses indicate that participants' evaluative ratings of the client were independent of the client's gender and type of trauma. Thus, there was no evidence of gender or trauma bias. However, psychiatrists evaluated the client more favourably than psychologists in terms of the client's suitability for their own clinical practice and the of the client's likely response to treatment, but not the client's GAF score.

Desired additional information. A series of three logistic regression analyses was conducted to examine whether client gender, type of trauma, participant gender, profession and the client gender by type of trauma interaction predicted whether or not participants' desired additional situational, dementia-related and relational information about the client. In each case the test for the significance of the change in likelihood due to the model was nonsignificant, situational information $\chi^2(5, N = 219) = 6.16, ns$, dementia-related information $\chi^2(5, N = 221) = 8.53, ns$, and relational information $\chi^2(5, N = 222) = 6.65, ns$.

Treatment recommendations. Four similar customized logistic regression analyses were conducted to identify the predictors of whether or not participants' recommended psychotherapy, medical intervention, dementia-related treatment, and trauma-specific therapy. These analyses indicated that the test for the change in likelihood due to the model was nonsignificant in the case of psychotherapy, $\chi^2(5, N = 198) = 6.80, ns$, and dementia-related treatment, $\chi^2(5, N = 198) = 1.89, ns$. The test for the change in likelihood due to the model was, however, significant for recommendations of medical intervention, $\chi^2(5, N = 200) = 33.69, p < .01$, and marginally significant for recommendations of trauma-related therapy, $\chi^2(5, N = 198) = 10.57, p = .06$. As shown in Table 13, in both cases the only significant predictor was profession, where the

probability of recommending a medical intervention was 13 times higher if the respondent was a psychiatrist rather than a psychologist (96.3% of psychiatrists vs. 66.7% of psychologists recommended medical intervention) and the probability of recommending trauma-specific therapy was 2.5 times higher if the participant was a psychologist rather than a psychiatrist (20.6% of psychologists vs. 9.3% of psychiatrists recommended trauma-specific therapy). These findings are not surprising in view of psychiatrists' medical backgrounds and psychologists' more exclusively psychological backgrounds.

Additional Analyses

The last set of analyses examined the relations between the predictor variables and participants' personal and professional characteristics to assess whether the random assignment of participants to the four client gender by type of trauma conditions was successful. To this end, a customized MANOVA examined the effects of client gender, type of trauma, participant gender, participant profession, the client gender by type of trauma interaction, the client gender by type of trauma by clinician gender interaction, and the client gender by type of trauma by profession interaction on the continuous measures of participants' characteristics (i.e., age, years of experience, percentage of time in psychotherapy, percentage of female clients, percentage of senior clients and amount of gerontological training). This analysis revealed two significant multivariate effects. The first was a main effect of participant gender, *Wilks' Λ* = .891, $F(6,196) = 4.01$, $p < .01$, $\eta^2 = .110$, which was associated with three significant univariate effects. Specifically, female clinicians were younger than male clinicians ($M_s = 49.94$ and 54.24 , $SE_s = 1.19$ and 1.11 , respectively), $F(1, 201) = 7.34$, $p < .01$, $\eta^2 = .035$, had fewer years

experience than male clinicians ($M_s = 16.94$ and 22.93 , $SE_s = 1.20$ and 1.12 , respectively), $F(1, 201) = 14.19$, $p < .01$, $\eta^2 = .066$, and worked with proportionately more females than did male clinicians ($M_s = 62.10$ and 54.37 , $SE_s = 1.99$ and 1.90 , respectively), $F(1, 201) = 7.98$, $p < .01$, $\eta^2 = .040$.

These findings suggest that participants' age, years of clinical experience and the proportion of female clients may provide alternative explanations for the observed effect of participant gender on diagnostic ratings of BPD. While the finding that the proportion of female clients was unrelated to diagnostic ratings of BPD rules out this alternative account, participants' age and years of experience may provide alternative explanations because both of these variables were significantly correlated ($r_s = -.20$) with participants' diagnostic ratings of BPD. To assess this possibility, a customized analysis of covariance (ANCOVA) was conducted with client gender, type of trauma, participant gender, participant profession and the client gender by type of trauma interaction as predictors. Given the strong correlation between participants' age and years of experience ($r = .89$), and hence the possibility of multicollinearity, only one of these variables was included as a covariate. Participant age was selected because previous research (Becker & Lamb, 1994) indicated that the diagnosis of BPD varied as a function of clinicians' age. In the results of this ANCOVA both the age by clinician gender interaction, $F(1, 195) = 0.33$, ns , and the age covariate, $F(1, 195) = 2.55$, ns , were nonsignificant. Moreover, the previously documented effects of client gender and profession were unaltered in that the effects of client gender, $F(1, 195) = 19.80$, $p < .01$, $\eta^2 = .092$, and profession, $F(1, 195) = 8.46$, $p < .01$, $\eta^2 = .042$, remained significant. The size of these effects were, however, somewhat smaller (in the previous analysis η^2 s = .177 and .091, respectively). However,

the previous effect of clinician gender became nonsignificant, $F(1,195) = 1.51, ns$. There were no other significant effects. Thus, participant age may provide an alternative explanation for the effect previously attributed to participant gender. As a result, the observed effect of participant gender on diagnostic ratings of BPD may be a result of clinician age rather than gender.

The second significant effect that emerged from the customized MANOVA on the continuous measures of participants' characteristics was a multivariate effect due to profession, $Wilks' \Lambda = .864, F(6, 196) = 5.14, p < .01, \eta^2 = .136$. This effect was associated with two significant univariate effects in which psychiatrists ($M = 63.14, SE = 1.88$) worked with proportionately more female clients than psychologists ($M = 53.33, SE = 1.93$), $F(1, 201) = 12.88, p < .01, \eta^2 = .060$, and psychiatrists ($M = 1.53, SE = 0.11$) reported more gerontological training than psychologists ($M = 1.01, SE = 0.12$), $F(1, 201) = 10.18, p < .01, \eta^2 = .048$. These findings suggest that the reported effects of profession on participants' ratings of the client's suitability for their practice and the client's responsiveness to treatment may actually be due to the proportion of female clients and/or the amount of gerontological training. These alternative explanations are especially tenable given the observed relations of the proportion of female clients with client suitability ratings ($r = .15$) and the amount of gerontological training with both client suitability ($r = .47$) and client responsiveness ratings ($r = .32$).

To assess the feasibility of these alternative accounts, a multivariate analysis of covariance (MANCOVA), customized as in the previous analysis, was conducted on participants' suitability and treatment responsiveness ratings with the proportion of female clientele and the amount of gerontological training included as covariates. Both

the proportion of female clientele by profession, $Wilks' \Lambda = .992$, $F(2, 192) = 0.74$, *ns*, and the gerontological training by profession, $Wilks' \Lambda = .984$, $F(2, 192) = 1.54$, *ns*, interactions were nonsignificant. Although multivariate test of the proportion of female clients covariate was significant, $Wilks' \Lambda = .965$, $F(2, 192) = 3.45$, $p < .05$, $\eta^2 = .035$, the related univariate analyses of both suitability ratings, $F(1, 193) = 3.07$, *ns*, and treatment responsiveness ratings, $F(1, 193) = 1.40$, *ns*, were nonsignificant. In contrast, the multivariate test, $Wilks' \Lambda = .793$, $F(2, 192) = 25.10$, $p < .01$, $\eta^2 = .207$, and the univariate tests for both suitability ratings, $F(1, 193) = 47.53$, $p < .01$, $\eta^2 = .198$, and treatment responsiveness ratings, $F(1, 193) = 17.04$, $p < .01$, $\eta^2 = .081$, revealed significant effects due to the amount of gerontological training. Moreover, the previously significant main effect of participant profession was nonsignificant, $Wilks' \Lambda = .975$, $F(2, 192) = 2.42$, *ns*, as were the other main and interaction effects. Thus the effects on client suitability and treatment responsiveness that were previously attributed to participants' profession appear to be due to the greater specialized gerontological training of psychiatrists relative to psychologists. Note, however, that the mean gerontological training scores of both psychiatrists and psychologists reflect little specialized gerontological training. Nevertheless, as observed in previous research (Hillman, et al., 1997) more gerontological training was associated with more favourable evaluations of senior trauma survivors.

Finally, two logistic regression analyses were conducted to examine whether participants' categorical characteristics (i.e., gender and profession) were related to which one of the four case histories they responded to. The first logistic regression analysis examined the extent to which client gender, type of trauma and the client gender by type

of trauma interaction were associated with participant gender. The test for the change in likelihood due to the model was nonsignificant, $\chi^2(3, N = 231) = 5.70, ns$. The second logistic regression analysis, which examined the extent to which client gender, type of trauma and the client gender by type of trauma were associated with participant profession, was also nonsignificant, $\chi^2(3, N = 231) = 0.68, ns$. Thus, neither client gender, participant profession, or their interaction were systematically confounded with type of case history participants responded to.

Discussion

The findings of this research speak to a number of aspects of clinicians' diagnostic practices with senior survivors of childhood trauma. These aspects include the effects of different kinds of childhood trauma, ageism and client gender on diagnostic practices, as well the extent to which participants' regarded the client as fulfilling the criteria for PTSD relative to dementia and depression.

Given the paucity of research examining the long-term effects of childhood sexual assault relative to a rather large body of research concerned with senior survivors of the Holocaust, as well as the stigmatization associated with child sexual abuse (Finkelhor & Browne, 1985) and clinicians' reluctance to inquire about clients' experiences of child sexual abuse (Somer, 2000), it was anticipated that clinicians would display less favourable and optimistic diagnostic practices with seniors who had experienced childhood sexual abuse relative to those who had endured the Holocaust. To the contrary, however, the present study yielded absolutely no evidence for such effects. Thus, to the extent that these findings are generalizable to clinicians' actual practices, it seems that senior survivors of childhood sexual abuse are likely to receive the same clinical treatment as senior survivors of the Holocaust.

Although senior survivors of childhood sexual abuse and the Holocaust may receive the same clinical treatment, this does not mean that such treatment is adequate. In this regard, there was substantial evidence that these clinicians gave little attention to the fact that the senior client had been chronically traumatized as a child. Less than a third of the participants indicated any desire for additional information about the client's earlier experiences of trauma and only one in five indicated an interest in additional

information about either the client's earlier traumatic experiences or their current experiences in the seniors' residential facility. Even more striking is the fact that only 5.6% of the clinicians expressed the desire for information about both the client's earlier and current life experiences. This is an important point because such information may have alerted them to the possibility that the client's symptoms were triggered by the similarity between their current experiences in the seniors' home and their earlier experiences of trauma (e.g., feelings of powerlessness; Fromuth & Burkhart, 1992; Heney & Kristiansen, 1997). Similarly, the fact that only 14% of these clinicians recommended trauma-related therapy stands in stark contrast to the frequency of all other treatment recommendations, namely medical intervention (83%), psychotherapy in general (54%) and efforts to rule out and/or treat dementia (36%). Together, these findings suggest that the lack of effects associated with the type of trauma may have stemmed from clinicians' lack of knowledge regarding the impact of childhood trauma on seniors (Honigman-Cooper, 1979; Kuch & Cox, 1992; Perkins, 1992; Reich, 1996), rather than their awareness of the comparability of the effects of different types of traumas.

Indeed, several findings suggest that the client's age overwhelmed the potential impact of the type of trauma. For example, the clinicians assigned the client relatively high diagnostic ratings for dementia and most indicated a desire for additional dementia-related information about the client. The latter finding is congruent with both Hillman et al.'s (1997) finding that clinicians more frequently elected to rule-out dementia with older relative to younger clients and James and Haley's (1995) finding that the difficulties of senior clients' were frequently related to organic brain disorder. In addition, these

clinicians were 1.5 times more likely to recommend some type of medical intervention than psychotherapy and, in line with Ford and Sbordone's (1980) finding that older clients were regarded as less suitable, the client in this study was perceived as relatively unsuitable for clinicians' practices. Although the client's age was not manipulated in the current study, these findings suggest that these clinicians may have viewed the client as suffering from the 'natural process of aging.' To the extent that this speculation is correct, the present findings indicate that these clinicians' diagnostic practices may, at least to some extent, be tainted by ageism.

There was also evidence that sexism may contribute to clinicians' diagnostic practices with senior trauma survivors. The findings of the analysis peripheral to the central concerns of this research, for example, revealed that male relative to female trauma survivors received moderately higher diagnostic ratings for Paranoid Personality Disorder (PPD) and slightly higher diagnostic ratings for Antisocial (APD) and Dependent Personality Disorder (DPD). The effects associated with PPD and APD are similar to those observed in a number of earlier studies where it has been suggested that the diagnostic criteria for personality disorders consist of caricatures of gender stereotypes (e.g., Ford & Widiger, 1989; Landrine, 1989). However, the nonsignificant effect of client gender on diagnostic ratings for Histrionic Personality Disorder is inconsistent with the findings of previous research (Ford & Widiger, 1989). Presumably no effect was observed in the present study because it involved clients who were older than those in prior research. The effect associated with DPD also runs contrary to earlier research that has found an overrepresentation of females, rather than males, among those diagnosed with DPD (Becker & Lamb, 1994; Bornstein, 1996; Ford & Widiger, 1989).

This effect, although small, may stem from the 'double standard of aging' (Palmore, 1997) which depicts signs of dependence as 'normal' on the part of senior women but problematic on the part of senior men because they defy the stereotype that portrays men as 'independent' and 'strong' regardless of age. In any case, that there were any significant effects of client gender on these diagnostic categories is especially striking because the case study was not designed to be relevant to these disorders. Thus gender biases in diagnostic practice seem to be alive and well and exerting their effects on senior survivors of childhood trauma.

There was also evidence of what one might call 'sexist neglect' in that, as reported by Becker and Lamb (1994), female and male trauma survivors were assigned the same diagnostic ratings for the situational-focused diagnoses of PTSD and adjustment disorder. This finding, which is in direct contrast to research indicating that female trauma survivors are more likely than male trauma survivors to develop PTSD (Breslau, et al., 1991; Breslau, et al., 1999), suggests that these clinicians were unfamiliar with the differential effects of trauma on women and men.

More direct evidence of sexism comes from the fact that, as observed by Becker and Lamb (1994), clinicians gave moderately higher ratings of BPD to female relative to male trauma survivors. This finding, taken together with the person-focused nature of BPD (i.e., it is a 'personality' disorder) and the devaluation and stigma associated with this diagnosis (Herman, 1992), suggests that clinicians may hold female trauma survivors responsible for their psychological fate and, in effect, direct characterological blame at them. This interpretation receives some support from the findings that clinicians who assigned a higher diagnostic rating for PTSD were moderately more likely to both desire

additional information about the client's earlier and current life experiences and recommend trauma-related treatment, while clinicians who made higher BPD ratings were only slightly more likely to desire additional situational information and not at all more likely to recommend trauma-related treatment. Given the central role of the clinician-client relationship in therapy, including trauma-related therapy (Herman, 1992), this possibility does not bode well for the success of therapy with senior women who have survived childhood trauma. Indeed, their experiences of therapy may recapitulate their earlier experiences of abuse to the extent that, like the perpetrators of their earlier traumatic experiences, clinicians show signs of disparagement, devaluation and dismissal (Fromuth & Burkhart, 1992; Heney & Kristiansen, 1997).

The analyses of the correlates of clinicians' diagnostic ratings for BPD and PTSD revealed a number of findings that go beyond the sexism underlying these diagnoses. On an optimistic note, the moderate correlation between a diagnostic rating for BPD and PTSD suggests that at least some of these clinicians were aware of the role of trauma in the lives of people diagnosed with BPD and the suggestion that BPD might be more accurately and empathetically characterized as 'complex PTSD' (Herman, 1992). However, a number of findings challenge the tenability of this suggestion, including the observation that, relative to male trauma survivors, female trauma survivors were given higher diagnostic ratings for BPD but not PTSD. Similarly, if clinicians appreciated the role of trauma in the lives of those diagnosed with BPD, it would be difficult to explain why clinicians' diagnostic ratings for BPD were only slightly related to their desire for additional situational information and totally independent of their trauma-related treatment recommendations. Their diagnostic ratings of PTSD, on the other hand, were

moderately related to both their desire for additional situational information and their trauma-related treatment recommendations.

The analyses of clinicians' diagnostic ratings for PTSD, dementia and depression, and the correlates of these ratings, were also associated with a number of interesting, and potentially important, findings. Especially noteworthy given the intent of the present research is clinicians' preference for the diagnosis of dementia over PTSD and the nonsignificant relation between clinicians' diagnostic ratings for PTSD and dementia. Two other sets of findings are also of note in this regard. The first is the independence of clinicians' diagnostic ratings for PTSD and both their desire for additional dementia-related information about the client and treatment recommendations that included efforts to rule-out or confirm the presence of dementia (i.e., cognitive testing). The second is the modest relation between clinicians' diagnostic ratings for dementia and their desire for both additional dementia-related information and dementia-related treatment recommendations. Taken together, these findings suggest that these clinicians were unaware that senior trauma survivors may manifest PTSD in the form of dementia-like symptoms (Aarts & Op den Velde, 1996; McCartney & Severson, 1997; Reich, 1996; Somer, 2000). Consistent with this suggestion, clinicians who gave the client higher diagnostic ratings for PTSD were moderately more likely to recommend both psychotherapy and trauma-specific therapy. In contrast, clinicians who gave the client higher diagnostic ratings for dementia were more likely to recommend medical intervention. Moreover, the small negative correlation between clinicians' diagnostic ratings for dementia and their GAF scores observed in this and other research (e.g., Hillman, et al., 1997) suggests that the diagnosis of dementia in itself may contribute to a

tendency to view a client as slightly more dysfunctional. If so, misconstruing senior trauma survivors symptoms of PTSD for those of dementia may detract from clinicians' perceptions of their functional abilities.

The preference for MDD over PTSD, which replicates previous reports of senior trauma survivors' PTSD symptoms being misconstrued for those of MDD (Nichols & Czirr, 1986), was associated with at least two clinical implications. In particular, while these clinicians' diagnostic ratings for PTSD were moderately correlated with their desire for additional situational information about the client, their diagnostic ratings for MDD were not. The diagnosis of MDD may therefore reduce, or at least delay, clinicians' awareness of the contribution of earlier traumatic experiences to clients' psychological distress. In addition, clinicians' diagnostic ratings for PTSD, but not their ratings for MDD, were moderately correlated with the recommendation of trauma-related therapy. The diagnosis of MDD may, therefore, result in less than ideal treatment.

Also worthy of note is these clinicians' preference for the diagnosis of MDD over dementia, which appears to run contrary to recent findings indicating a tendency for clinicians to misconstrue seniors' symptoms for dementia rather than depression (e.g., Moller, as cited in Goodman, 1999). Within the context of the present study, all that can be said is that these clinicians' preference for MDD may stem from their unawareness of the overlap in seniors' symptoms of MDD and dementia (Gintner, 1995; Moller, as cited in Goodman, 1999). Consistent with this interpretation, these clinicians were, on average, only 'moderately familiar' with dementia whereas they were at least 'very familiar' with the diagnoses of MDD and PTSD (as well as BPD). There was also twice as much variability in clinicians' familiarity with dementia relative to MDD. Further,

while clinicians' who gave the trauma survivor higher diagnostic ratings for either dementia and depression were slightly more likely to make dementia-related treatment recommendations, only those who gave the client higher ratings for dementia were more likely (albeit only slightly) to desire additional dementia-related information about the client. These findings suggest that clinicians may occasionally diagnose depression in the absence of any cognitive-related information about the possibility of dementia, a practice that may be problematic in view of the finding that clinicians were more likely to recommend psychotherapy to clients given higher MDD, but not dementia, ratings.

Finally, the findings regarding ageism and sexism, as well as the significant correlations between participants' age and their diagnostic ratings, adds to the literature regarding the unreliability of diagnostic practice (Caplan, 1996). Consistent with the findings reported by Becker and Lamb (1994), for example, younger clinicians gave the client somewhat higher diagnostic ratings for BPD. Younger clinicians were also somewhat more likely to make dementia-related treatment recommendations. As argued by Becker and Lamb (1994), such differences may stem from historical differences in the prominence of various diagnostic categories on the clinical landscape. To the extent that the criteria underlying these diagnoses have not changed substantially over time, however, they also suggest that clinicians' diagnostic decisions are not simply a function of the extent to which clients fulfill diagnostic criteria. Rather, clinicians' personal characteristics and experiences and/or the ambiguity of diagnostic criteria and procedures seem to be involved. Regardless of the reasons underlying the variability in clinicians' diagnostic ratings, such variability is worrisome in view of the implications of diagnosis for treatment.

As is true of all research, the validity of these findings and the recommendations that follow are limited by the weaknesses of the research. In this regard, the most salient potential challenge to the validity of the findings is posed by the fact that only 24.5% of the potential participants responded. However, this response rate is comparable to that attained in some studies of clinicians (Becker & Lamb, 1994; Ford & Widiger, 1989) and higher than that attained in others (e.g., Hillman et al., 1997). Nevertheless, it is useful to consider which clinicians may have been more or less likely to respond and how such bias might affect the present findings. Given that people with more interest in a topic under investigation are more likely to respond to a postal survey, it is conceivable that the present sample over-represented clinicians with more interest in seniors and/or trauma. If so, one would assume that the clinicians who responded were more informed about the issues under investigation. The present findings, then, may actually underestimate the role of sexism and ageism in clinicians' diagnostic practices with senior trauma survivors.

Another limitation of the present study, and one that may have detracted from the response rate, stems from the length of the survey. Indeed, some participants reported that it took them at least an hour to complete the questionnaire. This unintended demand on participants' time may have caused some to respond with less care and attention and, as a result, increased the error associated with the various responses. This increase in error would, however, reduce the likelihood of observing any significant effects. Once again, then, this limitation suggests that the present findings may underestimate the role of sexism and ageism in clinicians' diagnostic practices with senior trauma survivors.

A more fundamental limitation, perhaps, concerns the extent to which the survey used in this study accurately captured clinicians' actual clinical practices. Some

clinicians, for example, are reluctant to engage in the diagnostic process and prefer to focus on clients' particular difficulties. Indeed, 8 (0.01%) of the 1000 potential participants refused to take part in this study for this very reason. It must, therefore, be acknowledged that clinicians' practices with clients are undoubtedly more complex than suggested by the present finding. This, of course, suggests the need for more process-orientated research regarding clinicians' practices with senior trauma survivors.

Both the limited response rate and the potential unreliability of participants' responses draw attention to the need for the replication of these findings. Future research with this goal in mind might wisely endeavour to do so by conducting a series of less time demanding studies, each focusing on one particular research question such as sexism or the type of trauma rather than both.

The present findings also suggest the need for additional research in at least three areas. The first is the need for research systematically designed to assess the role of ageism in diagnostic practices with trauma survivors. While the present study yielded a number of findings suggestive of ageist assumptions and biases in clinicians' practices with senior trauma survivors, the presence of such biases would be assessed more conclusively by research in which the client's age is manipulated.

A second area in need of additional research concerns the role of client age in gender biases in diagnostic practices. That the male trauma survivor in the present study was seen as more, rather than less, likely to suffer from Dependent Personality Disorder suggests that gender stereotypes of mental health may be different for older relative to younger clients in ways consistent with the 'double standard of aging' (Palmore, 1997).

Given the increasing population of seniors (Statistics Canada, 2001), such research would be practically, as well as theoretically, important.

A third area in dire need of additional research concerns the long-term aftereffects of violence toward women and children. As noted earlier, relative to the amount of research examining the long-term effects of the Holocaust and combat-related trauma, there is a paucity of research in this domain. Indeed, the research that does exist consists of individual case studies of a handful of women. Thus, future research might endeavour to systematically document and compare the well-being and needs of senior women who did and did not experience physical or sexual assault earlier in life.

More generally, the present findings draw attention to the need for research examining the factors that affect, and ways of improving, the reliability of the diagnostic enterprise. One potentially fruitful avenue worthy of exploration might involve a comparison of the advantages and disadvantages of dimensional analyses of clients' psychological strengths and weakness and resources and needs relative to the categorical diagnostic taxonomy in current use.

The current findings also have a number of practical implications, specifically in regard to clinician education and training. Most fundamentally, the present research suggests that clinicians need education regarding the effects of earlier experiences of trauma on seniors' psychological and physical well-being. Clinicians' should, for example, be made aware of the potential of current stressors in seniors' lives to contribute to delayed-onset PTSD or the exacerbation of pre-existing PTSD. Such education should also draw clinicians' attention to the possibility that seniors' PTSD may manifest itself in symptoms akin to those of dementia, depression and BPD.

More generally, there was clear evidence of the need for more clinicians with specialized gerontological training. Indeed, on average both the psychologists and the psychiatrists in the present study reported having little gerontology training. This need seems particularly pressing in view of the increasing size of the senior population (Statistics Canada, 2001) and the observed relations between the amount of clinicians' gerontological training and the positivity of their perceptions of the senior trauma survivors' response to treatment and suitability for their practice. Further, while the negative correlation between clinicians' age and amount of gerontological training suggests that this need is currently being addressed, the small magnitude of this relation suggests little reason for complacency.

The findings of this research indicate that both such gerontological training and clinicians' training more generally might usefully draw clinicians' attention to the overlap in seniors' symptoms of depression and dementia (Moller, as cited in Goodman, 1999) and the need for assessments of cognitive function in either case. Clinician training regarding dementia might also be designed to ensure that the diagnosis of dementia is not associated with unfounded pessimism regarding seniors' well-being. Further, such training might also usefully be exploited to educate clinicians about the possibility of age- and gender-related biases in response to senior clients.

In closing, it is important to note that both the fact that the present study was conducted and that so many clinicians volunteered their time to participate suggest that the social climate is conducive to efforts to enhance the lives of seniors. Despite the pessimistic nature of some of the present findings, then, there is room for optimism regarding the status and well-being of elders.

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Appendix A
Research Materials

Diagnostic Decision-Making Survey

Your name was randomly selected from the registry of psychiatrists or psychologists for inclusion in a study of clinicians' diagnostic decision-making. The study is being conducted by Connie M. Kristiansen, Ph.D. and Suzanne Cooper, MA Candidate, of the Department of Psychology at Carleton University in Ottawa, and is being funded by the Social Sciences and Humanities Research Council of Canada. In this study, you will be asked to answer questions about your professional background, read a case history, and then answer a series of questions about the case. Given the reality of professionals' schedules, we have tried to make the survey as brief as possible. For the sake of the representativeness of the findings, we would be very grateful if you would take about a half an hour of your time to participate. Please feel welcome to complete the survey in bits and pieces, as your time allows.

It is important that you understand that your participation is entirely voluntary, that you are free to refuse to answer any question, and that your answers will be completely anonymous. Also, if you have any questions about the study you are welcome to contact Connie Kristiansen at (613) 520-2600 ext. 2674 (e-mail: ckristia@ccs.carleton.ca) or Suzanne Cooper at (613) 520-2600 ext. 2679 (e-mail: scooper@chat.carleton.ca). If you have any concerns about any ethical aspects of the study you are invited to contact Dr. Mary Gick, Chair of the Carleton University Research Ethics Committee for Psychological Research, at (613) 520-2600, ext. 2664. If you have any concerns about any other aspects of the study please contact Dr. Kim Matheson, Chair of the Department of Psychology, at (613) 520-2600, ext. 2648.

With sincere thanks for your time and effort,

Connie M. Kristiansen, Ph.D.
Associate Professor of Psychology

Suzanne Cooper
M.A. Candidate

Diagnostic Decision-Making Survey: Instructions

Please read the case history and respond to the remaining questions. Please feel free to use the DSM-IV to help make your diagnoses. If you have any additional comments, you are welcome to write them in the margins or attach them on a separate page.

Regardless of whether or not you have completed the survey, we would be grateful if you would complete and return the enclosed response card. Please do so separately from the survey itself so that your answers can remain anonymous. Also note that you may request a summary of the findings regardless of whether or not you have completed the survey.

After you have completed the survey, you can return it to us in the enclosed self-addressed stamped envelope.

Thanks.

Case History

Identifying Information. Judith (vs. Jerry) is a 71-year-old woman (vs. man) with one daughter. Five weeks ago she entered a medium-level seniors' care facility because her daughter took employment in another city and was unable to continue watching over her. A psychological evaluation was requested by her attending physician to make treatment recommendations.

Presenting Problem. Residence staff described Judith as "difficult." Judith often paces inconsolably across her room for hours. She also has difficulty sleeping, apparently because she is afraid of the dark and nightmares in which, she says, "some thing or person is overpowering her." Staff said they suspect Judith's lack of sleep may be responsible for her persistent irritability and argumentativeness. Judith also has days when she stays in bed all day, refuses to socialize and neglects her self-care and hygiene. One time Judith said "there's no point getting up" and claimed she didn't care because she "wasn't supposed to live this long any way." Staff also expressed considerable concern with Judith's lack of interest in going to the synagogue, doing her embroidery, and reading, activities that she had done consistently in the past but stopped shortly after her arrival at the residence.

Staff described Judith as having rigid boundaries and becoming extremely upset whenever she believes her roommate is "invading" her privacy. On one occasion she accused her roommate of stealing a cherished watch and insisted that staff put locks on her dresser. Judith has, on several occasions, complained of a "putrid smell" and said that someone is touching her body. At these times no smell was evident and no one was touching her. During these episodes Judith appears disoriented and unaware of where she is.

Residence staff reported a number of problematic interpersonal behaviours. Judith is very angry with her daughter, whom she once adored, and refuses to let her visit or talk to her on the phone because, according to Judith, "she abandoned a sinking ship." She has had no visitors except for a friend with whom she once worked. She is reluctant to socialize with other residents and prefers to eat her meals in her room rather than in the common dining area. On several occasions Judith displayed angry outbursts in response to male residents and attendants, whom she called by her father's name. After these outbursts Judith was found cowering, crying and banging her head on her bathroom wall. Because she had no memory of these incidents, Judith refused to apologize to the people whom she had verbally accosted.

Judith's daughter indicated that, although some of these problems existed in the past, they seemed to be more numerous, frequent and extreme since Judith entered the residence.

Mental Status. During evaluation by the residence physician, Judith was cooperative and presented in a quiet, constricted, and fearful manner. She is of average height, thin and has poor posture. She was dressed casually and groomed appropriately. Her eye contact was fair. Her intelligence seemed above average. Her mood was anxious and her affect was occasionally inappropriate to content. She appeared alert and orientated to self, but not to place. She

presented with no apparent speech or language disorder. She described difficulty concentrating and being "forgetful," both of which she said were getting worse. She also complained of difficulties balancing her checkbook and completing her income tax, both of which she had always done readily in the past. She displayed concrete thinking and poor insight in judgement and her thought process sometimes seemed unusual. Her remote and current memory appeared poor. She denied any current suicidal ideation.

Past Psychiatric History. No reported past psychiatric treatment. Judith described intermittent periods of alcohol and sleeping pill abuse during her adult years, which she claimed to have stopped 15 years ago. She also reported periods of depression characterized by fatigue, loss of appetite, anxiety and a sense of emptiness and futility.

Brief Medical History. There has been significant weight loss and a number of physical complaints since entering the residence, including diarrhea, upset stomach, and headaches. She also has arthritis and some loss of vision and hearing.

History of Presenting Illness/Significant Social History. Judith is the second of three children, two boys and one girl. All family members were born in Holland. Her father was steadily employed as a carpenter. Her mother stayed in the home. Judith reported that, from the ages of 8 to 11, her father would get into bed with her and "put it [his penis] inside" her (vs. During WW II, from the ages of 8 to 11, Judith was separated from her family and interned in a 'children's camp'). She described the experience as "horrific" and was unwilling to talk more about this period of her life. Judith also reluctantly described scratching her body and making it bleed during her teens and early 20s, although she could not explain why.

Following the accidental death of her parents when she was 22, Judith immigrated to Canada, where she found employment as a seamstress. Judith reported frequently changing jobs because her employers were unreasonably demanding. She also reported two brief whirlwind marriages during her late 20s and early 30s that ended because both husbands could not live with her being so "moody, jealous and demanding." Judith described difficulties after both divorces, including feeling depressed, anxious, suicidal, abusing alcohol and medications, and having indiscriminate affairs with men.

Please read the case history before responding to the remaining questions.

A. Diagnostic Decisions

- Please use the following scale to rate the extent to which you believe the person in the case history meets the DSM-IV criteria for each of the following diagnoses.
(Note that you are welcome to consult the DSM if you wish.)

0	1	2	3	4	5	6
Meets no criteria			Meets half of required criteria			Meets all of the required criteria

	<u>Rating</u>	<u>Disorder</u>
Axis I:	_____	Cyclothymia
	_____	Dysthymia
	_____	Intermittent Explosive Disorder
	_____	Major Depressive Disorder
	_____	Posttraumatic Stress Disorder
	_____	Adjustment Disorder (Mixed Emotional Features)
	_____	Generalized Anxiety Disorder
	_____	Delusional Disorder
	_____	Dementia
	_____	Delirium
	_____	Schizophrenia, Paranoid Type
	_____	Schizophreniform Disorder
Axis II:	_____	Narcissistic
	_____	Schizoid
	_____	Dependent
	_____	Histrionic
	_____	Obsessive Compulsive
	_____	Antisocial
	_____	Borderline
	_____	Schizotypal
	_____	Avoidant
	_____	Paranoid

2. What Global Assessment of Functioning (GAF) score would you assign? _____

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

- 100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
- 91
- 90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
- 81
- 80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
- 71
- 70 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
- 61
- 60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
- 51
- 50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
- 41
- 40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
- 31
- 30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
- 21
- 20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
- 11
- 10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
- 1
- 0 Inadequate information.

B. Familiarity with the Disorders

As a result of your professional practice, how familiar are you with each of these disorders? Please use the following scale to make your ratings:

0	1	2	3	4
Not at all familiar	Slightly familiar	Moderately familiar	Very familiar	Extremely familiar

	<u>Rating</u>	<u>Disorder</u>
Axis I:	_____	Cyclothymia
	_____	Dysthymia
	_____	Intermittent Explosive Disorder
	_____	Major Depressive Disorder
	_____	Posttraumatic Stress Disorder
	_____	Adjustment Disorder (Mixed Emotional Features)
	_____	Generalized Anxiety Disorder
	_____	Delusional Disorder
	_____	Dementia
	_____	Delirium
	_____	Schizophrenia, Paranoid Type
	_____	Schizophreniform Disorder
Axis II:	_____	Narcissistic
	_____	Schizoid
	_____	Dependent
	_____	Histrionic
	_____	Obsessive Compulsive
	_____	Antisocial
	_____	Borderline
	_____	Schizotypal
	_____	Avoidant
	_____	Paranoid

C. Questions You Would Want to Ask

What 3 questions would you want to ask the person in the case history if you had the opportunity?

1. _____

2. _____

3. _____

D. Additional Information You Would Like

Please describe any additional information you would want to obtain about this person:

G. Background Information

1. Age: _____ years
2. Gender (circle): male / female
3. Profession (circle): psychiatrist / psychologist
4. How long have you been in professional practice? _____ years
 Where? (tick all that apply): _____ private practice _____ institution
 _____ inpatient setting _____ hospital
 _____ other (please specify): _____
5. Do you have any particular area(s) of competency? No / Yes
 If yes, please describe this area: _____
6. What percentage of your working time is spent doing psychotherapy? _____ %
7. How would you describe your primary clinical orientation? (tick as many as apply)
 _____ Cognitive-behavioural
 _____ Eclectic
 _____ Feminist
 _____ Humanistic (i.e., Rogerian, existential)
 _____ Interpersonal
 _____ Psychobiological
 _____ Psychodynamic/psychoanalytic
 _____ Other (please describe): _____
8. What is the gender composition of your patients/clients? _____ % Male
9. What percent of your patients/clients fall into the following age groups?
 _____ % under the age of 18
 _____ % between the ages of 18 and 64
 _____ % 65 or older
10. How much specialized gerontological training or course work have you had? (tick one)
 _ none _ a little _ a moderate amount _ a good deal _ a great deal

Appendix B

Diagnostic Criteria and Associated Features of Posttraumatic Stress Disorder, Borderline Personality Disorder, Major Depressive Disorder and Dementia

Diagnostic Criteria and Associated Features of Posttraumatic Stress Disorder

A. *The traumatic event is persistently re-experienced in one (or more) of the following ways:*

1. recurrent and distressing recollections of the event, including images, thoughts or perceptions.
2. recurrent distressing dreams of the event.
3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

B. *Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by three (or more) of the following:*

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. inability to recall an important aspect of the trauma
4. markedly diminished interest or participation in significant activities.
5. feeling of detachment or estrangement from others.
6. restricted range of affect (e.g. does not have loving feelings).
7. sense of foreshortened future

C. *Persistent symptoms of increased arousal (as indicated by 2 or more):*

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response

Associated Features:

1. feelings of guilt, shame, despair, hopelessness
2. impaired relationships with others
3. impaired affect modulation
4. self-destructive, impulsive behaviour
5. feelings of guilt, shame, despair, hopelessness
6. hostility, social withdrawal
7. feeling constantly threatened
8. feeling permanently damaged
9. a change in previous personality characteristics.

Diagnostic Criteria and Associated Features of Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, (as indicated by five or more of the following):

1. frantic efforts to avoid real or imagined abandonment.
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization or devaluation.
3. identity disturbance: markedly and persistently unstable self-image or sense of self.
4. impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).
5. recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6. affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. chronic feelings of emptiness.
8. inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
9. transient, stress-related paranoid ideation or severe dissociative symptoms.

Associated Features:

1. psychotic-like symptoms during times of stress (hallucinations, body-image distortions, hypnagogic phenomena).
2. a pattern of undermining themselves.
3. physical handicaps due to self-mutilation or failed suicide attempts.

Diagnostic Criteria and Associated Features of Major Depressive Disorder

A. *The presence of two or more Major Depressive Episodes which include five or more of the following symptoms:*

1. depressed mood (e.g. feeling sad or empty; appears tearful)
2. marked diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease in appetite nearly everyday.
4. sleep disturbances (insomnia, or hypersomnia)
5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy
7. feelings of worthlessness or excessive, inappropriate guilt (which may be delusional).
8. memory impairment, difficulty thinking or concentrating
9. recurrent thoughts of suicide or suicide attempts

B. *The symptoms cause clinically significant distress or impairment in social, occupation, or other important areas of functioning.*

Associated Features:

1. somatic complaints (bodily aches and pains)
2. irritability, anxiety
3. obsessive rumination

Diagnostic Criteria and Associated Features of Dementia

A. *The development of multiple cognitive deficits manifested by both:*

1. memory impairment and;
2. one or more of the following cognitive disturbances:
 - a) aphasia (deterioration of language function)
 - b) apraxia (impaired ability to execute motor activities despite intact motor abilities, sensory function, and comprehension of the required task)
 - c) agnosia (failure to recognize or identify objects despite intact sensory function).
 - d) disturbances in executive functioning (the ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour).

B. Cognitive deficits are sufficiently severe to cause impairment in occupational or social functioning and must represent a decline from a previously higher level of functioning.

C. The course is characterized by gradual onset and continuing cognitive decline.

Associated Features:

1. spatially disoriented and have difficulty with spatial tasks
2. poor judgement and poor insight
3. motor disturbances of gait leading to falls.
4. individuals may exhibit little or no awareness of memory loss or other abnormalities
5. violent episodes
6. suicidal behaviour
7. disinhibited behaviour
8. delusions and hallucinations.
9. increased vulnerability to physical stressors
10. anxiety
11. mood and sleep disturbances

Appendix C

Tables of Statistical Analyses

Table 1

Criteria and Associated Features Common to Post Traumatic Stress Disorder (PTSD), Borderline Personality Disorder (BPD), Major Depressive Disorder (MDD) and Dementia

Symptom	PTSD	BPD	MDD	Dementia
Anxiety/agitation	X	X	X	X
Irritability/anger/hostility	X	X	X	X
Hallucinations/dissociation/ disorientation	X	X	X	X
Guilt/shame/hopeless/emptiness	X	X	X	
Relational problems	X	X	X	
Suicidal ideation		X	X	X
Self-destructive, self-harm	X	X		X
Impulsive	X	X		X
Feeling threatened/paranoid	X	X		X
Sleep disturbances	X		X	X
Difficulty concentrating	X		X	X
Memory impairment	X		X	X
Affective instability/reactivity	X	X		
Somatic complaints	X		X	
Diminished interest in activities	X		X	

Table 2

*Correlations between the Continuous Measures of Participants' Personal and Professional**Characteristics*

Characteristic	1	2	3	4	5
1. Age	-				
2. Years in practice	.89**				
3. Time doing psychotherapy	.33**	.31**			
4. Percent female clients	.01	-.05	.30**		
5. Percent senior clients	-.07	-.05	-.25**	.11	
6. Gerontological training	-.21**	-.20**	-.23**	.06	.61***

* $p < .05$. ** $p < .01$. *** $p < .001$. Two-tailed.

Note. Ns range from 223 to 232.

Table 3

Descriptive Statistics for Axis I Diagnostic Ratings

Diagnosis	<i>M</i>	<i>SD</i>
Major depression (MDD)	4.61	1.64
Dementia	3.43	1.93
PTSD	2.99	2.12
Adjustment disorder	2.76	2.22
Delirium	1.78	1.93
Dysthymia	1.72	1.83
Delusional disorder	1.70	1.68
General anxiety disorder	1.26	1.47
Schizophrenia, paranoid	0.83	1.33
Intermittent explosive	0.80	1.32
Schizophreniform disorder	0.80	1.29
Cyclothmia	0.64	1.08

Note. Scores could range from 0 (meets no criteria) to 6 (meets all required criteria).

Table 4

Descriptive Statistics for Axis II Diagnostic Ratings

Diagnosis	<i>M</i>	<i>SD</i>
Borderline	2.99	2.21
Paranoid	1.75	1.71
Dependent	1.17	1.61
Narcissistic	0.94	1.37
Schizoid	0.85	1.32
Histrionic	0.85	1.27
Schizotypal	0.84	1.44
Avoidant	0.84	1.34
Obsessive Compulsive	0.72	1.24
Antisocial	0.43	0.88

Note. Scores could range from 0 (meets no criteria) to 6 (meets all required criteria).

Table 5

Descriptive Statistics for Axis I Familiarity Ratings

Diagnosis	<i>M</i>	<i>SD</i>
Major depression (MDD)	3.60	0.68
General anxiety disorder	3.24	0.91
PTSD	3.21	0.98
Adjustment disorder	3.17	1.00
Dysthymia	2.98	0.96
Schizophrenia, paranoid	2.53	1.21
Delusional disorder	2.30	1.18
Dementia	2.30	1.32
Cyclothymia	2.20	1.09
Schizophreniform disorder	2.17	1.27
Delirium	2.05	1.43
Intermittent explosive	1.58	1.18

Note. Scores could range from 0 (not at all familiar) to 4 (extremely familiar).

Table 6

Descriptive Statistics for Axis II Familiarity Ratings

Diagnosis	<i>M</i>	<i>SD</i>
Borderline	3.05	1.03
Obsessive compulsive	2.83	1.06
Dependent	2.70	1.04
Narcissistic	2.67	1.08
Antisocial	2.59	1.15
Histrionic	2.57	1.04
Avoidant	2.53	1.08
Paranoid	2.39	1.04
Schizoid	2.22	1.08
Schizotypal	2.13	1.05

Note. Scores could range from 0 (not at all familiar) to 4 (extremely familiar).

Table 7

Correlations between Diagnostic and Familiarity Ratings for Axis I Disorders

Disorder	<i>r</i>
Cyclothymia	.05
Dysthymia	.07
Intermittent explosive	.06
MDD	.22**
PTSD	.16*
Adjustment	.00
General anxiety	.02
Delusional	.00
Dementia	.20**
Delirium	.12
Schizophrenia, paranoid type	-.07
Schizophreniform	-.02

* $p < .05$. ** $p < .01$. Two-tailed.

Note. *Ns* range from 228 to 231.

Table 8

Correlations between Diagnostic and Familiarity Ratings for Axis II Disorders

Disorder	<i>r</i>
Narcissistic	.25**
Schizoid	.09
Dependent	.22**
Histrionic	.15*
Obsessive compulsive	.17*
Antisocial	-.00
BPD	.13
Schizotypal	.00
Avoidant	.13
Paranoid	.17**

* $p < .05$. ** $p < .01$. Two-tailed.

Note. *Ns* range from 228 to 231.

Table 9

Correlations between Diagnostic Ratings

Diagnostic rating	1	2	3	4
1. Major depression	-			
2. PTSD	.16*	-		
3. Adjustment disorder	.11	.17*	-	
4. Dementia	.14*	.02	.11	-
5. Borderline	.11	.31**	.07	.05

** $p < .01$. * $p < .05$. Two-tailed.

Note. *Ns* range from 204 to 220.

Table 10

Correlations of Diagnostic Ratings with Client Evaluation, Desired Information and Treatment Recommendations

Diagnostic rating	<u>Client evaluations</u>				<u>Desired information</u>				<u>Treatment recommendations</u>			
	GAF	Suitability	Response	Situational	Dementia	Relational	Therapy	Medical	Dementia	Trauma		
Depression	-.06	.03	.12	-.04	.06	-.01	.19**	.25**	.17*	.02		
PTSD	.08	.13	.08	.24**	-.01	.07	.16**	-.03	.01	.26**		
Adjustment disorder	.11	-.03	.02	.08	.04	.08	.10	-.02	.16*	-.15		
BPD	-.13	-.02	-.05	.14*	-.06	.15*	.20**	-.04	.03	.07		
Dementia	-.16*	-.09	.02	.01	-.22**	-.09	-.04	.24*	.16*	-.15		

* $p < .05$. ** $p < .01$. Two-tailed.

Note. Ns range from 201 to 231. Desired information and treatment recommendations coded 0 if not indicated and 1 if indicated.

Table 11

Intercorrelations of Client Evaluations, Desired Information and Treatment Recommendations

Criterion variable	1	2	3	4	5	6	7	8	9
1. GAF	-								
2. Suitability	.03	-							
3. Treatment response	-.03	.45**	-						
4. Situational	.01	.17*	.07	-					
5. Dementia	.00	-.03	-.11	-.02	-				
6. Relational	.10	.06	.05	.10	-.17**	-			
7. Psychotherapy	.08	.02	.15*	.05	-.13	.13	-		
8. Medical	.04	.04	.21**	.03	.10	-.05	.00	-	
9. Dementia-related	-.03	-.03	.02	-.02	.22**	-.10	-.07	.15*	-
10. Trauma-related	.14	.19**	.08	.12	-.04	.00	-.08	-.04	-.02

* $p < .05$. ** $p < .01$. Two-tailed.

Note. *N*s range from 196 to 225. Desired information and treatment recommendations coded 0 if not indicated and 1 if indicated.

Table 12

Correlations between Participants' Characteristics and Criterion Variable Scores

Criterion variable	Age	Years in practice	Time doing therapy	% female clients	% senior clients	Gerontological training
Depression	-.15*	-.14*	-.10	.06	.03	.09
PTSD	.03	-.08	.09	.02	-.03	-.06
Adjustment disorder	-.11	-.14*	-.16*	-.13	.12	-.01
Dementia	-.08	-.05	-.06	-.06	.10	.09
BPD	-.20**	-.20**	-.06	.06	.01	-.01
GAF scores	.06	.05	.05	-.05	.02	.04
Suitability	-.01	-.04	-.04	.15*	.44**	.47**
Responsiveness	-.11	-.09	-.13	.04	.21**	.32**

* $p < .05$. ** $p < .01$. Two-tailed.

Note. Ns range from 197 to 231.

Table 12 (con't)

Correlations between Participants' Characteristics and Criterion Variable Scores

Criterion variable	Age	Years in practice	Time doing therapy	% female clients	% senior clients	Gerontological training
Situational Info.	-.07	-.09	.12	.03	.10	.10
Dementia	-.11	-.12	-.14	-.02	.05	.03
Relational	.09	.08	.06	-.09	.09	.04
Psychotherapy	-.01	-.01	.07	-.05	.01	-.04
Medical treatment	-.15*	-.07	-.14	.08	.03	.12
Dementia-related	-.24**	-.24**	-.12	.07	.08	.06
Trauma-specific	-.03	-.04	.05	.04	.06	.04

* $p < .05$. ** $p < .01$. Two-tailed.

Note. Ns range from 197 to 229.

Table 13

***Odds Ratios for Client Gender, Trauma, Clinician Gender and Profession for
Predicting Medical and Trauma-Related Treatment Recommendations***

Variable	<i>B</i>	<i>SE</i>	<i>Wald</i>	<i>df</i>	<i>Exp(B)</i>
Medical treatment:					
Client gender	-.005	.57	0.00	1	1.00
Trauma	.113	.67	0.03	1	1.12
Participant gender	-.131	.41	0.10	1	0.88
Profession	2.57	.56	21.28**	1	13.10
Client gender X trauma	-.417	.85	0.24	1	0.66
Trauma-related:					
Client gender	-.704	.64	1.22	1	0.50
Trauma	.352	.61	0.33	1	1.42
Participant gender	.510	.42	1.50	1	1.66
Profession	-.924	.43	4.65*	1	2.52
Client gender X trauma	.448	.85	0.28	1	1.56

* $p < .05$. ** $p < .01$.