Gender as a Factor in School-Based Mental Health Service Delivery

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Abstract. There is a large research base indicating numerous gender differences in prevalence rates of psychopathology, the expression of psychopathology, and the etiology of psychopathology across different disorders (Zahn-Waxler, Shirtcliff, & Marceau, 2008). Such documented gender differences in mental health among children and adolescents have significant implications for the provision of school-based mental health services. This article provides an overview of the research documenting differences in mental health among children and adolescents and a description of the delivery of gender-informed mental health services through a public health model framework of service delivery. Gender-informed prevention and intervention strategies are presented using specific examples to provide practitioners with a greater awareness of gender differences and their implications for providing mental health services to children and adolescents. The article concludes with recommendations for the field of school psychology.

Mental health in childhood and adolescence is defined by the achievement of expected developmental milestones and by establishing effective coping skills, secure attachments, and positive social relationships (U.S. Department of Health and Human Services [U.S. DHHS], 1999). Mentally healthy children and adolescents enjoy a positive quality of life; are free of symptoms of psychopathology; and function well at home, in school, and in their communities (Hoagwood, Jensen, Petti, & Burns, 1996). Unfortunately, recent epidemiologic studies have found that anywhere from 17% to almost 40% of children in
the United States meet criteria for a diagnos-
able mental or addictive disorder associated
with at least minimum impairment (Brown,

Several important federal initiatives have
brought children's mental health to the forefront
of national issues (New Freedom Commission
on Mental Health, 2003; The National Advisory
Mental Health Council Workgroup on Child and
Adolescent Mental Health Intervention Devel-
opment and Deployment, 2001; U.S. DHHS,
1999). These initiatives have highlighted re-
search showing that many children in need of
mental health services are not receiving them
and that substantial disparities exist in access to
mental health care for specific youth popula-
tions. To improve access to mental health ser-
vice among youth, The New Freedom Commis-
sion on Mental Health (2003) noted the poten-
tial of schools to provide all children with a com-
prehensive continuum of mental health promo-
tion and intervention services. In recent years,
the education system has expanded its role in
providing mental health services and is now
commonly considered the de facto provider of
mental health services for children and youth
(Farmer, Burns, Philip, Angold, & Costello,
2003), with an estimated 70%-80% of children
who receive mental health services receiving
them in school (Rones & Hoagwood, 2000).

Despite the expanding literature base on
school-based mental health (SBMH), many ques-
tions about how to best provide these services
remain unanswered (Power, 2003). One impor-
tant question is how to specifically tailor mental health services for different types
of children. This question is important because
although what is considered mentally healthy
may be similar for diverse types of children,
what is needed to achieve this outcome may
vary for different groups of children (Ringeisen,
Henderson, & Hoagwood, 2003; Weist et al.,
2000). For example, the needs of children in
rural schools may be quite different from those
of children in urban schools. Similarly, the
needs of children with developmental disabil-
ities may be different from the needs of those
who are intellectually gifted. Indeed, there has
been growing evidence that supports the influ-
ence of group differences on children’s vul-
article, we use specific examples to provide practitioners with a greater awareness of gender differences and their implications for mental health service delivery.

**Gender Differences in Mental Health Among Children and Adolescents**

**Gender and Prevalence**

Numerous studies have documented gender differences in rates of psychopathology that are well established by adolescence (Côté, Vaillancourt, Barker, Nagin, & Tremblay, 2007; Crick & Zahn-Waxler, 2003; McGee et al., 1990). Research indicates that gender plays a significant role in the prevalence rates of psychopathology from early childhood to adolescence. During infancy and toddlerhood, boys and girls are equally likely to exhibit adjustment difficulties (Keenan & Shaw, 1994). However, during the preschool and elementary years, boys are overwhelmingly identified as exhibiting more significant adjustment problems than girls (Broidy et al., 2003). These adjustment problems are primarily related to externalizing behaviors, including conduct disorder, physical aggression, and attention deficit hyperactivity disorder (ADHD). Most empirical estimates indicate that boys are three to ten times more likely than girls to experience psychopathology during this developmental period (Härtung & Widiger, 1998).

In adolescence, adjustment problems are more equally distributed across both genders (U.S. DHHS, 1999), although the types of problems that are most common differ by gender. Boys continue to outnumber girls in physical aggression and violence (Cohen et al., 1993), but girls outnumber boys in internalizing disorders such as eating disorders (Ackard, Fulkerson, & Neumark-Sztainer, 2007), anxiety, and depression (Lewinsohn, Rohde, & Seeley, 1995), with adolescent females more than twice as likely as males to become anxious and/or depressed (Nolen-Hoeksema & Girgus, 1994). Female students also are significantly more likely than male students to have considered, planned, and attempted suicide (Center for Disease Control and Prevention, 2008). In contrast, because they use more lethal means, adolescent boys are four times more likely than adolescent girls to complete suicide (U.S. DHHS, 1999). Notably, researchers have called for more attention to be paid to those mental health problems previously ignored in one gender because they are seen less frequently (Zahn-Waxler et al., 2008). For example, very little is known about the etiology and treatment of eating disorders in adolescent males because this disorder is more prevalent in the adolescent female population.

**Gender and Symptom Presentation**

In addition to gender differences in rates of psychopathology, research has documented differences in the expression of particular disorders (Crick & Zahn-Waxler, 2003). Although research in this area is relatively new, considerable evidence has accrued to support the significance of the role of gender in the manifestation of both externalizing and internalizing problems throughout childhood and adolescence. One example for which the expression of a disorder may differ based on gender is adolescent depression. A study by Bennett, Ambrosini, Kudes, Metz, & Rabinovich (2005) showed that although depressed adolescent girls and boys were similar to each other with regard to symptoms and severity on the Beck Depression Inventory, boys had higher mean clinician ratings of morning fatigue, depressed morning mood, and anhedonia. Girls, on the other hand, were found to experience more body image dissatisfaction, guilt, self-blame, self-disappointment, feelings of failure, concentration problems, difficulty working, sleep problems, overall fatigue, and health worries than boys.

**Gender and Etiology**

More recently, researchers have turned to the examination of similarities and differences in the etiology of disorders in boys and girls. Research on these gender differences has yielded a complex picture of similarities and differences in the antecedents, correlates, and consequences of different forms of psychopathology in boys and girls (Zahn-Waxler et al., 2008). For example, some researchers have found that the most common antecedents of substance use or abuse are depression in girls
and conduct disorder in boys (Bukstein, Glancy, & Kaminer, 1992). Although this example oversimplifies the complexity of the development of psychopathology in adolescents by focusing on just one process, it provides a representation of how important it is to examine gender differences in the development of psychopathology. These differences have implications for the prevention and treatment of mental health problems in boys and girls.

Gender Differences in School-Based Referrals

Given the gender differences that have been found in mental health problems in youth, it would be expected that there would be gender differences in the types of problems referred for mental health services in schools. Indeed, the available research shows that this is the case (Foster et al., 2005). In an examination of the provision of mental health services within the education system, a nationally representative random sample of school personnel from 1,147 public kindergarten through Grade 12 schools in 1,064 districts across the country responded to a survey about the problems most frequently presented by students in their schools (Foster et al., 2005). School personnel ranked the three most frequently seen problems for male and for female students out of a broad list of 14 psycho-social or mental health problems. For both male and female students, the mental health problem category most frequently endorsed was social, interpersonal, or family problems (73% male, 80% female). However, the second and third most frequently cited concerns differed for males and females. Anxiety (41%) and adjustment issues (36%) were cited as the second and third most frequent problems, respectively, for females. Aggression or disruptive behavior (63%) and behavior problems associated with neurological disorders (42%) were cited as the second and third most frequent problems for males.

Public Health Model as a Framework for SBMH Service Delivery

Although the field of SBMH is still emerging (Flaherty & Osher, 2003), there is a growing evidence base for efficacious mental health programs (Schaeffer, Weist, & Goldstein, 2002) and increasing recognition of the need for an integrated approach to service delivery (e.g., Weist, 2003). Educators and student support personnel have the opportunity to be proactive as well as reactive through the implementation of services and programs that foster resilience and positive social-emotional adjustment as well as address mental health and school adjustment difficulties. This emphasis on the development of strategies for prevention through the implementation of universal, secondary, and tertiary prevention strategies is consistent with the public health model approach to SBMH service provision (Myers & Nastasi, 1999). A public health model approach emphasizes the provision of empirically supported programming, data-based decision making, and analysis of risk and protective factors.

Support for the use of the public health model as the framework for the implementation of effective SBMH services has been recognized both within the field of psychology (Strein, Hoagwood, & Cohn, 2003; Weist, 2003) and by policy makers (U.S. Public Health Services, 2000). Prominent federal initiatives, such as The New Freedom Commission (2003), call for a public mental health promotion approach to improve the mental health and educational outcomes of youth. Hence, the public health model will be used as a framework for organizing our discussion of the implementation of SBMH services throughout the remainder of this article.

Considering Gender in Primary Prevention Services (Tier 1)

Preventive or universal mental health programs and services target all children in all school settings. Universal programs focus on decreasing risk factors, building resilience, strengthening protective factors, and establishing connections for all students to have access to community and family supports associated with positive emotional and educational outcomes (American Academy of Pediatrics, 2004). In this section, we examine the role of gender in the provision of universal programming. Specifically, considerations in the deliv-
Substance Abuse Prevention Programs for Girls

The potential need for gender-informed substance abuse programs for youth gained national attention in the mid-1990s when a number of reports indicated that substance use and abuse among girls was increasing (Johnston, O'Malley, Bachman, & Schulenberg, 2005) and outcome evaluations of current programs provided clear evidence that girls were not benefiting from the interventions (e.g., Yin & Kafetarain, 1998). Some of the main hypotheses for why the majority of these school-based substance abuse prevention programs were not found to be effective is because they (a) used general theories related to substance abuse prevention and failed to incorporate gender-informed or gender-specific theoretical models (e.g., gender-specific risk and protective factors), and (b) did not consider gender differences in the key elements (e.g., activities) of substance abuse prevention programs (Amaro, Blake, Schwartz, & Flinchbaugh, 2001; Blake, Amaro, Blake, Schwartz, & Flinchbaugh, 2001; Kumpfer, Smith, & Summerhayes, 2008).

A growing body of substance abuse research has demonstrated that gender is a major defining social factor in shaping specific risk and protective factors, substance choice, and patterns and consequences of substance use for boys and girls. For example, there is growing evidence that certain risk and protective factors might have differing effects or be more influenced by gender (Sale, Sambrano, Springer, & Turner, 2003). Similarly, unique causal mechanisms for substance use have been hypothesized for adolescent girls (Kumpfer et al., 2008). One hypothesized mechanism for substance use is the influence of social norms in our society, specifically the ideal of the thin body type that is glamorized through the media and popular teen culture, which is hypothesized to impact adolescent females' perceptions of their physical appearance (Amaro et al., 2001). This can lead to dissatisfaction with weight, decreased self-esteem, and the use of substances among girls to lose weight (Califano, 2001). Findings indicate that the more severely girls diet, the more likely they are to drink frequently and heavily as well as to use marijuana and elicit drugs. In addition, many researchers have reported on the kinds of substances used and the differential effects of those substances between female and males. In a recent study conducted by Chassin, Ritter, Trim, and King (2003), adolescent girls were found to favor stimulants whereas adolescent boys were more likely to favor alcohol.

Blake et al. (2001) and Kumpfer et al. (2008) identified a number of common elements that have fostered success in substance abuse prevention programs in the adolescent girl population. For example, although connectedness to school plays a significant role in substance use both for boys and for girls, it has been identified as more important and influential among girls (Substance Abuse and Mental Health Services Administration, 2002). A focus on connectedness through the development of life skills has been among the key elements identified in programs that decrease substance use in girls (Substance Abuse and Mental Health Services Administration, 2002). Session topics and program activities have revolved around teaching girls' effective communication, self-efficacy, and the skills necessary to attain positive inclusion in schools. In contrast, social interactions and milieu have been identified as more important and influential as risk and protective factors for boys. Those substance abuse prevention programs that have emphasized interactive modes of service delivery (e.g., peer activities) have been found to be more effective for boys.

In its current state, a review of the literature would suggest that substance abuse prevention programs are effective (National Institute on Drug Abuse, 2003). However, as noted by Kumpfer and colleagues (2008), support for classification as an "evidence-based" program has relied heavily on main effect analyses alone and rarely includes subgroup analyses by gender. In a review of published articles related to substance use prevention intervention published between 1980 and 2000, Guthrie and Flinchbaugh (2001) found that the...
majority of studies published on substance abuse prevention programs have not been analyzed and/or published separately by gender. Of those that did report gender analyses, very few evidence-based programs reported reducing initiation and/or use of alcohol and other drugs for girls. The one exception was in the reduction of one substance, tobacco, in which a number of programs were found to be more effective in reducing initiation in girls than boys (Blake et al., 2001). In a more recent review of substance abuse prevention programs, incongruent findings led Kumpfer et al. (2008) to conclude that there was insufficient research evidence or published articles to confirm that the current prevention programs available are effective for females.

One way the field of substance abuse treatment has responded to the unmet needs of girls is by developing gender-specific substance abuse programming. In 1994, the Center for Substance Abuse Prevention funded grants to develop 25 gender-specific substance abuse prevention programs for female adolescents, called the Female Adolescent Initiative. In a review of these programs by Guthrie and Flinchbaugh (2001), many of the program results were found to be nonsignificant or equivocal. They identified a number of factors likely to have impacted the results, including the fact that many programs were based on general theories related to substance abuse prevention rather than gender-informed theories; others experienced implementation issues (e.g., high staff turnover, lack of support from parent organizations); and many failed to incorporate gender-specific activities and elements. However, two programs, the Strengthening Hawaiian Families Program (Kameoke, 1996) and Nuevo Dia, reported statistically significant effects and show promise for being identified as an evidence-based gender-specific substance abuse prevention program (Kumpfer et al., 2008).

To develop substance use prevention programs that specifically target adolescent females, gender-specific, comprehensive theoretical frameworks must be developed that explain more fully the substance use patterns and risk and protective factors that differ between adolescent boys and girls. Once identified, empirical findings specific to adolescent girls can be integrated into current etiological models of substance abuse in girls and applied to prevention programs and future intervention development and application (Blake et al., 2001).

Considering Gender in Secondary and Tertiary Prevention Services (Tiers 2 and 3)

Secondary prevention involves intervening with children who have been identified as “at risk” for mental health problems. This identification may occur through a school-wide screening (often part of Tier 1), or it may occur through referral by parents, teachers, self, or others. Tertiary prevention programs target students with significant mental health needs not successfully addressed at Tier 1 or Tier 2. Students identified for tertiary programs often warrant a comprehensive clinical assessment to gather more detailed information about the mental health problem. We begin this section by describing how gender may play a role in which children are perceived as being at risk. We then describe gender-specific considerations within the assessment process, including how the tools that we use may not always be appropriate for both genders. Next, we discuss the issue of relational aggression in girls, including a gender-specific intervention developed for antisocial girls. Finally, interventions for girls with ADHD and considerations in the delivery of individual counseling services to boys are discussed.

Gender and Children Perceived as at Risk

The primary means for children to be referred for mental health services in schools is through teachers (Kavale & Reese, 1992). Notably, research shows that teachers are more likely to be concerned about externalizing problems than internalizing problems (Caseau, Luckasson, & Roger, 1994; Mirkin, Marston, & Deno, 1982). This is significant in a discussion of gender differences in mental health service provision because, as noted earlier, boys are more likely than girls to externalize their problems (Zahn-Waxler et al., 2008). As such, boys are more likely than girls
to be referred for further evaluation (Adams, Benshoff, & Harrington, 2007; Valdes, Williamson, & Wagner, 1990).

Once a child has been referred for evaluation, gender again becomes a salient variable, given that assessment tools and diagnostic criteria generally have been developed based on research dominated by one gender (e.g., conduct disorder for males, eating disorders for females). A unique study by Henning-Stout (1998) demonstrated how mental health professionals may fail to capture important information on behavior rating scales because the scales do not include items assessing gender-specific concerns. In this study, Henning-Stout examined how well three commonly used behavior rating scales addressed mental health issues that may be more salient for girls than boys. These concerns included issues such as desire for authentic relationship, sense of social disconnection, questioning validity of experience (credibility to self), feeling unheard, and replacing real with idealized notions of relationship and body image. Henning-Stout concluded that “the content analysis of these instruments indicated high likelihood for error in their application for understanding girls’ behaviors” (p. 452). She recommended that practitioners attend to what we may miss when we allow the results of standardized measures to drive our conceptualizations of girls’ primary issues.

Delligatti, Akin-Little, and Little (2003) also provided an example of how diagnostic criteria may not be equally appropriate for both genders. They noted that the current percentage of females diagnosed with conduct disorder (i.e., 2%-9% vs. 6%-16% of males) may be an underestimate because Diagnostic Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000) diagnostic criteria for conduct disorder (CD) were developed from research that either did not include females or aggregated male and female data. Developing diagnostic criteria from studies on boys means that characteristics of a disorder that may be unique to girls, such as displays of relational aggression, socially manipulative behavior, or somatic complaints, may be missed. These authors advocated for expansion of diagnostic criteria for CD to include internalizing behaviors displayed more frequently by girls with CD, less emphasis on overt aggressive behavior for females in making the diagnosis, the creation of overt and covert aggressive subtypes of CD, and gender-specific criteria regarding contact with the criminal justice system. Delligatti et al. (2003) suggest that until changes are made in the formal diagnostic criteria, it is the job of school professionals to help parents and teachers recognize CD in females in the consultation process so that they may receive the treatment they need to avoid the negative consequences associated with CD, such as contraction of sexually transmitted diseases, school failure, and early death.

Notably, at least one research group has been working to develop measures to specifically address CD in girls. The Early Assessment Risk List for Girls (Levene et al., 2001) is a consultation version of a risk assessment for girls with CD under the age of 12. This measure, described in Pepler, Walsh, and Levene (2004), includes questions related to caregiver–daughter interaction and sexual development, two factors that these authors identified as being particularly relevant for girls with serious aggressive and antisocial behaviors.

**Group Interventions for Aggressive Girls**

Prior to the 1990s, it was thought that boys engaged in considerably more aggression than girls (Underwood, 2003). However, the work of Crick and her colleagues (e.g., Crick & Grotpeter, 1995; Crick, Casas, & Ku, 1999) has focused attention on the construct of relational aggression (sometimes called “social aggression”; see Underwood, 2003), a form of aggression designed to hurt others through threats or direct acts to harm relationships. Relational aggression includes acts such as spreading rumors so that a child will be rejected by others, purposely excluding children from social groups in order to hurt them, and using tactics including the “silent treatment” as a form of social manipulation (Crick, Ostrov, Appleyard, Jansen, & Casas, 2004). When research on relational aggression first began in the mid-1990s, it was thought that
relational aggression was seen more commonly in girls whereas physical aggression was seen more commonly in boys. Subsequent research has shown that although physical aggression is more common among boys than girls, relational aggression is found in both genders, and whether it is found more frequently in boys or girls depends on the age groups studied and the measures used (Underwood, 2003). With regard to the focus of this article, the study of gender differences in aggression is an excellent example of how a program of research has resulted in a greater understanding of gender-specific forms of behavior (i.e., physical aggression vs. relational aggression) with direct implications for the assessment of behavior in children and for treatment programming. More of this type of study is needed in other areas where boys and girls may manifest symptoms differently, including disruptive behavior disorders (e.g., ADHD) and internalizing disorders (e.g., anxiety).

In addition to further inquiry into the impact of gender on the expression of aggression, it is also important for researchers to examine whether gender moderates treatment outcomes. Farrell and Meyer (1997) provided an example of this type of work in their controlled study of a school-based intervention to teach problem-solving skills and reduce aggression among sixth-grade students. They found that the intervention worked well for boys but showed iatrogenic effects for girls. Girls in the treatment group showed poorer outcomes following the intervention than girls in the control group. Farrell and Meyer attributed these results to two factors: (a) the problem-solving techniques taught in the group may not have addressed the types of aggression in which girls more commonly engage, and (b) the mixed-gender format and male leadership of the groups may have not worked well for the girls. This study is important because it highlights the need to investigate whether interventions work equally well for both genders. There are, of course, many programs that do not show gender differences in outcomes. We should not assume, however, this is the case without empirical investigation of this question, particularly when previous research has suggested gender differences in how symptoms are expressed.

Finally, with regard to aggression in girls, the research on relational aggression that began about 15 years ago is now being applied to develop gender-specific interventions for girls. This literature base is small but growing. An example of a gender-specific program that has been empirically evaluated is the Earls court Girls Connection (see Levene, Walsh, Augimeri, & Pepler, 2004), a program for aggressive and antisocial girls under the age of 12. This program was developed in response to the finding that a theoretically gender-neutral program being implemented by these researchers with both boys and girls was found to be less effective with girls. In developing the Earls court Girls Connection, the authors retained the parent training component of the program but added a 12-session girls group (Levene, 2003) that included gender-specific elements (e.g., how to respond to being labeled fat or ugly, a scenario that these researchers found to be a common “trigger” for girls). They also added a mother–daughter group (Girls Growing Up Healthy Program; see Levene et al., 2004) in response to evidence suggesting that a conflicted relationship between a girl and her mother is particularly important in the development of problems with aggression among girls (Pepler et al., 2004). Evaluation of the program showed significant improvements for girls with regard to externalizing behaviors and social skills (Walsh, Pepler, & Levene, 2002).

Interventions for Girls With ADHD

A recent national study indicated that approximately 8% of youth in the U.S. have been diagnosed with ADHD (Visser, Lesesne, & Perou, 2007). Despite the considerable literature available on ADHD, the majority of research has focused on clinically referred samples of boys and has conveyed a severely limited understanding of ADHD in girls (Gershon, 2002). The clear lack of research available on girls has led to problems with the
identification, assessment, and treatment of girls with ADHD.

In general, girls have been identified as displaying less disruptive behavior and more inattentive behavior than boys with ADHD. In a recent meta-analysis, Gershon (2002) concluded that girls with ADHD were significantly less impaired in hyperactivity, inattention, impulsivity, and externalizing problems as compared to boys with ADHD. However, girls and boys have been found to be at similar risk for deficits in academic and social functioning (DuPaul et al., 2006). In contrast, girls have been identified as performing significantly worse on measures of intellectual functioning and manifesting more severe internalizing problems (Gershon, 2002). The potential presence of comorbid internalizing disorders for girls can complicate diagnosis of ADHD as research suggests that these secondary conditions are more commonly diagnosed than the underlying ADHD (Quinn, 2005). Although less understood, there also appears to be the presence of differences in the course of ADHD for girls (Quinn, 2005). For example, it has been found that adolescent girls with ADHD are more likely than adolescent boys to have attentional and organizational difficulties (Faraone, Biederman, Weber, & Russell, 1998).

Gender differences in the expression of symptoms have been identified as a potential reason for why girls are referred significantly less often than boys for mental health services for ADHD (Barkley, 2006). Recent empirical findings also suggest that differences in teacher perceptions of boys’ and girls’ behaviors may contribute to gender differences in ADHD referrals (Scuitto, Nolfi, & Bluhm, 2004). Other researchers and clinicians have been increasingly voicing concerns that the symptom criteria in the DSM insufficiently represent how girls manifest the core symptomology of ADHD (Ohan & Johnston, 2002).

Underrepresentation in school-based referrals and incongruous diagnostic criteria for girls with ADHD clearly have implications for treatment. In 1996, participants at the National Institute of Mental Health Conference on Sex Differences in ADHD concluded that inferences drawn from studies of boys with ADHD could not be routinely applied to girls with ADHD (Arnold, 1996). Unfortunately, very few studies have investigated the effects of gender on the mental health treatment of ADHD in youth, with the majority of studies analyzing the effects of gender with respect to medication. Ralph, Oman, and Forney (2001) analyzed the effects of medication and parent training on a relatively large sample of children and adolescents and found no difference between boys and girls with regard to treatment outcome. Similarly, the Multimodal Treatment Study of Children with Attention-Deficit/Hyperactivity Disorder (Owens et al., 2003) conducted an analysis of moderator variables, including gender, and found no moderator effect for gender for the three treatment groups in the study (i.e., medication management, behavioral interventions, combined treatment). However, in a review of social skills training outcome studies for children with ADHD, De Boo and Prins (2007) found that none of the studies reported gender differences in treatment results. Likewise, in a recent review of the treatment literature on ADHD published since 1998, despite identifying multiple evidence-based treatments, Pelham and Fabiano (2008) identified only one study that analyzed gender as a moderator of treatment outcome (i.e., Owens et al., 2003). They noted that gender is a moderator generally understudied and that most studies have inadequate sample sizes of girls diagnosed with ADHD, yielding studies underpowered for testing differences between boys and girls.

Future research efforts should include comparisons of the subtypes of ADHD as delineated in the DSM-IV-TR in the examination of gender differences and the diagnostic heterogeneity of ADHD (Gershon, 2002). Gender differences in the developmental course of the disorder are poorly understood, and longitudinal studies including comprehensive batteries of gender-sensitive measures need to be conducted. Finally, researchers need to include larger samples of girls in ADHD research studies that incorporate analyses of gender effects on treatment.
Gender in SBMH Service Delivery

Counseling With Boys

One of the most common tertiary interventions is individual counseling or therapy. Because this is the case, it is important to note that in general, girls tend to be more aware of their feelings than boys as well as more comfortable talking about them with another person (Kiselica & Englar-Carlson, 2008). This can have a considerable impact on how each gender feels about talking to an adult who is in a helping role. Pollock (1998) noted that boys have been socialized to believe they should handle their problems on their own rather than reach out to others for help. As a result, it is less likely that boys, as compared to girls, will readily open up to a school adult about their feelings when asked about a problem. This may be particularly true when the adult is female and/or of a different racial background. Pollock's research suggests that, in such situations, boys may feel more comfortable focusing on an activity (e.g., games, role plays) and having discussions of thoughts and feelings that arise out of the activity rather than simply being asked to share what is on their minds. Similarly, Kiselica and Englar-Carlson (2008) have suggested several “male-friendly” counseling strategies, including (a) providing counseling in informal settings (e.g., holding the first few sessions in a gym or on a playground); (b) using flexible schedules and drop-in times (e.g., shorter sessions to begin, perhaps 10–20 min rather than the standard 50 min); (c) helping boys and their families with practical needs (e.g., assisting families in getting needed services as a way of demonstrating sincerity and concern); and (d) creating a “welcoming space” for boys (e.g., providing Koosh or Nerf balls to keep hands busy while talking; keeping objects and posters of interest to boys in the counseling room). Each of these suggestions was derived from research identifying effective ways of working with teenage fathers (e.g., Mazza, 2002), but they have not been subject to empirical investigation with boys in counseling. Clinical evidence to suggest that there is a mismatch between the typical counseling environment and the preferred communication style of boys suggests that this is an area where research is sorely needed.

Conclusion

Many children have mental health problems that interfere with normal development and functioning. School-employed mental health professionals, namely school psychologists, have been recognized as natural leaders for schools to expand and improve mental health programming through a public health model of service delivery (Weist, 2003). In recent years, the school psychology literature has published calls for school psychologists to respond proactively with respect to providing mental health services to children in schools (e.g., Phelps & Power, 2008). Such calls have identified school psychologists as uniquely qualified to take action in the development, implementation, and evaluation of comprehensive mental health programming in schools. The present article expands on this role by providing pertinent information on the influence of gender in the provision of SBMH services. Our goal was to begin to lay the groundwork for practitioners to recognize gender differences in achieving psychological wellness and the implications of these differences in the provision of SBMH services.

The gender differences described in this article have implications for how school psychologists will prevent and treat mental health problems in boys and girls. If the services of school psychologists are to be maximized to meet the needs of both genders, then clearly the training of school psychologists needs to be reexamined. Although most training programs may cover such topics as gender differences in the rates of psychopathology, school psychologists should be provided with knowledge on how to ensure that all students with potential mental health problems are identified (e.g., both internalizing and externalizing problems). Additional training is needed in how to effectively identify and assess gender differences in the expression of particular disorders. Such training should involve identifying valid, reliable, and comprehensive measures of psychopathology for both genders.

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Finally, research that has identified the gender differences and similarities in the development, antecedents, correlates, and consequences of different forms of psychopathology point to the importance of training school psychologists to provide individualized assessments and to be trained to modify and adapt services to meet the unique needs of each child.

Although well-trained school psychologists may have some understanding of the influence of gender on mental health based on the research available, the question of whether gender moderates treatment efficacy for many of the SBMH programs developed is clearly understudied and has significant implications for identifying efficacious treatments for boys and girls. This is not to say that the current evidence-based programs available do not potentially address the mental health needs of both genders; however, to reach a more definitive conclusion, separate gender analyses need to be conducted. It is also important to note that there are studies that have investigated gender as a moderator and have failed to find gender differences in responsiveness to treatment. Hence, there are many evidence-based programs currently available for implementation in schools that are equally efficacious for boys and girls. However, as identified throughout this article, for some mental health problems, girls and boys face different gender-related challenges that need to be taken into account when developing interventions.

With regard to the development of gender-informed mental health programming, there continues to be a paucity of literature, both applied and experimental. In reviewing the intervention literature, we found very few empirically validated gender-informed or gender-specific programs currently available for implementation in schools; moreover, the gender-specific programs evaluated systematically and empirically were conducted, for the most part, in outpatient clinical settings and/or detention centers. An increase in research on gender-specific universal, secondary, and tertiary school-based programming is clearly needed. Notably, these programs need to be developed based on etiological models that integrate current empirical findings specific to girls and boys. A critical step will be to examine whether these gender-informed and gender-specific interventions result in different outcomes from the standard treatment of care. A significant limitation of the current research available on gender-specific interventions is the lack of empirical support on the superior benefits of gender-specific interventions. Similarly, schools should begin to take steps towards evaluating the outcome data on their current universal, secondary, and tertiary programming to identify whether these programs are effective for both genders. Researching current intervention programs may also be useful in identifying how to better design programs for boys and girls.

With a gap in empirical support for how to best adapt programs to meet the needs of both boys and girls, a gray area exists for how practitioners can begin to proactively respond to gender differences when providing SBMH services. One of the first steps that practitioners can take to ensure that the mental health services currently being provided within their schools are meeting the needs of both boys and girls is to monitor and evaluate the effectiveness of mental health programming. Data collection should incorporate measures of multiple mental health outcomes such as reduction of risk factors (e.g., violence exposure) and enhancement of protective factors (e.g., positive support from adults). Separate gender analyses also should be conducted to evaluate whether current programs are equally effective for both boys and girls.

Secondly, practitioners can begin to evaluate whether school personnel are well informed about gender differences in psychopathology and mental health promotion. Qualitative (e.g., interviews with counselors) and quantitative data (e.g., surveys) can inform practitioners if additional training is needed for educators and other school personnel. Staff development programs can enhance school professionals’ identification of emotional/behavioral problems in youth so that they can better assist in connecting students to mental health services and improve the quality of services currently being provided. Multimethod identification processes (e.g., screen-
ings, discipline referrals) should also be implemented in schools in an effort to identify those at risk or in need of services who exhibit internalizing and externalizing problems.

Another step that practitioners can take is to become responsive and flexible to each individual child’s unique mental health needs, particularly when providing selective and tertiary mental health programming. Identifying and analyzing mental health problems involves gathering rich information, which should aid practitioners in identifying potential differences in the expression of a disorder, as well as differences in the development, antecedents, correlates, and consequences of a disorder unique to a given child. Assessment data should also inform treatment planning and therefore aid in identifying and planning effective, individualized interventions. Progress monitoring interventions will allow practitioners to assess whether they are effective and to quickly identify when one may need to be modified or changed altogether.

Although we can begin to make headway as practitioners and educators in the school system, public policy makers must also take heed to the plethora of research that documents the need to consider gender in mental health programming. In 1993, the Coalition for Equal Access for Girls promoted a bill (ORS 417.270) through the Oregon State legislative branch to respond to gender needs and equity in the social, juvenile justice, and community service arenas (Morgan & Patton, 2002). The guidelines that were developed based on this legislation are entitled “Oregon’s Guidelines for Effective Gender-Specific Programming for Girls” (Patton & Morgan, 2000) and a manual was created to guide practitioners. The guidelines developed are an excellent prototype for other states or even schools or organizations to use.

Despite the progress that has been made in providing comprehensive and effective SBMH services, many questions still remain as to how best provide these services to meet the needs of both boys and girls. This article is a first attempt at presenting some of the studies that have been completed as a means to propel the field forward to establish and develop more gender-informed mental health services. Learning more about how gender and other group differences impact children’s health and well-being will help us to fine-tune assessment, prevention, and intervention initiatives to ensure that we deliver services that have the best chance of truly making a difference in mental health outcomes for children.

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and Drug Abuse (CASA) at Columbia University Conference.


Date Received: March 20, 2009
Date Accepted: September 14, 2009
Action Editor: Thomas Power

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