

MAINTAINING THE POWER IN THE THERAPY
ROOM:
A CONCEPTUAL MODEL OF SOCIAL DOMINANCE
ORIENTATION, MEDICALIZATION
AND OVERPATHOLOGIZING

A THESIS

SUBMITTED TO ABDULLAH GÜL UNIVERSITY

SOCIAL SCIENCES INSTITUTE

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF SCIENCE

By

Mehmet Ali Sevim

August 2025

Kayseri

Mehmet Ali

Sevim

MAINTAINING THE POWER IN THE THERAPY ROOM:

A CONCEPTUAL MODEL OF SOCIAL DOMINANCE

ORIENTATION, MEDICALIZATION AND OVERPATHOLOGIZING

AGU

2025

MAINTAINING THE POWER IN THE THERAPY ROOM:
A CONCEPTUAL MODEL OF SOCIAL DOMINANCE
ORIENTATION, MEDICALIZATION
AND OVERPATHOLOGIZING

A THESIS

SUBMITTED TO ABDULLAH GÜL UNIVERSITY

SOCIAL SCIENCES INSTITUTE

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF SCIENCE

By

Mehmet Ali Sevim

August 2025

Kayseri

SCIENTIFIC ETHICS COMPLIANCE

I hereby declare that all information in this document has been obtained in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all materials and results that are not original to this work.

Name-Surname: Mehmet Ali Sevim

Signature:

REGULATORY COMPLIANCE

M.Sc. thesis titled Maintaining the Power in the Therapy Room: A Conceptual Model of Social Dominance Orientation, Medicalization and Overpathologizing has been prepared in accordance with the Graduate Thesis Preparation Guidelines of the Abdullah Gül University, Social Sciences Institute.

Prepared By

Mehmet Ali Sevim

Advisor

Assoc. Prof. Ahmet oymak

Head of the Data Science Program

Assoc. Prof. Umut Trk

ACCEPTANCE AND APPROVAL

M.A. thesis titled Maintaining the Power in the Therapy Room: A Conceptual Model of Social Dominance Orientation, Medicalization and Overpathologizing and prepared by Mehmet Ali Sevim has been accepted by the jury in the Data Science Graduate Program at Abdullah Gül University, Social Sciences Institute.

..... / /

(Thesis Defense Exam Date)

JURY:

Advisor : Assoc. Prof. Ahmet Çoyrak

Member : Dr. Muhammet Coşkun

Member : Assoc. Prof. Olga Selin Hünler

APPROVAL:

The acceptance of this M.A. thesis has been approved by the decision of the Abdullah Gül University, Social Sciences Institute, Management Board dated / / and numbered

..... / /

(Date)

Director of Social Sciences Institute

Name Surname : Mehmet Ali SEVİM

Program : Data Science (Master of Science)

Advisor : Assoc. Prof. Ahmet oymak

Thesis Title : Maintaining the Power in the Therapy Room: A Conceptual Model of Social Dominance Orientation, Medicalization and Overpathologizing

Date and Place: August, 2025 – Kayseri, Turkey

ABSTRACT

This thesis examines how therapists' orientation towards social hierarchies and their medicalization beliefs shape the risk of overpathologizing in psychotherapy. Drawing on Social Dominance Orientation (SDO), it develops a conceptual model in which SDO influences clinical judgement through medicalizations, understood as an ideological framework that legitimizes expert authority. Study 1 analyzed 1,675 naturally occurring client complaints from a public platform using large language model-based text classification. The complaints were coded for overpathologizing and grouped into the themes of overprescribing, overdiagnosis, pessimistic prognosis, and coercive treatment, providing ecological evidence that overpathologizing is a repeated problem in professional practice. Study 2 employed an online vignette experiment designed to activate SDO would increase medicalization beliefs and, in turn, overpathologizing tendencies. The manipulation produced no group differences, but medicalization beliefs were positively associated with overpathologizing, and post hoc analyses suggested an indirect pathway from SDO to overpathologizing via medicalization. Together, these findings emphasize overpathologizing as both an

empirical reality and a theoretically explicable bias rooted in hierarchy-maintaining ideologies. Positioning clinical judgement within broader dynamics of power and legitimizing discourse, the thesis advances a framework for understanding how institutional authority can subtly translate into client harm, underscoring the ethical imperative for power-aware psychotherapy.

Keywords: overpathologizing, social dominance, medicalization, nlp, artificial intelligence



Ad Soyad : Mehmet Ali Sevim

Anabilim Dalı, Program : Veri Bilimi (Yüksek Lisans)

Tez Danışmanı : Doç. Dr. Ahmet Çoymak

Tez Başlığı : Gücün Terapi Odasında Sürdürülmesi: Sosyal Baskınlık Yönelimi, Medikalizasyon ve Aşırı Patolojikleştirmenin Kavramsal Modeli

Tarih ve Yer : Haziran, 2025 – Kayseri, Türkiye

ÖZET

Bu tez, psikoterapide hiyerarşiye yönelik yönelimleri ifade eden Sosyal Baskınlık Yönelimi (SBY) ve sosyal normların ne ölçüde tıbbi açıklamalar yönünde değişmesi gerektiğine ve toplumun bu açıklamalar aracılığıyla ne kadar düzenlenmesi gerektiğine ilişkin görüşleri içeren medikalizasyon inançlarının aşırı patolojikleştirme üzerindeki rolünü incelemektedir. Bu çerçevede, çalışmanın modeli SBY'nin medikalizasyon inançları aracılığıyla terapistlerin aşırı patolojikleştirme eğilimlerini etkilediği yönündeki varsayımı test etmektedir. Çalışma 1'de çevrim içi bir platformda yer alan 1.675 ruh sağlığı uzmanına yönelik danışan şikâyeti analiz edilmiştir. Şikâyetler, aşırı patolojikleştirme içerip içermediğine göre kodlanmış ve aşırı ilaç yazma, aşırı tanı koyma, kötümser prognoz ve zorlayıcı tedavi temaları altında kategorize edilmiştir. Bulgular, aşırı patolojikleştirmenin mesleki pratikte de ortaya çıktığını göstermiştir. Çalışma 2'de, SBY'yi manipüle ederek, medikalizasyon inançlarını ve dolayısıyla aşırı patolojikleştirme eğilimlerini artırıp artırmayacağını test etmek amacıyla çevrim içi bir vinyet deneyi yürütülmüştür. Deney ve kontrol grupları arasında SBY, medikalizasyon inançları veya aşırı patolojikleştirme açısından

anlamalı bir fark gözlenmemiştir. Ancak, medikalizasyon inançları ile aşırı patolojikleştirme arasında pozitif bir ilişki bulunmuş; medikalizasyonu daha güçlü benimseyen terapistlerin danışanları aşırı patolojikleştirme eğiliminde oldukları görülmüştür.

Anahtar kelimeler: aşırı patolojikleştirme, sosyal baskınlık, medikalizasyon, NLP, yapay zeka



TABLE OF CONTENTS

ABSTRACT	1
ÖZET	3
TABLE OF CONTENTS	5
LIST OF ABBREVIATIONS.....	8
LIST OF TABLES	9
LIST OF FIGURES	11
1. INTRODUCTION	12
2. THEORETICAL FRAMEWORK.....	21
2.1. Theoretical Framework: Power Dynamics in Psychotherapy	21
2.1.1. <i>Conceptualizing Power in the Clinical Context</i>	22
2.1.2. <i>Power Asymmetry in Psychotherapy</i>	25
2.1.3. <i>Power and Overpathologizing</i>	26
2.2. Theoretical Framework: Social Dominance Theory, Explaining the Hierarchy in Psychotherapy	26
2.2.1. <i>Social Dominance Orientation</i>	29
2.2.2. <i>Medicalization as a Legitimizing Myth in Psychotherapy</i> ..	31
3. CURRENT STUDY	33
3.1. Current Study: Conceptual Model	34
3.2. Current Study: Hypotheses	36

4. STUDY 1	37
4.1. Study 1: Introduction	37
4.2. Study 1: Method	38
4.2.1. Data Collection	38
4.2.2. Text Classification	39
<u>4.2.2.1. Detecting Overpathologizing</u>	<u>41</u>
<u>4.2.2.2. Detecting Overpathologizing Themes</u>	<u>42</u>
4.2.3. Detecting the Occupations	43
4.3. Study 1: Results	47
4.4. Study 1: Discussion	50
5. STUDY 2	54
5.1. Study 2: Introduction	54
5.2. Study 2: Method	56
5.2.1. Procedure	57
5.2.2. Participants	59
5.2.3. Materials	60
5.2.4. Analysis Strategy	66
5.3. Study 2: Results	68
5.4. Study 2: Discussion	79
5.4.1. Limitations	82
6. GENERAL DISCUSSION	85
7. APPENDICES	89

7.1. APPENDIX 1: Psychometric Properties of MBS	89
7.2. APPENDIX 2: Psychometric Properties of ATPQ.....	93
7.3. APPENDIX 3: Full Experimental Materials and Measures	97
7.4. APPENDIX 4: The English Version of the Materials and Measures.....	111
7.5. APPENDIX 5: AI Policy.....	125
7.6. APPENDIX 6: Data Transparency	126
8. REFERENCES	128

LIST OF ABBREVIATIONS

AI	Artificial Intelligence
CFA	Confirmatory Factor Analysis
CSV	Comma-Separated Values
DSM	Diagnostic and Statistical Manual of Psychology
EFA	Exploratory Factor Analysis
HTML	Hypertext Markup Language
LLM	Large Language Model
MBS	Medicalization Beliefs Scale
MMPI	The Minnesota Multiphasic Personality Inventory
NLP	Natural Language Processing
OSF	Open-Source Framework
SBY	Sosyal Baskınlık Yönelimi
SDO	Social Dominance Orientation
SDO-E	Social Dominance Orientation - Equality
SDT	Social Dominance Theory
XML	Extensible Markup Language

LIST OF TABLES

Table 4.3.1 Number of Complaints by Overpathologizing	47
Table 4.3.2 Overpathologizing	48
Table 4.3.3 Occupations	49
Table 4.3.4 Occupations and Themes.....	49
Table 5.3.1 Demographic Variables.....	70
Table 5.3.2 Variables by Groups.....	71
Table 5.3.3 Independent Samples t-Test for Manipulation Check ...	72
Table 5.3.4 Independent Samples t-Test for Overpathologizing by Groups	72
Table 5.3.5 Independent Samples t-Test for Medicalization Beliefs by Groups	73
Table 5.3.6 Pearson Correlations Between Medicalization Beliefs and Overpathologizing	74
Table 5.3.7 Mediation Analysis of the Effect Model	75
Table 5.3.8 Nonparametric Group Comparisons by Gender	76
Table 5.3.9. Spearman Correlations Between MBS and ATPQ by Gender	77
Table 5.3.10 Post-Hoc Mediation Analysis of the Effect Model.....	78
Table 7.1.1. Item–Total Correlations and Cronbach’s Alpha if Item Deleted by Factor for the MBS.....	90

Table 7.1.2. Exploratory Factor Analysis Factor Loadings and Uniqueness for MBS.....	91
Table 7.1.3. Item–Total Correlations and Cronbach’s Alpha if Item Deleted for the Revised MBS.....	92
Table 7.1.4. Confirmatory Factor Analysis Fit Indices for the MBS	92
Table 7.2.1. Item–Total Correlations and Cronbach’s Alpha if Item Deleted for the ATPQ	94
Table 7.2.2. Exploratory Factor Analysis Factor Loadings and Uniqueness for the ATPQ.....	95
Table 7.2.3. Confirmatory Factor Analysis Fit Indices for the ATPQ	95

LIST OF FIGURES

Figure 3.1.1. Mediation Model of Medicalization Beliefs in the Relationship Between Social Dominance Orientation and Overpathologizing	35
---	-----------



1. INTRODUCTION

One of the important biases that may occur in therapists' clinical judgment is overpathologizing. In general, overpathologizing is the assessment of behaviors and thoughts that can be considered normal as symptomatic, abnormal, or unhealthy. In other words, overpathologizing is the process of framing contextually appropriate behaviors and thoughts as symptoms of disorders and perceiving the client's psychological stress as higher than it actually is and the client as more in need of intervention (Lopez, 1989; Suhr & Johnson, 2022). This bias has significant individual-level consequences such as the development of an illness identity, increased anxiety, and dependency on inappropriate or unnecessary treatments (Suhr & Wei, 2017). It may also reinforce therapeutic pessimism and undermine the client's sense of agency in the recovery process. At the systemic overpathologizing contributes to resource misallocation and weakens the boundaries between health and pathology, potentially compromising the credibility of mental health knowledge (Wakefield, 2016). Although several cognitive and situational factors, such as overconfidence, fatigue, or training gaps, have been proposed to explain this bias, these accounts often overlook how therapists' judgments are shaped by broader power asymmetries and ideological framing. To address this gap, the present study introduces a theoretical model that explains how therapists' orientation toward social hierarchies may influence their clinical judgment in hierarchy-consistent ways.

To address the often-overlooked role of power dynamics in clinical judgment processes, this thesis proposes a theoretical model linking therapists' orientation to social hierarchies with their tendency toward overpathologizing. Specifically, the model posits that therapists' social dominance orientation (SDO), their orientation for group-based hierarchies, can shape clinical judgments. This influence is proposed to occur through medicalization beliefs, which can serve as legitimizing myths by providing biomedical justifications for interpreting psychological distress. These beliefs may help therapists maintain their positions of power by framing clients as subjects requiring further expert intervention. To understand this model, it is first

necessary to explain how overpathologizing, problematized by the author as a clinical judgment bias, operates.

Clinical judgment is a detailed assessment of the client's psychological distress, past experiences, history and symptoms, and guides therapists in determining appropriate treatment. Effective clinical judgment involves not only recognizing the client's abnormal behaviors and experiences but also distinguishing them from "normal" behaviors and experiences that may simply refer to culturally and historically situated standards of psychological functioning that do not cause significant distress or impairment. Although clinical judgment is based on specific expertise, it may include subjective elements due to its interpretive nature and may, therefore, involve biases.

Overpathologizing in clinical settings is not merely a theoretical concern, it has far-reaching and concrete consequences that compromise both individual wellbeing and the integrity of mental health systems. When therapists interpret normative or contextually understandable human experiences as symptoms of psychopathology, this can result in serious harm. Clinical judgment bias has many negative consequences for the client, such as the adoption of a false illness identity, increased psychological distress, dependence on inappropriate support systems, and avoidance of more appropriate interventions (Leventhal et al., 1980). For example, clients may experience emotions, thoughts, or behaviors that are typical and understandable in their specific life context but interpret them as signs of a serious mental disorder (Suhr & Wei, 2017). They may experience anxiety and stress caused by the perception that they will never recover or will have difficulty recovering (Leventhal et al., 1980; Suhr & Wei, 2017). Also, they may be exposed to misdiagnosis, as a potential result of overpathologizing, internalize the diagnoses and be subject to unnecessary and inappropriate treatments. In this sense, they may also become financially vulnerable. All of these indicate that the over pathologized client may be harmed by the therapist's biases (Suhr & Wei, 2017).

The negative consequences of overpathologizing extend beyond the individual client. It also has negative consequences for public healthcare institutions and the state. It puts pressure on health systems by causing unnecessary, inappropriate interventions and causing resources to be inappropriately distributed. For example, misdiagnosis and clinical judgment errors based on insufficient or unreliable evidence may lead to the unjust use of psychological services and educational supports and consume resources needed by individuals who truly need them (Suhr & Johnson, 2022). This misallocation not only puts a burden on public budgets, but also leads to inequality in access, favoring those with financial means in these services. It may also undermine public trust about the mental health system and contribute to skepticism at the societal level about the benefits of psychotherapy (Blanco & Surman, 2024).

Overpathologizing may cause diagnostic boundaries that determine differences between the pathological and the healthy to become increasingly blurred (Harrison et al., 2021a). Moreover, it may cause epidemiological data to be provided for academic studies to be inaccurate and affect the reliability of scientific knowledge (Wakefield, 2016). Considering the indicated problems related to overpathologizing, we can claim that understanding the psychological mechanisms behind the overpathologizing tendencies of therapists is necessary.

Several cognitive and situational factors have been proposed as possible determinants of overpathologizing, including overconfidence, illusory correlation, confirmation bias, fatigue, and professional inadequacy (Lilienfeld, 2017; Meehl, 1954). These factors are typically conceptualized as individual-level cognitive processes that may distort clinical judgment. As such, much of the existing literature highlights overpathologizing as a technical failure of reasoning, rooted in the clinician's mental shortcuts, stress, or training gaps. This framing tends to overlook the broader social or institutional dynamics in which clinical decisions are made, including dynamics of power and status between therapist and client. Only limited attention has been given to how clinicians' judgments may be shaped not just by individual cognition but also by their position within broader systems of social hierarchy. While previous research has addressed how overpathologizing may emerge

as the consequence of the social context, such as gender or race-based biases (Crosby & Sprock, 2004; Rosenthal, 2004), they typically attribute such bias to individual prejudice or stereotyping, without fully accounting for the larger social hierarchies and institutional power dynamics that maintain overpathologizing bias.

Given that psychotherapy is not only a technical practice but also a socially situated interaction between individuals, it is essential to consider how systemic dynamics of social hierarchy may inform the ways psychological distress is evaluated. Therefore, this study adopts that perspective by focusing on the embedded power asymmetry between therapist and client, not only a dynamic that may shape how clinical authority is exercised but also how psychological distress is interpreted.

Psychotherapy is not only a set of techniques for alleviating psychological difficulties, but also a structured relationship in which the therapist grants recognized authority to define problems and guide change (Aaron, 2012). The authority of a clinician stems from what is known as expert power, the influence that arises from being perceived as knowledgeable and competent. According to Foucault (1980), therapists possess this power because they produce knowledge that shapes norms and definitions of normality in society. In other words, the source of therapists' expert power is their ability to define what is normal and abnormal by categorizing behaviors, thoughts, and experiences (Zur, 2014). With this authority, they have the legitimacy to frame individuals or groups as dysfunctional or in need of correction.

Within the clinical setting, a clinician's authority produces a clear power asymmetry. Clients typically enter the psychotherapy setting in position of need, while psychotherapist holds the specialized knowledge and intuitional authority, a clear power asymmetry. Clients often respond to this imbalance by complying with the therapist's authority, sometimes even when they feel misunderstood or mistreated. Research supports this dynamic: even when clients have concerns about their therapist's approach, they are often reluctant to voice criticism or express dissatisfaction (Bohart & Tallman, 2010). In fact, clients may withhold negative

opinions and provide overly positive evaluations of therapy (Blanchard & Farber, 2020). For instance, they may pretend to find the psychotherapy helpful or act as if they like their therapist, even when they do not (Blanchard & Farber, 2020).

The unbalanced power dynamics described above reveal not only the structural vulnerability of clients, but also the potential for therapists to exercise their authority without challenge. Therefore, this expert power, which is one of the causes of the power imbalance in therapy, carries some inherent risks. Indeed, studies often examine cases of explicit unethical behavior by therapists, such as sexual and financial abuse. Beyond this explicit unethical behavior, this power dynamic also creates a context in which more implicit tendencies of therapists may emerge. For example, Yalom (1980) has suggested that therapists may become invested in validating their own expertise rather than prioritizing the client's needs. De Varis (1994) similarly argues that information from clients that may challenge the therapist's position of authority could be ignored (De Varis, 1994). These observations suggest that some therapists may prioritize maintaining their dominant position at the cost of client-centered clinical judgment.

Social Dominance Theory (SDT) offers a comprehensive framework to explain how ideological and institutional power dynamics interact in shaping therapists' clinical judgment, such as overpathologizing (Sidanius & Pratto, 2001). This framework explains how societal power hierarchies are formed, justified, and maintained through legitimizing beliefs and social role-based asymmetries. In psychotherapy, therapists, occupy a socially dominant role by virtue of their institutional authority and perceived expertise, while clients enter this relationship from a position of dependency and need. Within this hierarchical context, SDT provides a theoretical basis for understanding how therapists may, even unintentionally, engage in clinical judgments like overpathologizing as a way of reinforcing and legitimizing their position of authority.

Building on this framework, this thesis investigates how therapists' legitimate professional authority, which has been grounded in institutionalized expertise, may unintentionally be transformed into a form of harm through everyday clinical judgments. Specifically, it explores how overpathologizing emerges when clients are perceived as more disturbed than they truly are, not due to overt prejudice, but through subtle, everyday mechanisms that reflect and reinforce social hierarchies. At the core of this inquiry lies in identifying the psychological and ideological mechanisms such as medicalization and SDO respectively that may foster such misuse of professional authority. In particular, the study focuses on SDO a central construct within SDT that reflects individuals' preference for social hierarchies. Medicalization, meanwhile, is considered an ideological framework that may legitimize and reinforce this power dynamic within the therapeutic setting. By exploring how SDO and medicalization interact to influence clinical judgment, this research seeks to clarify the roots of overpathologizing and inform the development of more ethically grounded psychotherapy practices that prioritize client welfare.

This thesis applies SDO to the concept of overpathologizing by focusing on how therapists' SDO may influence their clinical judgments. SDO reflects an orientation for group-based hierarchies and social dominance. In contexts where hierarchical cues are present, therapists' SDO may become more salient, potentially leading them to maintain their authority in the therapeutic relationship. Such dominance-oriented disposition may lead them to interpret clients' distress in exaggerated terms or frame them as more impaired than they are, thus reinforcing their expert position. In this way, SDO may contribute to overpathologizing by shaping how therapists perceive and evaluate their clients. To understand how these dispositions are sustained and rationalized within social systems like psychotherapy, SDT introduces the concept of legitimating myths. These myths answer the question of how power structures are justified and maintained, by providing ideological narratives that make dominance appear natural, necessary, or morally acceptable (Sidanius & Pratto, 2001).

In the context of SDT, legitimating myths may be defined as ideological systems that legitimize and maintain or reduce social hierarchies by providing moral and

intellectual support for the dominance of certain groups over others (Pratto, 2001: 217-218). While ideological systems such as classism, racism, nationalism, or sexism, which are considered among the hierarchy-enhancing myths, ensure the preservation of status in intergroup relations and the maintenance of the hierarchical structure, myths such as human rights and feminism are considered hierarchy-reducing myths (Pratto et al., 1994: 742-743). In the clinical context, the ideological system proposed as a hierarchical myth is medicalization. As Zola (1972), Illich (1976), Hislop & Arber (2003), and Rafalovich (2013) have argued, medicalization functions as an ideological system that extends medical authority into everyday life, operates as a mechanism of social control, and shapes dominant social norms. In line with these explanations, Conrad (2007) explains medicalization as a process in which human experiences and problems are frequently defined and interpreted in medical terms, influenced by the institutional authority wielded by medicine.

In this sense, medicalization may serve as a legitimating myth by enabling psychotherapists and other mental health professionals to define what abnormal behaviors are, positioning them as authorities on mental health problems and normality. Examples of medicalization legitimizing hierarchies include the inclusion of homosexuality as an official category of mental illness in the Diagnostic and Statistical Manual of Psychology (DSM) until the publication of the DSM-II (Spitzer, 1981), or the disproportionate prevalence of schizophrenia among African Americans compared to whites despite no significant difference in MMPI test scores (Sue & Sue, 1971). Both situations are examples of how social hierarchies are supported by pathologizing disadvantaged and powerless social groups under the authority of medicalization. However, as discussed in this thesis, hierarchies do not only occur between groups such as ethnicity, socioeconomic status, or sexual orientation. The therapy setting is also a form of social interaction and contextually involves a vertical power differential. The therapist is in a position of greater knowledge and expertise, while the client often enters the relationship seeking guidance and support. López-Aybar and Gonzales (2024) reported that some therapists, as “infallible experts who know everything,” evaluate the therapist-client relationship as “them” and “us.”

López-Aybar and Gonzales (2024) also stated that they reduce clients' identities and experiences to diagnostic labels, make dire prognoses that they will not recover, and use medical terminology while doing so. In addition, they observed that therapists' exert control over clients without their consent under the pretext of helping and often engage in paternalistic practices. All these situations demonstrate how certain characteristics of human nature can be defined as deviations that require treatment, and how medical terminology creates a legitimizing power for the maintenance of hierarchical structures and helps maintain authority and dominant power. Therefore, medicalization also serves to provide moral and intellectual justifications for maintaining the social power of mental health professionals over clients and serves as a legitimizing myth.

Sidanius and Pratto (2001) stated that individuals with relatively higher SDO, who tend to support and maintain hierarchies and power, will want to confirm and maintain legitimating myths more strongly. These individuals may see hierarchy-enhancing myths as fundamental tools that validate their worldview or high status. Therefore, psychotherapists with high SDO may also use medicalization as a legitimating tool-particularly given that medicalization serves as a mediator in the proposed model. It explains how a therapist's orientation for hierarchy (SDO) may translate into overpathologizing tendencies by providing a framework that justifies increased intervention and reinforces professional authority. Through this process, therapists' clinical judgments may be influenced in a way that frames clients as more pathologized and in need of intervention than they actually are. This reinforces a dynamic where clients are positioned as passive recipients of treatment, which may ultimately reduce their perceived agency and amplify existing power imbalances.

In conclusion, this thesis aims to identify the factors that cause psychotherapists to over pathologize clients, often in subtle and unintended ways. By examining how the interactions between psychotherapists' orientation to institutionalized hierarchy in society and their belief in medicalization affect clinical judgment, this thesis seeks to clarify how hierarchical attitudes, and legitimizing narratives shape the perception of clients' psychological distress. Rather than considering overpathologizing as an

isolated cognitive bias or simply error, this situates it within broader ideological and relational dynamics. Understanding these dynamics may help inform ethically grounded psychotherapy practices that prioritize clients' safety, promote epistemic humility, and reduce the risk of harm.

To pursue this goal, the following chapters systematically develop the theoretical, methodological, and empirical foundations of the thesis. Chapter Two establishes the theoretical framework, critically engaging with power dynamics, overpathologizing, SDO, and medicalization. Through a systematic review, it examines how therapist–client power relations operate within this framework and proposes that the relationship between SDO and medicalization, as a legitimizing myth, may constitute a key mechanism underlying overpathologizing. Chapter Three presents the current study, detailing the proposed research model and hypotheses. Chapters Four and Five describe the methodology, analyses, results, and discussion of Study 1 and Study 2, respectively. Finally, Chapter Six discusses the results in light of existing literature, addresses the limitations of the study, and offers recommendations for future research.

2. THEORETICAL FRAMEWORK

This chapter introduces the theoretical framework guiding the study by integrating perspectives on power, Social Dominance Orientation (SDO), medicalization, and overpathologizing in psychotherapy. The central claim is that overpathologizing is not merely a cognitive error, but a form of clinical judgment bias shaped by ideological beliefs and structural power dynamics. Therapists' assessments of clients may be influenced by their orientation toward social hierarchy, reflected in SDO. This effect is proposed to be mediated by medicalization, understood as an ideological system that legitimizes medical authority by reframing social and moral deviance, in other words, transforming social norms as medical pathology.

This chapter begins by situating the therapist-client relationship within broader structures of interpersonal power asymmetries and institutional power structures. It then introduces Social Dominance Theory (SDT) as a framework for understanding how group-based hierarchies are maintained through legitimizing ideologies and therapist psychological orientation, such as SDO, that perpetuates these dynamics in psychotherapy. Finally, it conceptualizes medicalization as a legitimizing myth shaping how dominance-oriented motives are expressed in clinical settings, thereby leading cognitive bias such as overpathologizing.

2.1. Theoretical Framework: Power Dynamics in Psychotherapy

Power is a foundational concept in both psychology and the social sciences, yet it remains one of the most contested and complex constructs. In general terms, power refers to the capacity to influence, shape, or control the behavior, beliefs, or experiences of others (White et al., 1990). This influence is often embedded in interpersonal relationships and shaped by social and institutional structures (Miller, 1991). However, power is not merely a matter of explicit control or domination; it also

manifests in implicit, relational, and normative ways, especially in professional settings like psychotherapy (De Varis, 1994).

To examine the power dynamics of the therapeutic relationship, it is first necessary to outline broader conceptualizations of social power. These foundational ideas provide the essential framework for understanding how power operates in clinical contexts and help explain how such dynamics contribute to overpathologizing.

2.1.1. Conceptualizing Power in the Clinical Context

One influential framework is French and Raven's (1959) typology of power, which distinguishes between different "basis" of power: expert, legitimate, reward, coercive, informational, and referent. Among these, expert power refers to influence based on the perception that one possesses specialized knowledge or competence. This takes the form of the therapist's education and expertise in psychotherapy. Legitimate power, on the other hand, is derived from formal social or institutional roles; for example, therapists are granted authority by licensure boards, ethical codes, and the legitimacy of their profession. In addition, reward and coercive powers are also relevant to therapists' institutional roles in psychotherapy. Reward power may emerge when clients perceive that therapist approval, validation, or emotional responsiveness depends on their cooperation or obedience, potentially reinforces compliance through the promise of psychological relief or relational warmth (Morrill, 2021). On the other hand, coercive power arises when therapists are perceived to hold the ability to impose negative consequences, such as reporting to external authorities, denying access to affirming care, or initiating involuntary treatment (Fors, 2021). These dynamics may not always be intentional, but they reflect the structural asymmetries that shape how authority is experienced in therapeutic relationships. Informational power, meanwhile, refers to influence based on access to or control over relevant knowledge, systems, or procedures (Polifroni, 2009).

French and Raven's (1959) typology presents expert power as a discrete basis of power, but in the context of psychotherapy, expert power often functions as a gateway by which other forms of power are activated and sustained. As Morrill (2022) explains, expert power in psychotherapy is not isolated; it is interconnected and facilitative of other power bases such as legitimate, coercive, reward, and informational power. For instance, the authority to prescribe behavioral change (i.e., legitimate power), to impose treatment consequences (i.e., coercive power), or to guide relational dynamics through reinforcement (i.e., reward power) is enabled by the therapist's professionalism. In this sense, expert power is not an independent power structure from these other forms, it supports them, granting therapists a broader platform.

While French and Raven's (1959) model helps articulate how power is operationalized and distributed in interpersonal settings, it does not engage with the deeper question of where expert power stems from or how it relates to broad social structures. For this, Foucault's (1980) conceptualization of power offers a crucial framework (Roberts, 2005). Rather than seeing power as solely repressive, as something one person or group wields over another, Foucault (1980) argued that power is productive, that it creates categories, norms, knowledge systems, and subjectivities (Foucault, 1980). In other words, power does not merely limit or prohibit; it constructs the frameworks through which people understand themselves and others. It is in this sense that power is said to produce reality.

In the psychotherapy context, Foucauldian conceptualization of power means that therapists do not merely apply diagnostic labels to pre-existing psychological states; rather, they participate in defining what those states are (Zur, 2014). When a therapist identifies a client's experience as a symptom of a disorder, that act is not simply descriptive, but performative. This performative act shapes how the client understands their distress and how that person comes to perceive their reality (Brown, 2007). In other words, once a psychological difference is categorized as a disorder, it becomes entangled in institutional practices, including diagnostic frameworks, treatment guidelines, insurance policies, and even legal classifications that regulate what counts as usual and what requires intervention. Therefore, the effect of expert

power is not limited to the therapist-client relationship; it operates at a broader societal level, embedded within institutional and corporate systems that shape how individuals are governed and understood.

Foucault also emphasized that power operates most effectively when it is normalized and invisible through its embedding in everyday practices, institutions, and language (Foucault, 1980). Because therapists' authority is often perceived as legitimate and objective, their interpretations are rarely questioned, even when they reflect dominant cultural norms rather than universal truths.

The complementary relationship between the French and Raven's model of power and the Foucault's (1980) model of power enables a critical examination of the therapist's role in psychotherapy. Therapists are not only empowered by their profession, but their ability to define and normalize mental health is also a form of productive power that shapes how clients come to see themselves. Importantly, this power is not always coercive; even well-intentioned acts of care can contribute to the reproduction of dominant norms and expectations about mental health (Brown, 2007).

Understanding power in this multidimensional way prepares us to critically examine the power asymmetry between therapists and clients, which is not simply a reflection of training or role differences, but a complex interplay of professional authority, institutional legitimacy, and normative discourse. The next section will explore how this asymmetry is enacted in psychotherapy and how it may influence clinical interactions in ways that are not always visible, yet have significant implications for clients' experiences, especially in relation to overpathologizing.

2.1.2. Power Asymmetry in Psychotherapy

As described in the previous section, a power asymmetry inherently shapes the therapeutic encounter. Clients often seek psychotherapy in times of distress, uncertainty, or vulnerability. However, they may lack the resources and frameworks to make sense of these experiences. Therapists, in contrast, possess, theoretical knowledge, and institutional legitimacy.

Therefore, this power asymmetry often underlies the client's decision to enter therapy, as they seek to benefit from the therapist's expertise. In this respect, how the therapist uses this expert power becomes crucial. Because the therapist has the power to define which behaviors or thoughts are important or unimportant, normal or abnormal, they also have the power to render certain aspects of the client's reality visible or invisible. This means that clinical judgment is shaped by the relational and structural asymmetry between therapist and client. Therefore, while therapists strive for objectivity, their interpretations are inevitably influenced by the frameworks, social structures, or power relations embedded in their roles. For example, a therapist from a majority social group working with a client from a marginalized or minority background may unknowingly reproduce the dynamics of othering (Lee & Bhuyan, 2013; Morgan, 2002).

This brings us to a critical implication of therapeutic power: its potential to influence clinical judgment biases, particularly overpathologizing. When therapists, consciously or unconsciously, interpret contextually appropriate or culturally prescribed behaviors as abnormal, they may over pathologize the client. This process is not merely a cognitive distortion; it reflects the ways in which power operates in the therapist-client relationship, shaping what is noticed, how it is interpreted, and what is rendered clinically meaningful. Understanding this dynamic sets the stage for examining the specific mechanism through which power relations inform clinical judgement.

2.1.3. Power and Overpathologizing

Overpathologizing is the process of interpreting normal, contextually appropriate behaviors and thoughts as signs of mental illness, and framing everyday experiences as symptoms of psychological disorders (Lopez, 1989; Suhr & Johnson, 2022). It has been conceptualized as a clinical judgment bias that can arise from multiple resources, including prejudice against disadvantaged or minority groups, as well as broader ideological and structural dynamics that shape what is considered as “normal” or “pathological” in a given context (Lopez, 1989; Wisch & Mahalik, 1999). In line with the power framework outlined in the previous sections, overpathologizing can thus be understood as one way in which the structural and relational asymmetries of therapeutic encounter, combined with legitimizing narratives, are translated into clinical judgments that may unintentionally reinforce hierarchy.

2.2. Theoretical Framework: Social Dominance Theory, Explaining the Hierarchy in Psychotherapy

To understand how hierarchy in the therapist–client relationship in psychotherapy may be maintained, this study draws on SDT which offers a comprehensive framework to explain the psychological and ideological foundations of hierarchical social structures.

SDT was developed by Sidanius and Pratto (2001) as a framework to understand the psychological and institutional mechanisms that produce and maintain intergroup oppression, discrimination, and inequality in society. SDT suggests that societies are structured in group-based hierarchies and that dominant groups have disproportionate privileges compared to disadvantaged groups (Lee and Bhuyan, 2013; Morgan, 2002; Sidanius & Pratto, 2001). According to this theory, three basic hierarchical systems shape hierarchical societies: age, gender, and arbitrary-set systems.

The age hierarchy, as defined in SDT, refers to the systematic dominance of older individuals over younger ones, a pattern seen across nearly all human societies (Sidanius & Pratto, 2001). In psychotherapy, this hierarchy becomes particularly salient due to the structured nature of the therapist–client relationship. When therapists are significantly older than their clients, this age gap may reinforce the perception of authority and expertise. Studies show that clients often attribute greater competence and legitimacy to older therapists, which may reduce their likelihood of questioning therapeutic interpretations or recommendations (Robiner, 1987). From an SDT perspective, this age-based power asymmetry may also lead to overpathologizing, particularly when a therapist’s interpretations reflect generational norms that differ from the client’s lived context.

The second basic hierarchical system proposed by SDT is gender-based and states that men tend to occupy dominant positions relative to women in most societies (Sidanius & Pratto, 2001). SDT emphasizes that gender hierarchy is often legitimized through social myths that frame male dominance as natural or necessary (Sidanius & Pratto, 2001). These myths foster beliefs that male therapists are more rational or decisive, while female therapists are more maternal and less competent (Kaplan, 1979). Additionally, Wisch and Mahalik (1999) found that male therapists who embraced traditional gender norms perceived emotionally expressive male clients more negatively and as less likely to recover, which is a clear example of gendered overpathologizing in clinical judgement. These findings illustrate how therapists’ internalized gender ideologies can reproduce social hierarchies in clinical judgment and in the client-therapist relationship, consistent with SDT’s claim that members of dominant groups often act to maintain latent power structures.

The third hierarchical system proposed by SDT is the arbitrary-set system, which includes social groups created through human imagination and cultural construction, such as race, ethnicity, religion, social class, nationality, caste, or ideological affiliation (Sidanius & Pratto, 2001). Unlike age and gender hierarchies, which are relatively

stable across cultures, arbitrary-set hierarchies are historically and contextually shaped. These group distinctions change over time and across cultures. However, they consistently produce dominant and subordinate social groups, the unequal positions of which are often perceived as legitimate through dominant ideologies and institutional practices Sidanius & Pratto, 2001.

In psychotherapy, these distinctions may influence the clinical process, particularly when differences in race, class, or cultural background exist between therapists and clients. Therapists, as members of dominant social groups, may make biased interpretation of clients' psychological distress, especially when clients belong to historically disadvantaged groups. Studies have shown that ethnic minorities are more likely to receive misdiagnosis, more serious diagnostic labels, or unnecessary psychiatric interventions (Crosby & Sprock, 2004; Snowden, 2003).

2.2.1. Social Dominance Orientation

The central psychological construct within SDT is Social Dominance Orientation (SDO), which captures individual difference in orientation for group-based hierarchy and inequality (Sidanius & Pratto, 2011). In the context of this thesis, it serves as key mechanism linking the macro-level framework of SDT to the micro-level processes of clinical judgement. Building on the power-oriented analysis grounded in SDT, this section examines how hierarchy-related motives, as reflected in SDO, may shape clinicians' diagnostic practices. If SDT offers a theoretical framework for understanding how group-based hierarchies are reproduced, SDO explains how individuals internalize and enact these dynamics in their everyday decisions and interpretations. Therefore, in this section, focus is on how SDO may influence clinicians' likelihood of overpathologizing, that is, applying diagnostic labels in ways that amplify perceived deviance or abnormality beyond what is clinically justified.

Understanding SDO solely as an innate and universal personality trait is problematic because it obscures the role of social context, institutional structure, and lived experiences in shaping hierarchy-related attitudes (Turner & Reynolds, 2003). This view risks naturalizing dominance motives as inevitable feature of human nature, thereby underestimating how changeable social environments and professional norms shape clinicians' interpretations. Although early formulations treated SDO as a stable personality trait (Pratto et al., 1994), more recent research has demonstrated its contextual flexibility. SDO levels have been shown to vary based on perceived intergroup threat, relative group status, and institutional roles (Levin, 2012; Sidanius et al., 2016). In this study, SDO is understood as a context-sensitive orientation, one that reflects how clinicians perceive and relate to power differences in the therapeutic setting. This approach allows for a more dynamic understanding of how dominance motives may influence clinical judgment, rather than attributing overpathologizing to fixed personal prejudice

Importantly, overpathologizing is not defined by the identity of the client, but by the interpretive stance of the clinician. While marginalized clients are often the target of diagnostic excess in practice, this is a consequence of how SDO shapes interpretive frames, not a necessary condition. Clinicians with higher levels of SDO, particularly in its anti-egalitarian dimension (SDO-E), may be more inclined to interpret behaviors, expressions, or worldviews as deviant when they are perceived to challenge normative structures or status hierarchies. These clinicians may default to medicalizing interpretations that individualize distress or dissent, rather than situating them in broader relational or structural contexts.

SDO operates as a motivational orientation, in a way that it guides individuals toward interpretations that justify inequality and resist redistribution of power or legitimacy. In a clinical context, this may manifest in subtle ways, for instance, through more rigid application of diagnostic criteria, lower tolerance for ambiguity or cultural variation, or a preference for treatment approaches that emphasize conformity. These interpretive tendencies can result in overpathologizing of clients whose behaviours, identities, or values are perceived as challenging authority, questioning the therapeutic frame, or deviating from dominant cultural norms.

Because SDO is responsive to institutional and macrostructural factors, it is also important to consider how clinical environments shape and reflect these orientations. Research shows that hierarchy-enhancing institutions tend to attract and socialize individuals toward higher SDO (Sidanius et al., 1994; Sidanius & Pratto, 2001). If therapeutic settings are embedded in systems that prioritize order, compliance, or bureaucratic efficiency, they may indirectly reinforce dominance-oriented interpretations, even when clinicians personally identify as egalitarian. This makes SDO not only a predictor of clinical judgment, but a potential product of institutional dynamics.

In this framework, overpathologizing best understood as a power-informed interpretive act, influenced by the clinician's orientation toward social hierarchy. It

may affect any client whose behavior or worldview is framed as disruptive to perceived norms, not only those from socially marginalized groups. By identifying SDO as a key variable in this process, we can begin to trace how dominance motives are translated into clinical language and institutional practice. The next section extends this model by examining medicalization as a legitimizing myth, a concept within SDT that helps explain how diagnostic categories themselves can serve to naturalize and justify hierarchical interpretations of distress.

2.2.2. *Medicalization as a Legitimizing Myth in Psychotherapy*

The concept of medicalization has long been a focus of sociological critique, particularly in discussions of how power operates through expert authority (Van Dijk et al., 2020). As first articulated by Zola and Illich and later developed by Conrad (1992), medicalization is not only the process of applying medical knowledge to health conditions, but also a mechanism through which non-medical problems are redefined and organized within the medical realm. Conrad (2007) defined medicalization as "defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to treat it" (Van Dijk et al., 2020). Within the framework of Social Dominance Theory (SDT), medicalization can operate as a legitimizing myth, providing ideological support for hierarchical clinical judgment. Therefore, social and moral concerns are depoliticized and reframed as individualized, biomedical problems, falling under the control of medical professionals in the context of the mental health framework.

This definitional shift is not value-neutral. Van Dijk et al. (2020) demonstrate that many empirical definitions of medicalization, particularly those rooted in feminist and critical traditions, frame medicalization as a form of social control, emphasizing how medical authority can be used to shape norms, regulate behavior, and limit individual autonomy. These critical perspectives frequently emphasize how medicalization operates at the macro level to naturalize hierarchy, transform deviance

into disease, and concreate the power to define and intervene in the medical profession. This is particularly evident in definitions that describe it as the transfer of self-determination and decision-making authority from ordinary people to professionals, often for purposes of social control (Hislop & Arber, 2003, as cited in Van Dijk et al., 2020).

Lupton (1997) further elaborates this critique by framing medicalization not only as social control but also as a productive form of power. From this perspective, medicine is a discursive apparatus that constructs what is considered pathology and, in doing so, produces identities, norms, and knowledge systems. As Foucault (1980) described, the "medical gaze" is not only diagnostic but also constitutive; it defines who the patient is and what intervention is appropriate, thereby positioning the clinician as both an epistemic and moral authority. This process legitimizes expert judgments through claiming scientific neutrality, even when these judgments are deeply embedded in power relations.

In psychotherapy, this Foucauldian understanding has specific implications. The medical authority granted to psychotherapists through the discourse of mental illness allows them to frame a wide range of client behaviors and experiences as symptoms requiring intervention. When combined with individual-level orientations such as SDO, this expert authority can be used selectively or exaggeratedly, leading to overpathologizing, in a way that frames of contextually normal behaviors as problematic, or abnormal behaviors as more complicated than they are. In this sense, medicalization functions as a legitimizing myth, its ideological infrastructure enabling hierarchical judgments to be framed as therapeutic imperatives.

Thus, in the case of psychotherapy, medicalization not only expands the scope of clinical categories but also masks the normative and power-laden aspects of clinical judgment. In contexts where power differences are salient, the legitimating power of medical discourse becomes a tool for reproducing and reinforcing social hierarchies.

3. CURRENT STUDY

Building on the framework outlined in Chapter 2, this chapter introduces the conceptual model proposed in this thesis and outlines the hypotheses tested in Study 2. This model integrates the principles of Social Dominance Theory (SDT), the construct of Social Dominance Orientation (SDO) as its psychological expression, and the concept of medicalization as a legitimating myth, linking them to the clinical phenomenon of overpathologizing.

SDO was experimentally manipulated through a status-based cue embedded in a clinical vignette. Specifically, participants in the experimental condition were informed that the client had previously received support from a non-psychology licensed life coach (e.g., power threat). This subtle cue was designed to establish a professional hierarchy between the participant and the client's prior support figure, thereby activating power threat to the psychology licensed professional, which translates into a tendency associated with dominance maintenance and aligning with SDT's account of hierarchy preservation.

Medicalization is conceptualized as a legitimating myth, operationalized as an ideological framework that enables medical interventions to appear neutral, necessary, or therapeutic. By framing ambiguous or socially contextual client behaviors as medical dysfunctions, medicalization reinforces the authority of the therapist and legitimizes more pathologizing forms of clinical judgment (Conrad, 2007; Van Dijk et al., 2020). It is expected to serve as a mediator linking SDO activation to overpathologizing tendencies.

Overpathologizing is defined here as a clinical judgment bias in which ambiguous or subclinical client presentations are interpreted as more disordered or severe. Study 1 provided empirical support for the prevalence of overpathologizing in complaints about mental health services, showing that contextually appropriate

behaviours may be reframed as pathological. Study 2 builds on these findings by testing whether a theoretically informed manipulation of SDO increases overpathologizing judgments, both directly and indirectly through the endorsement of medicalized beliefs.

3.1. Current Study: Conceptual Model

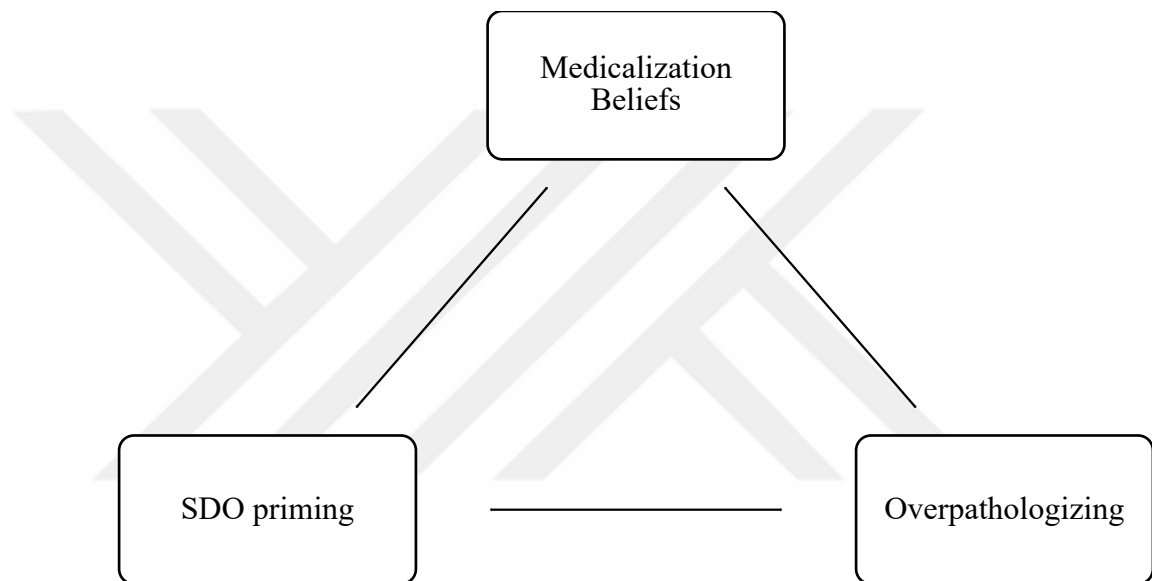
In line with the theoretical foundations outlined in Chapter 2, the conceptual model tested in Study 2 proposes a sequential process in which the experimental activation of SDO (independent variable) leads to increased overpathologizing (dependent variable), both directly and indirectly through endorsement of medicalization beliefs (mediator). This model builds on SDT's proposition that legitimizing myths, such as medicalization, sustain hierarchical relationships, and integrates it with the clinical bias literature on overpathologizing.

On the one hand, as seen in the Figure 1, path a (SDO priming, medicalization beliefs) reflects the assumption that exposure to a hierarchy-reinforcing cue, for instance, learning that a client previously received support from a non-credentialed life coach, activates dominance-related interpretive frameworks. This activation is expected to increase participants' endorsement of medicalization beliefs, which function as ideological justifications for clinical authority and as a means of framing social or relational issues in biomedical terms. This path draws directly from SDT's account of how legitimizing myths are mobilized to maintain group-based dominance.

Path b (medicalization beliefs to overpathologizing), on the other hand, represents the expectations that stronger endorsement of medicalization beliefs will facilitate the interpretation of clients' ambiguous or subclinical presentations as pathological, thereby increasing overpathologizing. Finally, Path c (SDO priming to overpathologizing) captures the possibility of a direct effect of SDO activation on clinical judgement bias, independent of medicalization beliefs, consistent with the

view that hierarchy-oriented interpretive evaluation can operate without explicit ideological framing. Together these paths operationalize the theoretical claim that dominance motives can shape clinical judgements both through and beyond legitimizing myths, setting the context for the specific hypotheses tested in Study 2.

Figure 3.1.1. Mediation Model of Medicalization Beliefs in the Relationship Between Social Dominance Orientation and Overpathologizing



The following section presents this conceptual model, derived from theoretical arguments in the preceding chapters, as a set of testable hypotheses, outlining the expected relationships between SDO priming, medicalization belief and overpathologizing.

3.2. Current Study: Hypotheses

Based on this model, the following hypotheses are proposed:

H1: Participants exposed to the SDO-priming condition (i.e., the vignette referencing a life coach) will exhibit significantly higher overpathologizing scores compared to those in the control condition.

H2: Participants in the SDO-primed condition will report stronger medicalization beliefs than those in the control condition.

H3: Medicalization beliefs will be positively associated with overpathologizing tendencies.

H4: Medicalization beliefs will significantly mediate the relationship between SDO priming and overpathologizing.

4. STUDY 1

4.1. Study 1: Introduction

The main research aim of this thesis is to investigate how SDO and medicalization influence mental health professionals' tendencies toward overpathologizing. However, despite the relevance of theoretical models such as SDT and medicalization, which offer valuable theoretical frameworks for understanding how therapists may use expert power to reinforce hierarchical dynamics, exploratory research into how these processes unfold in actual therapeutic interactions remain scarce. To address this gap, Study 1 aims to demonstrate that overpathologizing is not only a theoretically meaningful construct but also an observable issue in therapy.

In accordance with the exploratory aim of Study 1, to investigate how overpathologizing occurs in real-world settings, this study focused on the subtle indicators of overpathologizing. Client complaints were chosen as the primary data source, because complaints may point out implicit forms of harm, such as excessive labelling, inappropriate interventions, or dismissive clinician behavior, that are often invisible to outcome-based metrics (Skär & Söderberg, 2012). This approach is consistent with Lindgren and Rozental's (2022) qualitative study, which explored malpractice through patients' lived experiences in official complaint records submitted in Sweden. Their findings showed that patient narratives in complaints may reveal meaningful insights into malpractice by identifying patterns such as inappropriate diagnoses, coercive treatment recommendations, and disrespectful therapeutic behavior. Similarly, Haw et al., (2010) showed that patient complaints may reveal subtle forms of harm often overlooked by standard outcome-based measures.

In this study, the collected complaints were classified using a large language model (LLM), a type of artificial intelligence trained on large-scale, diverse, and

multilingual corpora encompassing academic, professional, and conversational domains. Specifically, the analysis employed the Llama 4 Maverick model, which integrates advanced natural language processing capabilities for contextual understanding and semantic classification, to detect the presence of overpathologizing. In addition to identifying whether overpathologizing was present, the analysis also involved classifying each complaint into predefined themes, such as overprescribing, overdiagnosis, catastrophic prognosis, and coercive treatment, derived from relevant literature.

4.2. Study 1: Method

4.2.1. Data Collection

A total of 1,682 client complaints were collected from Şikayetvar.com, an open-access Turkish consumer feedback platform where individuals post public complaints about companies, products, or services. Registered users can submit a complaint about any service, and they are allowed to edit or delete their submission. Additionally, users of the platform can mark their complaints as resolved. This platform was chosen because it provides naturally occurring feedback from individuals, offering insight into real-life experiences with mental health services. Unlike structured surveys or interviews, these complaints reflect authentic client concerns, often expressed in emotionally charged and context-rich language. Therefore, Şikayetvar.com presents a unique opportunity to examine clinical judgment biases, such as overpathologizing, through the lens of everyday therapeutic interactions reported by clients.

I conducted web scraping techniques in Python using the Selenium library (which automates website crawling) and the Pandas library (which facilitates storage, organization, and manipulation of tabular data). These tools retrieve search result pages for each relevant keyword. The keywords used were "psychiatrist,"

"psychologist," "psychological counselor," "psychotherapy," and "psychotherapist." From these result pages, the URLs of individual complaint entries were extracted. Each complaint page was accessed and automatically downloaded in HTML format. Using the BeautifulSoup library (a tool for parsing and extracting data from HTML and XML documents), the textual content, date, and title of each complaint were extracted and stored in comma-separated values (CSV) format, which is a simple text format for storing tabular data. This process ensured that the dataset consisted of detailed user experiences relevant to mental health professionals.

After downloading the HTML content and extracting the relevant fields, the dataset was cleaned to ensure quality and consistency. Duplicate complaints were identified and removed. Additionally, complaints that lacked actual text content (e.g., those with missing or empty complaint bodies) were excluded from the dataset. After cleaning, 1,675 complaints remained.

4.2.2. Text Classification

The aim of the study was to demonstrate that overpathologizing is a real and observable concern in everyday clinical contexts, particularly in the therapist-client relationship. To address this aim, and in accordance with the collected textual data, the study employed a Natural Language Processing (NLP; a computational approach for analyzing and extracting meaning from human language) method using large language models (LLMs; AI systems trained on massive text datasets that can understand and generate natural language). Specifically, multi-label text classification and source analysis were performed as part of the NLP methods.

The reason for using an LLM-based NLP method lies in its ability to perform high-quality classification on unstructured, large-scale text with minimal supervision, an essential requirement when human annotation is infeasible. Previous research confirms that LLMs can effectively handle “zero-shot” classification tasks (assigning

labels without prior task-specific training) across multiple domains and languages, which is directly applicable to the task involving Turkish complaint texts (Zhang et al, 2024; Zhang et al., 2025). In addition, Kuckartz and Rädiker (2024) emphasize that LLMs function as powerful assistants in qualitative content analysis by supporting classification, theme extraction, and inductive categorization, especially in contexts involving large-scale or solo research. These models offer capabilities beyond traditional NLP methods by enabling iterative interaction with the data and producing nuanced, context-aware interpretations. Their dual role, as both analytical tools and interpretive assistants, makes them particularly suitable for exploring complex social patterns like overpathologizing in clinical narratives. These properties make LLMs, particularly in zero-shot setups, a theoretically sound and practically efficient choice for the classification of client-generated clinical complaints.

Among various LLM options, the Llama 4 Maverick model, released by Meta AI on 5 April 2025, was selected for this analysis (Meta AI, 2025). Llama 4 Maverick is designed to efficiently handle language understanding and generation tasks using 17 billion active parameters (model variables fine-tuned for processing language) out of a total of 400 billion parameters. It operates based on a transformer architecture (a neural network design that uses multi-head self-attention to capture relationships between words across long sequences taking contextual meaning into account).

As many LLM models, input text is first “tokenized” (split into smaller units such as words or subwords), which are then embedded into high-dimensional vectors and processed through stacked attention layers that dynamically weight the importance of each token. Llama 4 Maverick is autoregressive, in a way that it predicts the next token based on the preceding ones, and this mechanism is repurposed in classification tasks by prompting the model to generate specific labels (e.g., “1” or “0”) in response to a question or instruction.

I decided to use the Llama 4 Maverick model, taking several technical, methodological, and practical justifications into account. First, the model is designed

for high-performance multilingual understanding, including low-resource languages (languages with fewer digital training resources) like Turkish, which is essential given the nature of the complaint dataset. The complaints from Şikayetvar.com analyzed in this study are written in informal, user-generated Turkish and often include non-standard expressions, emotionally charged narratives, and complex, context-dependent judgments. These features require a model with strong contextual comprehension and language adaptability, capabilities that the model possesses. It offers competitive performance in zero-shot and few-shot tasks, thanks to architectural improvements and extensive training on diverse datasets (Meta AI, 2025). According to Meta AI (2025), the model exhibits successful multimodal reasoning and natural language understanding, making it particularly effective for nuanced classification tasks such as identifying overpathologizing behavior in clinical texts.

Additionally, Llama 4 Maverick is open source and accessible by using Application Programming Interface (API, a structured way for software to communicate with the model), allowing scalable and transparent analysis, features that are compatible with open science practices and reproducibility standards (Meta AI, 2025). The combination of its multilingual performance, zero-shot capabilities, and transparent access makes Llama 4 Maverick a proper and practically efficient model choice for this analysis.

The analysis was performed using a prompt-based (instruction-driven), zero-shot classification approach (where the model assigns categories based solely on the provided instruction without task-specific training). The model was accessed via an API interface and evaluated each complaint using custom-designed prompts.

4.2.2.1. *Detecting Overpathologizing*

To identify whether a complaint involved overpathologizing, I conducted a multi-label text classification task (a method where a single text can be assigned to

more than one category). Each complaint was input into the model using a prompt designed to determine whether the behavior described reflected overpathologizing, defined here as interpreting the client's condition as more severe than warranted (for example, assigning unnecessary diagnoses, recommending aggressive treatments, or implying that the condition is permanent). The model responded with either a “2” (overpathologizing present) or “1” (related to mental health but no overpathologizing), and “0” (unrelated to mental health). These responses were parsed (read and extracted from the model output) and recorded accordingly. This approach enabled automated analysis of 1,675 real-world client complaints without requiring prior manual labeling by human coders.

4.2.2.2. Detecting Overpathologizing Themes

Next, all complaints labeled "2" (indicating overpathologizing) were subjected to a secondary thematic classification task (grouping text by recurring content patterns) to identify four specific patterns of overpathologizing behavior. How these themes were identified is presented in the following sections.

Theme 1 Overprescribing: Research has shown that overpathologizing emotional experiences is directly linked to overprescribing (prescribing medication at a frequency or dosage beyond what is clinically necessary). Bryant (2013) argues that overpathologizing may lead to overdiagnosis, which in turn can lead to unnecessary prescribing. Similarly, Yako (2023) addresses the societal impact of unnecessary prescribing, criticizing the mental health industry’s tendency to medicalize normal life problems, which can lead to patterns of overdiagnosis and overprescribing. All of this points to the theme of overprescribing as a theme of overpathologizing.

Theme 2 Overdiagnosis: Previous research has shown that overdiagnosis both as a consequence and a marker of overpathologizing (Billieux et al., 2015; Crosby & Sprock, 2004; Suhr & Johnson, 2022). Expanding on this, López-Aybar and Gonzales

(2024) emphasized that reducing a client's thoughts, emotions, and experiences solely to diagnostic categories constitutes another dimension of overpathologizing. In line with these findings, the present analysis identifies overdiagnosis as one of the thematic indicators of overpathologizing within the complaint narratives.

Theme 3 Catastrophic Prognosis: This theme was adopted from López-Aybar and Gonzales (2024) qualitative study, which categorized it as a subtheme of overpathologizing. In that study, prosumers (patients who also act as co-creators of their care experiences) reported witnessing clinicians express deterministic and hopeless predictions about patients' futures based solely on their diagnoses. This conceptualization provided a foundational rationale for including *catastrophic prognosis* as a distinct theme in the current analysis.

Theme 4 Coercive Treatment: Overpathologizing, as a clinical judgment bias, plays an important role in enabling coercive inpatient treatment (hospitalization or treatment administered without a patient's voluntary consent) in mental health care. When clinicians interpret a psychological difficulty as more symptomatic than it actually is, they may justify involuntary or recommended inpatient treatment as necessary for safety or therapeutic benefit. Previous studies suggest that overpathologizing makes coercive interventions more likely (Gonzalez et al., 2011; Legha & Miranda, 2020). Therefore, coercive treatment was selected as the fourth theme of overpathologizing.

4.2.3. *Detecting the Occupations*

A third and final prompt was used to extract the occupational title of the professional being complained about, but only from complaints previously classified as involving overpathologizing behavior. The model was instructed to choose from a predefined list of professional categories: psychologist, psychiatrist, or psychological

counselor. These responses enabled exploratory comparisons across occupations, specifically in contexts where overpathologizing was identified.

Overall, this analysis utilized the Llama 4 Maverick model's advanced language capabilities to conduct zero-shot NLP tasks, including classification, theme identification, and entity extraction, on unstructured Turkish complaint data. This method aligns with recent trends in NLP research that emphasize prompt-driven analysis for efficient, scalable, and context-sensitive text interpretation (Kuckartz & Rädiker, 2024).

After completing the NLP analysis using the Llama 4 Maverick model, the prediction outputs were exported for statistical analysis. All analyses were conducted in Python using Pandas and NumPy (a library for numerical computations) for data processing, Seaborn and Matplotlib (libraries for data visualization) for visual outputs, and Scipy (a library for statistical computing) for statistical testing.

The full data processing and analysis workflow for Study 1 is summarized in Table 4.2.3.1, which presents each stage of the process alongside its purpose, the data or tools used, and key methodological details.

Table 4.2.3.1. Workflow for Study 1 (Part 1 of 2)

Stage	Purpose	Data/Tools	Key Details
Data Collection	Gather naturally occurring client feedback relevant to mental health services.	Şikayetvar.com (Data source); Selenium, Pandas, BeautifulSoup (Python libraries).	1,682 complaints collected using relevant keywords ('psychiatrist,' 'psychologist,' etc.); extracted title, text, and date; duplicates and empty entries removed (final N=1,675).
Text Classification	Identify complaints involving overpathologizing.	Llama 4 Maverick LLM (Meta AI, 2025) via API; prompt-based zero-shot classification.	Prompt instructed model to label each complaint as 2 = overpathologizing, 1 = mental health-related but no overpathologizing, 0 = unrelated.

Notes. 1) *N* = number of complaints.

Table 4.2.3.1. Workflow for Study 1 (Part 2 of 2 – Continued from Page 45)

Stage	Purpose	Data/Tools	Key Details
Theme Identification	Detect specific thematic patterns within overpathologizing complaints.	Llama 4 Maverick; zero-shot thematic classification prompts.	Four themes identified from literature: Overprescribing, Overdiagnosis, Catastrophic Prognosis, Coercive Treatment.
Occupation Detection	Extract occupational category of the professional being complained about.	Llama 4 Maverick; predefined list: psychologist, psychiatrist, psychological counselor.	Only applied to complaints previously classified as overpathologizing; used for exploratory comparisons across professions.
Data Export & Statistical Analysis	Prepare and analyze classified data.	Python (Pandas, NumPy, SciPy, Seaborn, Matplotlib).	Exported predictions for statistical testing; visualized distributions and patterns.

Notes. 1) N = number of complaints.

4.3. Study 1: Results

In this section, the results of the analysis conducted using the Llama 4 Maverick model are presented. The analysis aimed to detect instances of overpathologizing behavior in 1,675 real-world mental health complaints obtained from the Şikayetvar.com platform. The outputs are organized around overall classification outcomes, thematic patterns, and occupational distribution of the complaints.

Analysis using Llama 4-Maverick identified overpathologizing in a significant number of mental health complaints. Of the 1,675 complaints, 422 represented non-mental health-related complaints. After removing this number, 228 of the remaining 1,253 complaints (18.2%) were classified as overpathologizing behaviors (Table 4.3.1). This indicates that nearly one in five mental health complaints contained concerns about excessive or inappropriate pathologization.

Table 4.2.3.1 Number of Complaints by Overpathologizing

	Overpathologizing		Total
	With	Without	
Number	228	1025	1253
Ratio	0,19	0,81	1

Notes: 1) This table shows how many complaints involved overpathologizing and how many did not.

The thematic classification of overpathologizing complaints revealed that Theme 1: Overprescribing was the most frequent, which accounted for 81% of all classified cases. This was followed by Theme 2: Overdiagnosis (17%), Theme 3: Catastrophic Prognosis (10%), and Theme 4: Coercive Treatment (28%). A small

portion (9%) did not align with any predefined theme and were classified as uncategorized (Table 4.3.2).

Table 4.2.3.2 Overpathologizing

	Theme 1	Theme 2	Theme 3	Theme 4	Uncategorized
Number	186	39	24	65	22
Ratio	0,81	0,17	0,10	0,28	0,09

Notes: 1) This table shows number of each theme of overpathologizing appeared in the complaints.

When grouped by the practitioner's profession (Table 4.3.3), the majority of overpathologizing complaints involved psychiatrists (87%), followed by psychologists (7%), with the remaining complaints distributed among counselors, clinical psychologists, and other professionals.

Table 4.2.3.3 Occupations

	Psychiatrists	Psychologist	Psychological Consultant	Clinical Psychologist	Others
Number	199	18	6	3	2
Ratio	0,87	0,07	0,02	0,01	0,01

Notes: 1) This table shows how many complaints that includes were linked to different mental health professional occupation.

The distribution of themes across professions (Table 4.3.4) showed that psychiatrists were associated with the majority of complaints in all thematic categories. Specifically, 168 of the 186 complaints (Theme 1) and 50 of the 65 coercive treatment complaints (Theme 4) involved psychiatrists. Other professional groups appeared much less frequently in all themes.

Table 4.2.3.4 Occupations and Themes

	Psychiatrists	Psychologist	Psychological Consultant	Clinical Psychologist	Others
Theme 1	168	13	2	1	2
Theme 2	33	6	0	0	0
Theme 3	20	3	0	1	0
Theme 4	50	8	5	1	1
Uncategorized	19	2	0	1	0

Notes: 1) This table presents how each overpathologizing theme is distributed across different mental health professions.

4.4. Study 1: Discussion

By applying a large language model (Llama 4 Maverick), Study 1's findings demonstrate that overpathologizing is not only a theoretical construct but also an observable tendency in client-generated narratives. As Table 4.3.1 shows, approximately 19% of complaints ($n = 228$) contained overpathologizing content. This is a significant proportion, especially considering that these complaints were written organically by clients outside of any research context and thus reflect naturally occurring perceptions of clinical practice.

Table 4.3.2 shows the thematic breakdown of complaints containing overpathologizing, revealing that Theme 1 (Overprescribing) was the most frequent theme, occurring in 81% of cases. This high prevalence reflects concerns expressed in both qualitative and theoretical literature about the overuse of pharmacological solutions in response to psychological distress (Conrad, 2007). Overprescribing reflects a clinical mindset in which complex emotional experiences are rapidly medicalized through psychiatric medications, which often fail to address the root causes of distress. This theme resonates with the findings of López-Aybar and Gonzales (2024) who reported that clients witnessed professionals immediately turning to medication rather than exploring relational or contextual factors. In this framework, medication becomes a tool of control rather than a tool of care, especially when used without adequate dialogue, explanation or consent.

Theme 2 (Overdiagnosis), which occurred in 17% of complaints, reflects a different but closely related dimension of overpathologizing. This theme involves the overuse of psychopathological labels to the client's experience or symptom severity. Previous studies have highlighted that overdiagnosis can result from both clinician-level biases and systemic pressures to categorize clients (Crosby & Sprock, 2004; Suhr

& Johnson, 2022). It may lead to stigmatization, particularly when diagnoses are made early or without sufficient evidence.

Themes 3 (Catastrophic prognosis) and 4 (Coercive treatment) clearly violate structured ethical rules in psychotherapy, particularly the principles of client's autonomy and nonmaleficence. Catastrophic prognosis, for example, involves psychotherapists suggesting that clients will never recover or are permanently impaired. This directly violates the principle of nonmaleficence, as such predictions may demoralize clients, undermine their sense of initiative, and hinder recovery. Similarly, coercive treatment, even when framed as a therapeutic necessity, contradicts the basic ethical principle of respect for autonomy.

In terms of professional distribution (Table 4.3.3 and 4.3.4), most complaints were directed at psychiatrists. This may not be surprising, as psychiatrists, unlike psychologists and counselors, have the authority to prescribe medication and to hospitalize in Turkish health system. This also means that they have more opportunities to engage in practices such as over prescribing or coercive treatment, which were two of the main themes I identified (Theme 1 and 4). In addition, more psychiatric work in public institutions that provide free healthcare services in Türkiye than other professions. As a result, psychiatrists encounter a higher number of clients in Türkiye and therefore receive more complaints. Thus, the observed dominance may partly reflect their greater presence and case load in mental health system rather than inherently higher bias.

While the frequency results presented earlier offer a quantitative map of overpathologizing, covering its thematic distribution, relative prevalence, and occurrence across different professional groups, such statistics cannot, by themselves, convey how these tendencies are enacted in practice. The classification process identifies the presence of specific themes (e.g., overprescription, overdiagnosis, catastrophic prognosis, coercive treatment) within the complaints, but it does not capture the interpersonal and communicative dynamics through which these patterns

emerge. To provide a more grounded understanding, two illustrative complaints are discussed below. These cases were selected because they exemplify the interplay of hierarchical stance, medicalization, and overpathologizing, the key components of the conceptual pathway examined in this study, while also reflecting the thematic categories identified in the analysis.

In the first case, the complainant described a psychiatrist who, across multiple visits, “gave me a different diagnosis each time” and ultimately warned, “you might develop schizophrenia in the future,” despite having “no evidence.” Such a statement reflects a catastrophic prognosis (Theme 3). The power dynamic became even more explicit when the patient expressed a wish to discontinue medication, and the psychiatrist, “seeming upset” and speaking in a reproachful tone, responded, “you haven’t recovered, but you will stop anyway.” This episode illustrates a hierarchical stance in which the clinician’s authority was used to override the patient’s treatment preference. Here, medical authority functioned not only as a means of care but also as a mechanism of control (medicalization), with the unsubstantiated and fear-inducing prognosis serving as a clear instance of overpathologizing.

The second case involved a client who, during the pandemic, sought help for low mood and was initially told that her distress “would pass when schools reopen.” Nevertheless, the psychiatrist recorded a diagnosis of major depression, even though the client reported having “no functional impairment” and not meeting the diagnostic criteria. When she requested that the diagnosis be removed, the psychiatrist replied, “this diagnosis will follow you for the rest of your life.” This statement situates the clinician in a dominant, non-negotiable position (hierarchical stance) and frames the diagnosis as a permanent, socially significant label whose influence extends beyond the medical context (medicalization). Assigning such a severe diagnosis without adequate basis aligns with the overdiagnosis category (Theme 2) and represents another form of overpathologizing.

These examples do not serve as definitive proof of the causal mechanism but illustrate how the components of the study model may manifest together in real-world encounters. They provide a tangible link between the statistical patterns identified in Study 1 and the lived experiences of clients, offering a grounded perspective on how professional authority, when exercised hierarchically, can shape medicalized interpretations and, in turn, contribute to overpathologizing judgments.

Several limitations should be considered when interpreting the findings. First, the data source was limited to self-reported complaints from a single online platform, which may not represent the broader population and is subject to selection bias, as individuals with negative experiences may be more likely to post. Second, the zero-shot classification was performed using the Llama 4 Maverick model without an independent performance evaluation, meaning that potential misclassifications could have affected the thematic distribution and frequency estimates. Third, the complaint texts often lacked contextual details about the therapeutic process, making it difficult to assess the full circumstances of the reported incidents. Finally, the cross-sectional and retrospective nature of the data prevents any causal inferences about the mechanisms underlying overpathologizing.

While these patterns provide compelling descriptive evidence that overpathologizing occurs in everyday clinical contexts, they also raise questions about the psychological and structural factors that drive such judgments. In particular, the dominance of themes involving hierarchical authority (e.g., overprescribing, coercive treatment) suggests that ideological orientations favoring inequality, such as Social Dominance Orientation (SDO), may play a role. Similarly, the prevalence of biomedical rationales points to medicalization as a possible legitimizing framework that reinforces these biases. However, the observational design of Study 1 cannot establish whether these factors causally influence clinical judgment. Study 2, therefore, uses an experimental approach to test the impact of SDO and medicalized framing on overpathologizing tendency, moving from description to explanation.

5. STUDY 2

5.1. Study 2: Introduction

Study 1 demonstrated that overpathologizing is not only a conceptually meaningful construct but also an observable tendency in client-reported complaints about mental health services. Through large-scale text classification and thematic coding, the first study identified clear manifestations of overpathologizing, such as overprescribing, exaggerated diagnostic labeling, and coercive treatment decisions. Furthermore, these patterns varied across mental health professions, raising important questions about the psychological and structural mechanisms that may give rise to such biased judgments. However, while Study 1 provided strong descriptive evidence of the phenomenon, its observational design limited the ability to draw causal inferences about why overpathologizing occurs and under what conditions it is more likely to be expressed.

Study 2 was designed to address these limitations by experimentally testing two theoretically grounded antecedents of overpathologizing: Social Dominance Orientation and medicalized framing. The design and hypotheses of Study 2 are directly informed by the empirical patterns and conceptual implications of Study 1. Specifically, the tendency to pathologize clients beyond what is clinically warranted appeared to reflect not only professional culture but potentially deeper ideological commitments to hierarchy and control, especially when clinical authority was not openly contested. For example, in Study 1, the dominance of overprescribing (Theme 1) and coercive treatment (Theme 4) indicated patterns in which authority was exercised in ways consistent with hierarchy reinforcing practice. Study 2, therefore, examines whether these tendencies can be experimentally elicited through a combination of dispositional factors (e.g., SDO) and situational cues.

The theoretical foundation for this study is provided by Social Dominance Theory (Sidanius & Pratto, 2001), which posits that individuals differ in the extent to which they endorse group-based social hierarchies, captured by the construct of SDO. Higher SDO is associated with the endorsement of inequality, reduced empathy, and a greater tendency to legitimize harsh or authoritarian responses to deviance or non-conformity. In clinical settings, such tendencies may translate into biased judgments about clients, particularly in ambiguous or borderline cases where interpretive flexibility is high. Existing research has shown that individuals high in SDO may support more punitive interventions and are more accepting of hierarchical control across domains, including education, law enforcement, and healthcare (Ho et al., 2015; Kugler et al., 2010). However, to my best knowledge, their potential influence of SDO on mental health professionals' clinical judgment has not been systematically examined.

A second construct central to this study is medicalization, defined as the framing of everyday experiences, emotions, and behaviors through the lens of biomedical dysfunction (Conrad, 2007). As suggested in Study 1's thematic analysis, overpathologizing is often justified through a medical discourse that obscures social, relational, and contextual explanations of client distress. By portraying the client's behavior as a clinical symptom rather than a normative reaction to circumstances, such framing can subtly reinforce therapist authority and render more aggressive interventions legitimate. In this way, medicalization may act as a legitimizing myth (Sidanius & Pratto, 2001) that provides ideologically motivated clinicians with a culturally accepted rationale for enforcing hierarchy.

In summary, Study 2 extends the findings of Study 1 by shifting from descriptive observation to causal testing. Whereas Study 1 demonstrated the real-world prevalence and thematic patterns of overpathologizing in client narratives, Study 2 examines the psychological and cultural mechanism that may underlie these patterns. By experimentally manipulating medicalized framing and assessing dispositional SDO, I aim to determine whether hierarchy-reinforcing orientation and medicalization beliefs jointly increase the likelihood of overpathologizing judgments. This multi-method

approach provides a more comprehensive account of overpathologizing as a potential bias in clinical decision-making.

5.2. Study 2: Method

In this experiment, I conducted a vignette-based, between-groups experimental design administered online. Vignette methodology has long served in clinical and social psychology as a valid tool for eliciting judgments in a standardized way (Finch, 1987; Hughes, 1998). This approach enables researchers to manipulate specific contextual cues while holding all other information constant, making it particularly well suited for investigating subtle decision-making processes in professional populations (Aguinis & Bradley, 2014).

In this study, I delivered the experiment in a survey format via online platform. Online experiments are increasingly common in psychological research since they combine efficiency, accessibility, and capacity to reach diverse and geographically dispersed samples (Birnbaum, 2004; Reips, 2002). In this study, the online format also served to minimize evaluation apprehension and increase anonymity, two factors that are particularly important when participants are asked to make judgments within their domain of expertise (Krantz & Dalal, 2000). Moreover, prior research shows that well-designed online experiments yield data quality comparable to that of lab-based studies, even for sensitive topics (Gosling, et al., 2004). Overall, this design allowed me to combine experimental control and ecological validity, while efficiently recruiting mental health professionals and trainees across various institutions.

5.2.1. Procedure

The study was conducted online using Google Forms. Participants were randomly assigned, via a single survey link, to the experiment or control condition, ensuring automatic, condition-blind allocation before they viewed any study materials. Each form began with an informed consent page, followed by participants were presented a cover story describing the research as an investigation into the relationship between short-term memory processes and approaches to professional situations in mental health practice. This explanation was intended to mask the study's true purpose and reduce evaluation apprehension.

The vignettes described a hypothetical client ("Deniz") presenting ambiguous psychological symptoms. Ambiguity was deliberately incorporated to simulate conditions under which clinical judgement biases, such as overpathologizing, are more likely to emerge, thereby allowing individual difference in interpretive stance to play a greater role. The experimental condition included one additional sentence indicating that the client had previously visited a *life coach*. This detail served as a subtle yet theoretically grounded manipulation of hierarchy threat, selected because it implies that a non-licensed practitioner had previously occupied part of the therapist's professional domain. In SDT, such cues signal a potential challenge to the authority and legitimacy of the high-status group thereby activating dominance maintenance motives among practitioners who have a high tendency of SDO. By framing the prior help-seeking as occurring outside the licensed professional hierarchy, the manipulation operationalized SDO as a context-sensitive orientation rather than a fixed trait, consistent with evidence that SDO levels can be temporally shifted in response to salient status relevant cues (Guimond, 2003; Ho et al., 2012; Levin et al, 2012). The control condition omitted this detail.

Immediately after reading the vignette, participants completed a manipulation-reinforcing question that asked them to rate how helpful they believed the client's prior coping strategy had been. This question was designed to sustain the manipulation

without drawing explicit attention to it in the experimental condition (Bargh & Chartrand, 2000), while functioning as a neutral evaluative item in the control condition.

Following the manipulation-reinforcing question, participants proceeded to the “Memory Task and Professional Approach Questionnaire” section, which contained a filler task and the Assessment and Treatment Planning Questionnaire (ATPQ). They first completed a short-term memory task, recalling a word mentioned in the vignette, which reinforced the cover story by simulating a memory-based cognitive assessment. Then, participants completed the ATPQ, evaluating the client across multiple domains, including distress severity, urgency, treatment recommendations, prognosis, pharmacotherapy support and client characteristics. However, the questionnaire was presented as a measure of individual differences in professional reasoning styles.

In the next section, titled “Beliefs on Psychology” participants completed a brief filler task (short-term memory oriented) and then the Medicalization Beliefs Scale (MBS). Afterward, participants completed the “Professional and Institutional Views Inventory”, which included three SDO-E targeting attitudes toward professional hierarchies. These items were adapted from the Egalitarianism (SDO-E) subdimension of the Turkish short form of the SDO scale (Kaynak et al., 2021), reworded to focus on professional rather than intergroup hierarchies, and embedded without SDO labelling to preserve the cover story. They served as both a manipulation check and, in post hoc analyses, a measured SDO variable.

Finally, participants completed a demographic questionnaire capturing age, gender, education level, therapeutic orientation, and professional experience. The overall procedure took approximately 5–7 minutes to complete, balancing sufficient exposure to the manipulation with minimal participant burden.

5.2.2. *Participants*

Participants were eligible to take part if they had a background in mental health training or practice. Specifically, the sample included: (a) undergraduate students enrolled in Psychology or Guidance and Psychological Counseling (GPC) programs who had completed at least one clinically relevant course (such as psychopathology, clinical psychology, or clinical interviewing); (b) graduates of Psychology or Psychological Counseling programs; and (c) professionals including psychiatrists, psychiatry residents (assistants), child and adolescent psychiatrists, and child and adolescent psychiatry residents. All included participants were assumed to have sufficient exposure to clinical frameworks to evaluate the client vignette meaningfully. A total of 131 eligible individuals participated in the study, with equally random assignment to the experimental ($n = 66$) and control ($n = 65$) conditions.

One participant was excluded from the final sample because their professional background did not meet the inclusion criteria. With the exclusion of this participant from the sample, the total number of participants became 130. Among the participants, 99 identified as female and 31 as male. Participants' ages ranged from 20 to 53 ($M = 27.66$, $SD = 3.82$).

In terms of professional background, the majority of participants identified as psychologist ($n = 68$), followed by clinical psychologist ($n = 19$), psychological counselor ($n = 12$), psychologist with graduate education in non-clinical subfields ($n = 12$), and psychology undergraduate student ($n = 11$). Most held a bachelor's ($n = 72$) or master's degree ($n = 38$), while a smaller portion held doctoral ($n = 8$) or medical specialist degrees ($n = 1$).

Regarding therapeutic orientation, the most frequently endorsed approach was Cognitive-Behavioral Therapy ($n = 67$), followed by Eclectic ($n = 25$), Humanistic (n

= 20), and Psychodynamic ($n = 15$) orientations. A few participants reported systemic, EMDR, or other approaches ($n = 3$)

Prior to data collection, a priory sample size estimation was conducted through statistical power analysis using python statsmodels package (Seabold & Perktold, 2010), based on Cohen's (1988) guidelines. The calculation was based on a medium effect size (Cohen's $d = 0.50$), a conventional benchmark for psychological research (Cohen, 1988). I chose a statistical power of 80% ($1 - \beta = .80$) to ensure a high probability of detecting true effects while maintaining 5% Types I error rate ($\alpha = .05$). This threshold balances between avoiding false negatives and minimizing sample size inflation (Lakens, 2022). The analysis indicated that a minimum of 64 participants per group (128 total) would be sufficient. Therefore, the final sample size of 130 participants ($n = 65$ per group) was considered adequate for the planned analyses.

Before testing my hypotheses, I performed outlier detection. A total of seven participants, five from the experimental group and two from the control group, were flagged as univariate outliers based on standardized Z scores ($|z| > 3.0$), either at the mean scale level or at the item level. No multivariate outliers were identified using Mahalanobis distance (all p-values $> .001$). Upon closer examination, the flagged responses were not indicative of careless or random responding; rather, they reflected strong but plausible beliefs or judgments. Accordingly, all flagged cases were retained in the dataset.

5.2.3. Materials

Vignettes: To assess overpathologizing, participants in the experimental and control group read two vignettes describing a hypothetical client named Deniz, who presented with multiple ambiguous psychological symptoms. The vignettes simulated real-life clinical judgement and enabled control over potential biasing factors (Hieger,

2007; Mounet et al., 2024). Previous studies have shown that biases in clinical judgement often occur under uncertain diagnostic conditions (Hieger, 2007)).

The Vignettes was adapted from Hieger (2007), which used symptomatically uncertain case definitions to examine how racial similarity and diagnostic clarity affect clinicians' discomfort and prognosis decisions. In this study, I preserved this methodological approach by maintaining equal diagnostic uncertainty for all participants. The vignettes described symptoms such as instability, sleep disturbance, somatic complaints, intrusive thoughts, and social withdrawal. This design ensured that the participants' interpretations would be shaped primarily by their conceptual frameworks rather than by explicit diagnostic labels or interpretive cues.

To avoid activating pre-existing group-based stereotypes or identity-related cues, the client was given a gender-neutral name common in Türkiye, and no information was provided about gender identity, race, social class, or sexual orientation. Moreover, the vignette excluded any indicators of trauma history, abuse or marginal group membership. This decision was deliberately made to prevent the known sources of low or excessive pathological prejudice observed in previous research (Findor, 2017).

The only difference between conditions was the inclusion of a single sentence in the experimental condition stating that the client had previously received support from a certified life coach. This is designed as a manipulation that triggers the SDO by reminding the participants of their dominant-group professional status and implying competition from non-licensed practitioner. In this framework, SDO is not a fixed personality trait; it aligns with conceptualizations of SDO as context-dependent orientation that can shift in response to salient status relevant cues (Gerber, 2012; Ho et al., 2013; Huang & Liu, 2005). In the control condition, only the manipulation sentence was omitted, and all other aspects of the vignette remained identical.

Full versions of control and experimental vignettes are provided in Appendix 3 and 4. Immediately following the vignette, participants rated how much Deniz benefited from their previous coping strategy. This item served as a cognitive reinforcement of the manipulated content while avoiding explicit reference to the manipulation itself. This approach is grounded in priming research showing that subtle cognitive reminders help sustain activation of experimental manipulations across tasks without raising participant suspicion (Bargh & Chartrand, 2000).

Filler Tasks: To support the cover story and mask the study's true aim, I administrated two filler tasks. First, participants answered a short-term memory question that asked them to identify content from the vignette. Second, they completed "problem-solving style inventory." These tasks aligned with the fake study purpose described in the consent form, framing it as the research on short-term memory and problem-solving tendencies in clinical contexts. The inclusion of plausible and meaningful filler tasks was necessary because of participants' professional training in psychology, which increases their sensitivity to experimental aims.

Assessment and Treatment Planning Questionnaire (ATPQ): Overpathologizing tendencies were assessed using the ATPQ adapted from previous studies focusing on clinical judgment biases in mental health contexts (Franklin, 1985; Hieger, 2007). Originally developed by Franklin (1985), the ATPQ examines how clinicians assess clients based on various aspects of treatment planning, including the perceived severity of the client's psychological disturbance, their prognosis, and clinician perceptions of client insight, maturity, and treatment urgency.

In their dissertation, Hieger (2007) operationalized overpathologizing tendencies using two specific ATPQ items, those evaluating perceived severity of symptoms and prognosis. In the present study, I selected seven items from the original ATPQ pool, translated them into Turkish, and identified four items, 4 of these items to assess distress severity, urgency of treatment, prognosis, and recommendation of pharmacological treatment that all together constituted the overpathologizing index.

These four ATPQ items were combined into a single composite score, which constituted the primary dependent variables for testing the experimental hypotheses. All items were rated on a 7-point Likert scale. Together, these items cover judgments of distress severity, urgency of treatment need, estimated number of sessions required, expected course of the condition, perceived need for medication, client insight, and ego strength.

The overpathologizing score used in statistical analyses was calculated as the average of the four selected items. I selected these items based on both theoretical considerations and psychometric indicators, including internal consistency and inter-item correlations. Full details of the selection process and reliability statistics are reported in Appendix 2. The remaining three items were retained solely for exploratory and post hoc purposes.

Medicalization Beliefs Scale (MBS): I assessed medicalization beliefs with the MBS developed specifically for this study. Medicalization has been widely problematized in the literature, particularly within clinical psychology and psychiatry. Scholars define it as the extension of medical authority into areas of human life traditionally viewed as non-medical (Conrad, 2007; Van Dijk et al., 2020). While much of the existing literature focuses on biogenetic or medical explanations, for instance, the framing of non-biological or socially originated behaviors as biologically determined diseases (Lampropoulos and Apostolidis, 2018; Read et al., 2006), Van Dijk et al.'s (2020) conceptual review argues that medicalization also operates at the societal level through mechanisms such as social control and the redefinition of societal norms.

Building on this multidimensional framework, I developed a nine-item Turkish MBS comprising three theoretically informed factors: (1) biogenetic and medical explanations, (2) social control, and (3) social norms. The first factor, consistent with the dominant trend in the literature, captures beliefs that interpret socially complex or morally ambiguous behaviors as primarily due to biological or medical causes (Barker,

2017; Clarke, 2013; Gammel & Stoppard, 1999; Westfall & Benoit, 2004). The second factor, social control, captures the idea that medicalization can shift decision-making and self-governance from lay individuals to medical professionals (Brubaker, 2007; Moreira, 2006). This transfer of authority is often legitimized by appeals to social order and institutional expertise (Hislop & Arber, 2003). Finally, the social norms factor addresses how medical discourse can reshape societal understandings of what is considered healthy or unhealthy, normal or abnormal. This involves not only the reclassification of everyday behavioral variations but also the transformation of behaviors once perceived as moral flaws or “bad” into treatable conditions. As such behaviors come to be viewed as medically modifiable rather than morally reprehensible, individual responsibility diminishes and the authority to intervene is increasingly delegated to the medical realm.

The initial version of the MBS consisted of nine items, with three items representing each of the three theoretical factors (biogenetic and medical explanations, social control, and social norms). All items were rated on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree), and item 2 was reverse-coded. Internal consistency for the entire nine-item scale in the present study was moderate (Cronbach's $\alpha = .76$), but the first factor (biogenetic and medical explanations) showed poor reliability ($\alpha = .25$). This reflected the low and negative item-total correlation of the reverse-coded item (see Appendix 1). Exploratory factor analysis (EFA) also indicated a poor fit for the proposed three-factor structure. Although the social control and social norms factors exhibited acceptable psychometric properties ($\alpha = .68$ and $\alpha = .64$, respectively), EFA results, and internal consistency of the scale supported a six-item unidimensional model with good factor loadings of the items and satisfactory internal consistency (Cronbach's $\alpha = .80$). Based on these findings, I retained a six-item unidimensional version of the MBS as the final measure for all subsequent analyses. A detailed account of the psychometric evaluation, including exploratory factor analysis results, reliability coefficients, and item-total correlations, is provided in Appendix 1.

Manipulation Check (SDO-E): I assess the manipulation effectiveness using the Egalitarianism (SDO-E) subdimension of the short version of the Social Dominant Orientation (SDO) scale developed by Ho et al., (2015). The short form consists of eight items representing two theoretically distinct dimensions such as SDO-Dominance (SDO-D), which reflect support for group-based dominance and hierarchy, and SDO Egalitarianism (SDO-E), which reflects opposition to equality between social groups. In the original validation, the SDO-E subscale demonstrated excellent internal consistency (Cronbach's $\alpha = .90$)

The Turkish short form of the SDO was adopted and validated by Kaynak et al. (2021), confirming the two-factor structure in Turkish sample and reported good reliability for the SDO-E subscale (Cronbach's $\alpha = .89$). From the Turkish version, I selected the SDO-E (3 items) to compute a mean SDO-E score as the manipulation check variable.

For the present study, I reworded the SDO-E items to address attitudes toward professional status differences (e.g., licensed clinicians vs. non-licensed coach) rather than general intergroup relations. To preserve the cover story and minimize suspicion of manipulation, I embedded these items in a broader section titled *Professional and Institutional Attitudes*, without identifying them as part of an SDO measure. The SDO-E subscale showed adequate internal consistency (Cronbach's $\alpha = .78$).

SDO-E was primarily intended as a manipulation check, however, consider its measure participant's egalitarianism, I strategized if manipulation did not work, it may use for further post-doc analysis and model testing. This additional role strengthens the capacity to test theoretically relevant pathways, even if the manipulation itself does not produce a strong effect.

Demographic Form: Participants also completed a demographic questionnaire capturing age, gender, highest education level, current professional role, therapeutic

orientation, and years of clinical experience. I used these variables to provide a detailed description of the sample and to examine potential associations with study variables in secondary analyses.

5.2.4. *Analysis Strategy*

Based on the procedures, sample characteristics, and materials described in the preceding sections, I designed the statistical analysis strategy to test the experimental hypotheses in a between-subject design and to ensure alignment between analytic choices and the specific outcomes and comparisons reported in the Results section. Data visualization and preparation were conducted in Python within the Google Colab environment for data visualization and cleaning, and Jamovi for statistical analysis. Psychometric evaluations of all measures are reported in the Measures section; therefore, the present section focuses exclusively on the statistical procedures for evaluating the experimental effects and supplementary analyses.

Prior to hypothesis testing, I systematically evaluated the statistical assumptions required for parametric tests. The normality of each continuous variable was assessed using the Shapiro-Wilk test. The results showed that MBS ($W = 0.995$, $p = .921$) and ATPQ ($W = 0.986$, $p = .218$) did not significantly deviate from normality. In contrast, the manipulation check variable (SDO-E) exhibited a statistically significant deviation ($W = 0.964$, $p = .002$). However, a closer examination of the distributional properties indicated limited practical consequences such as no extreme outliers were detected. The absolute standardized differences between group means and medians were 0.0066 in the experimental group and 0.0684 in the control group; both values well below the 0.10 threshold commonly used to flag significant skewness (Osborne & Waters, 2002; Wilcox, 2012). Visual inspection of histograms confirmed approximate symmetry in both groups, although the control group displayed mild multimodality. While unimodality is a defining characteristic of normality, such deviations are not uncommon in the applied data and do not invalidate parametric procedures when other conditions are met (Osborne & Waters, 2002).

Homogeneity of variances, as assessed by Levene's test was met for all variables: MBS ($p = .095$), ATPQ ($p = .638$), and SDO ($p = .225$). Given the balanced design (65 participants per condition), these diagnostics meet robustness criteria under the Central Limit Theorem (Ghasemi & Zahediasl, 2012) and align with simulation evidence showing that the independent samples t-test remains robust to moderate non-normality when group sizes are equal and variances are homogeneous (Zimmerman, 1998).

For each t-test, I reported Cohen's d together with 95% confidence intervals estimated via nonparametric bootstrapping (5,000 resamples). Bootstrapping was selected because it generates robust interval estimates without relying on the strict normality assumptions of parametric method (Cumming, 2014; Efron & Tibshirani, 1993), thereby increasing accuracy when sample distributions deviate from ideal Gaussian form or contain mild irregularities.

Where relevant, I conducted complementary rank-based Mann-Whitney U test as nonparametric sensitivity analysis. Such nonparametric tests are less sensitive to non-normality and heteroscedasticity (Field, Miles, & Field, 2012) and particularly suitable when subgroup comparisons such as gender-stratified analyses where reduced sample sizes or thereby weaken the robustness of parametric estimate (Zimmerman, 1998)

Mediation analysis followed Hayes' (2018) Model 4 framework, which provides a statistically rigorous approach for estimating direct and indirect effects in simple mediation models. Model 4 was chosen because the study aimed to test a single hypothesized mediator (MBS) linking an experimental condition to an outcome (ATPQ), without additional moderators. Bias-corrected bootstrapped confidence intervals (5,000 resamples) were used, as recommended by Hayes (2018) and Preacher and Hayes (2004), to produce accurate interval estimates of indirect effects. This method does not assume normality of the indirect effect sampling distribution, a key

advantage since indirect effects are often skewed in finite sample (MacKinnon et al., 2004)

The primary model tested whether MBS mediated the effect of experimental condition on ATPQ. A post hoc mediation replaced the experimental condition with the manipulation check (SDO-E) to explore theoretically relevant indirect pathways, given theoretical claims that hierarchy-related attitudes may shape both medicalization beliefs and overpathologizing tendencies.

Finally, supplementary analyses comprised gender-stratified subgroup tests for SDO-E, MBS, and ATPQ, using Mann-Whitney U test with effect size r reported for rank-based outcomes. Reporting effect size r for these nonparametric outcomes follows recommendations by Fritz et al. (2012) to facilitate interpretation and comparison across different statistical approaches.

5.3. Study 2: Results

This section presents the results of statistical analyses conducted to evaluate the study model. Following the analysis strategy described in the Method section, the findings are reported in four sections. First, descriptive statistics summarize the demographic characteristics of the participants. Second, the main study variables such as medicalization beliefs, overpathologizing tendencies, and the manipulation check, are described. Third, the effectiveness of the experimental manipulation is assessed. Finally, the study's four hypotheses are addressed, including the effects of the experimental condition on medicalization beliefs (H2) and overpathologizing tendencies (H1), the hypothesized positive correlation between medicalization beliefs and overpathologizing (H3), and the proposed mediation model (H4) in which medicalization was expected to mediate the effect of the manipulation on overpathologizing.

In terms of gender, 76.2% of participants identified as female ($n = 99$), and 23.8% identified as male ($n = 31$). Regarding educational attainment, 55.4% of participants had a bachelor's degree ($n = 72$), while 29.2% had a master's degree ($n = 38$). A smaller portion had a bachelor's degree (8.5%, $n = 11$) and a doctoral degree (6.2%, $n = 8$). One participant (0.8%) reported completing a medical residency in psychiatry.

Participants' educational backgrounds were diverse. More than half had a bachelor's degree in psychology (53.8%, $n = 70$). Others were educated in subfields such as clinical psychology (14.6%, $n = 19$), counseling psychology (10.8%, $n = 14$), or cognitive, developmental, or experimental psychology (13.8%, $n = 18$). Nine participants (6.9%) reported receiving interdisciplinary training or alternative academic qualifications (e.g., educational administration, double major).

Theoretical orientations also varied across the sample. Slightly more than half of the participants (51.5%, $n = 67$) adopted cognitive-behavioral approaches, including schema therapy and mindfulness-based interventions. The remainder reported humanistic (15.4%, $n = 20$), psychodynamic (11.5%, $n = 15$), or eclectic (19.2%, $n = 25$) orientations. A small number (2.3%, $n = 3$) reported adopting other approaches.

Participants ranged in age from 20 to 53, with a mean age of 27.7 years ($SD = 3.82$). Participants rated their socioeconomic status as moderately high ($M = 3.09$, $SD = 0.63$) on a 7-point scale.

Table 5.3.1 Demographic Variables

Variable	Category	<i>n</i>	%
Gender	Female	99	76.2%
	Male	31	23.8%
Education Level	Bachelor's Degree	72	55.4%
	Master's Degree	38	29.2%
	Undergraduate Student	11	8.5%
	Doctorate	8	6.2%
	Psychiatry	1	0.8%
Theoretical Orientation	Cognitive-Behavioral	67	51.5%
	Eclectic	25	19.2%
	Humanistic	20	15.4%
	Psychodynamic	15	11.5%
	Others	3	2.3%

Notes. 1) Percentages are calculated based on the total sample size ($N = 130$)

Descriptive statistics for the main variables, including group-level and total sample values, are presented in Table 5.3.2. Mean scores for MBS were slightly lower in the experimental group ($M = 3.92$, $SD = 1.07$) than in the control group ($M = 4.17$, $SD = 1.29$). A similar pattern was observed for ATPQ scores, which were $M = 4.06$ ($SD = 0.65$) in the experimental group and $M = 4.15$ ($SD = 0.62$) in the control group.

The mean manipulation check score was 3.32 ($SD = 1.51$) in the experimental group and 3.55 ($SD = 1.75$) in the control group. Pooled total scores for each variable are provided in the bottom row of the Table 5.3.3.

Table 5.3.2 Variables by Groups

Variable	Group	N	M	SD	Min	Max
MBS	Experimental	65	3.92	1.07	1.17	7.00
	Control	65	4.17	1.29	1.00	7.00
	Total	130	4.05	1.18	1.00	7.00
ATPQ	Experimental	65	4.06	0.65	2.33	5.33
	Control	65	4.15	0.62	3.00	5.67
	Total	130	4.11	0.64	2.33	5.67
SDO-E	Experimental	65	3.32	1.51	1.00	6.67
	Control	65	3.55	1.75	1.00	7.00
	Total	130	3.44	1.63	1.00	7.00

Notes. 1) *N* = Sample size, *M* = mean, *SD* = Standard deviation, *Min* = Minimum, *Max* = Maximum.

To assess the effectiveness of the experimental manipulation, an independent samples t-test was conducted on the manipulation check variable. Participants in the experimental group did not report significantly higher endorsement of SDO-E compared to the control group, $t(128) = -0.80, p = .423$. The mean manipulation check score was 3.32 ($SD = 1.51$) in the experimental group and 3.55 ($SD = 1.75$) in the control group. The manipulation did not produce a statistically significant difference in participants' SDO.

Table 5.3.3 Independent Samples t-Test for Manipulation Check

Variable	Experimental (<i>n</i> = 65)		Control (<i>n</i> = 65)		<i>t</i> (128)	<i>p</i>	<i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
SDO-E	3.32	1.51	3.55	1.75	−0.80	.423	−0.14

Notes. 1) *M* = Mean; *SD* = Standard Deviation; *t* = Student's *t* test; *p* = significance level; *d* = Cohen's *d* (effect size)

An independent samples *t*-test was conducted to examine whether the experimental manipulation affected participants' overpathologizing tendencies. Mean ATPQ scores were 4.06 (*SD* = 0.65) in the experimental group and 4.15 (*SD* = 0.62) in the control group. The difference between groups was not statistically significant, *t*(128) = −0.83, *p* = .409, with a small effect size (*d* = −0.14). Hypothesis 1 was not supported.

Table 5.3.4 Independent Samples t-Test for Overpathologizing by Groups

Variable	Experimental (<i>n</i> = 65)		Control (<i>n</i> = 65)		<i>t</i> (128)	<i>p</i>	<i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
ATPQ	4.06	0.65	4.15	0.62	−0.83	.409	−0.14

Notes. 1) *M* = Mean; *SD* = Standard Deviation; *t* = Student's *t* test; *p* = significance level; *d* = Cohen's *d* (effect size)

A second independent samples *t*-test was conducted to determine whether the manipulation influenced participants' medicalization beliefs. Participants in the experimental condition had a mean MBS score of 3.92 (*SD* = 1.07), while those in the control condition had a mean of 4.17 (*SD* = 1.29). The difference was not statistically

significant, $t(128) = -1.17, p = .243$. The effect size was small ($d = -0.21$). Hypothesis 2 was not supported.

Table 5.3.5 Independent Samples t-Test for Medicalization Beliefs by Groups

Variable	Experimental ($n = 65$)		Control ($n = 65$)		$t(128)$	p	d
	M	SD	M	SD			
MBS Scores	3.92	1.07	4.17	1.29	-1.17	.243	-0.21

Notes. 1) M = Mean; SD = Standard Deviation; t = Student's t test; p = significance level; d = Cohen's d (effect size)

A Pearson correlation analysis was conducted to test the hypothesized association between medicalization beliefs and overpathologizing tendencies. The results revealed a significant positive correlation, $r(128) = .27, p = .002$. Hypothesis 3 was supported, indicating a statistically positive association between MBS and ATPQ scores.

Table 5.3.6 Pearson Correlations Between Medicalization Beliefs and Overpathologizing

	MBS	ATPQ
MBS	1.000	.266**
ATPQ	.266**	1.00
Sig. (2-tailed)	—	.002
	.002	—
N	130	130

Notes. 1) MBS = Medicalization Beliefs Scale; ATPQ = Assessment and Treatment Planning Questionnaire. $p < .01$ (two-tailed).

To test Hypothesis 4, a mediation analysis was conducted. The independent variable was condition (0 = control, 1 = experimental), the mediator was medicalization beliefs (MBS), and the dependent variable was overpathologizing tendency (ATPQ). Consistent with the conceptual model, it was expected that the manipulation would primarily influence overpathologizing tendencies through its effect on medicalization beliefs. Drawing on prior methodological guidelines, where indirect effects accounting for 50% or more of the total effect are typically interpreted as substantial mediation (MacKinnon et al., 2007; Wen & Fan, 2015), the mediation was anticipated to be strong, with the indirect pathway explaining the majority of the total effect.

A mediation analysis with 5,000 bias-corrected bootstrap samples was conducted to examine whether medicalization beliefs mediated the relationship between condition (0 = control, 1 = experimental) and overpathologizing tendencies. The indirect effect of condition on overpathologizing through medicalization beliefs was not statistically significant, $B = -0.0344$, $SE = 0.0320$, $Z = -1.08$, $p = .281$, 95% CI $[-0.1010, 0.0285]$. The direct effect of condition on overpathologizing was also nonsignificant, $B = -0.0271$, $SE = 0.1292$, $Z = -0.21$, $p = .834$, 95% CI $[-0.2830, 0.2269]$, as was the total effect, $B = -0.0615$, $SE = 0.1318$, $Z = -0.47$, $p = .641$, 95% CI $[-0.3200, 0.1978]$. Path coefficients showed that condition did not significantly

predict medicalization beliefs (*a* path: $B = -0.2436$, $p = .248$), while medicalization beliefs significantly predicted overpathologizing tendencies (*b* path: $B = 0.1414$, $p = .009$). These findings indicate that although medicalization beliefs were positively associated with overpathologizing tendencies, the experimental manipulation did not produce a significant indirect, direct, or total effect.

Table 5.3.7 Mediation Analysis of the Effect Model

Effect / Path	B	SE	p	95% CI LL	95% CI UL
a: Condition → MBS	−0.243	0.211	.248	−0.660	0.171
b: MBS → ATPQ	0.141	0.054	.009	0.034	0.246
c (Total effect)	−0.061	0.132	.641	−0.320	0.198
c' (Direct effect)	−0.027	0.129	.834	−0.283	0.227
a × b (Indirect effect via MBS)	−0.034	0.032	.281	−0.101	0.028

Notes: 1) Condition was coded as 0 = control, 1 = experimental. MBS = Medicalization Beliefs Scale; ATPQ = Assessment and Treatment Planning Questionnaire. B = unstandardized coefficient; SE = standard error; CI = confidence interval; LL = lower limit; UL = upper limit. Bootstrap confidence intervals are based on 5,000 resamples.

Although not included in the primary model, supplementary analyses examined whether the effects of the experimental manipulation and the association between medicalization beliefs (MBS) and overpathologizing tendencies (ATPQ) differed by gender.

For subgroup analyses, Mann–Whitney U tests were conducted due to reduced subgroup sample sizes and potential non-normality. For the manipulation check (SDO-E), among male participants, median scores were higher in the control group ($Mdn =$

4.67) than in the experimental group (Mdn = 4.00), but this difference was not statistically significant, $U = 69.5$, $p = .123$. Among female participants, no median difference was observed (Mdn = 4.00 in both conditions), $U = 1113$, $p = .509$. For medicalization beliefs (MBS), male participants in the experimental condition reported significantly lower median scores (Mdn = 3.67) compared to those in the control condition (Mdn = 4.67), $U = 59.5$, $p = .038$. No significant differences were found for ATPQ among male participants ($U = 89.0$, $p = .395$). Among female participants, no significant differences emerged for MBS ($U = 1190$, $p = .863$) or ATPQ ($U = 1204$, $p = .941$).

Table 5.3.8 Nonparametric Group Comparisons by Gender

Gender	Variable	Experimental <i>Mdn</i>	Control <i>Mdn</i>	<i>U</i>	<i>p</i>
Male	MBS	3.67	4.67	59.5	.038
	ATPQ	3.75	4.25	89.0	.395
	SDO-E	4.00	4.67	69.5	.123
Female	MBS	4.00	4.00	1190	.863
	ATPQ	4.00	4.00	1204	.941
	SDO-E	4.00	4.00	1113	.509

Notes. 1) MBS = Medicalization Beliefs Scale; ATPQ = Assessment and Treatment Planning Questionnaire; SDO-E = Social Dominance Orientation–Equality. Mdn = Median; U = Mann–Whitney U statistic; p = significance level.

To explore whether the MBS and ATPQ association differed by genders, I computed Spearman's rank-order correlations (ρ). Among males, the correlation was moderately positive ($\rho = .309$, $p = .091$). Among females, the correlation was weaker ($\rho = .173$, $p = .086$). Neither correlation reached statistical significance, but the point estimate was slightly higher for males (Table 5.3.9)

Table 5.3.9. Spearman Correlations Between MBS and ATPQ by Gender

Gender	ρ (Spearman)	n	p
Male	.309	31	.091
Female	.173	99	.086

Notes. 1) ρ = Spearman's rho correlation coefficient; n = sample size; p = significance level.

A post hoc mediation analysis was conducted to test whether medicalization beliefs mediated the relationship between the manipulation check and overpathologizing. The indirect effect of the manipulation check on overpathologizing through medicalization beliefs was significant, $B = 0.029$, $SE = 0.014$, 95% CI [0.004, 0.058], $p = .033$. The direct effect of the manipulation check on overpathologizing was not significant, $B = -0.030$, $SE = 0.046$, 95% CI [-0.114, 0.062], $p = .510$, while the total effect was also non-significant, $B = -0.001$, $SE = 0.045$, 95% CI [-0.087, 0.090], $p = .983$. Path estimates indicated that higher manipulation check scores significantly predicted stronger medicalization beliefs ($B = 0.190$, $SE = 0.065$, 95% CI [0.053, 0.312], $p = .004$), which in turn significantly predicted greater overpathologizing tendencies ($B = 0.153$, $SE = 0.055$, 95% CI [0.042, 0.264], $p = .005$).

Table 5.3.10 Post-Hoc Mediation Analysis of the Effect Model

Effect / Path	B	SE	p	95% CI LL	95% CI UL
a: SDO-E → MBS	0.190	0.065	.004	0.053	0.312
b: MBS → ATPQ	0.153	0.055	.005	0.042	0.264
c (Total effect): SDO-E → ATPQ	-0.001	0.045	.983	-0.087	0.090
c' (Direct effect): SDO-E → ATPQ	-0.030	0.046	.510	-0.114	0.062
a × b (Indirect effect via MBS)	0.029	0.014	.033	0.004	0.058

Notes: 1) SDO-E = Manipulation Check; MBS = Medicalization Beliefs Scale; ATPQ = Assessment and Treatment Planning Questionnaire. B = unstandardized coefficient; SE = standard error; CI = confidence interval; LL = lower limit; UL = upper limit. Bootstrap confidence intervals are based on 5,000 resamples.

5.4. Study 2: Discussion

This study examined whether a manipulation intended to activate social dominance orientation (SDO) would influence therapists' medicalization beliefs and their clinical judgment tendencies. Four main hypotheses were tested: (a) SDO manipulation would increase the medicalization beliefs (H2) and (b) overpathologizing tendencies (H1); (c) medicalization beliefs would positively be associated with overpathologizing (H3); and (d) mediation of the relationship between manipulation and overpathologizing (H4). Among these hypotheses, only H3 was supported, and it is discussed first below.

The relationship between medicalization beliefs and overpathologizing supports the claim that clinical judgments in mental health are not purely neutral or technical; rather, they are shaped by broader social and ideological frameworks. This aligns with a significant body of research demonstrating that clinical judgement may be influenced by socially embedded biases. For example, studies have documented racism in diagnosis; Black patients have historically been more likely than White patients to receive a diagnosis of schizophrenia under similar clinical presentations (Metzl, 2009). Similarly, gender biases have been observed, such as women being more easily labeled with affective or histrionic disorders, and men with diagnoses related to antisocial or substance abuse (Broverman et al., 1970; Rieker and Bird, 2005).

In addition to this documented biases, the current finding points to a distinct mechanism. Specifically, it reveals a hierarchy embedded within the clinician–client relationship that operates through the authority to define knowledge and norms, rather than through prejudices linked to the client's social group. From Foucault's (1980) knowledge–power perspective, the therapist is not merely a provider of treatment, but also an epistemic authority who determines which behaviors are categorized “normal” or “pathological,” thereby defining and legitimizing norms. This authority stems not

from individual skill or personal traits but from the monopoly of knowledge production held by medical institutions and the legitimacy this knowledge carries in shaping social norms. Accordingly, clinicians who more strongly endorse the role of medical institutions in defining and enforcing social norms may lower the threshold for pathologizing.

López-Aybar and Gonzales (2024) observation of a “us–them” distinction offers a concrete illustration of this mechanism. Therapists positioned themselves as a knowledgeable, rational, and competent, while framing clients as individuals who require guidance, correction, or treatment. This linguistic and relational separation reinforces professional boundaries and creates an institutional distance that strengthens the tendency to pathologize, regardless of the client’s social group membership.

This mechanism appears to operate largely independently of the identity of the targeted client; in this sample, it was not influenced by social group categories such as race, gender, or class. In this respect, the finding reflects not a discriminatory bias toward specific groups but an ideological commitment to the normative power of medical authority. However, this does not preclude intersection with broader social hierarchies; on the contrary, institutional authority may align with and reinforce existing inequalities. As previous research show, medical and psychiatric classifications have historically mirrored prevailing power relations. For example, the historical classification of LGBTQI+ identities as psychiatric disorders in the DSM (Drescher, 2015), the disproportionate schizophrenia diagnoses among Black individuals (Metzl, 2009), and the frequent labeling of women as neurotic or hysterical (Broverman et al., 1970) illustrate how medical authority can pathologize specific social groups, thereby reproducing social hierarchies through medicine.

While H3 revealed a theoretically consistent association between medicalization beliefs and overpathologizing, H1 and H2, which reflect the relationships between SDO and medicalization beliefs, and between SDO and over-pathologization were not

supported. This lack of support likely stems from the absence of group differences following the manipulation. One possible explanation is that the experimental status cue was too weak. Although recent studies highlight that SDO can be contextually sensitive (Ho et al., 2015; Sheehy-Skeffington, 2020), other research suggests that SDO is relatively stable and resistant to minor situational changes (Duckitt & Sibley, 2010; Pratto et al., 1994). Even when context influence SDO, strong and emotionally engaging cues, such as salient group competition, visible inequality, or direct status threats, are often necessary to shift SDO (Duckitt & Sibley, 2010; Sheehy-Skeffington, 2020). Many prior experiments have used ideologically loaded scenarios; for example, Levin et al. (2012) heightened hierarchy salient by presenting a fabricated news article on the U.S. national norms that emphasized ethnic group boundaries and status differences. In contrast, the present study's cue, a brief mention that the client had seen a life coach, signaled lower professional legitimacy but did not connect to broader status hierarchy, limiting its capacity to activated hierarchy-related thinking.

Given these null effects for H1 and H2, an exploratory, post hoc mediation analysis was conducted, threatening manipulation check scores as a measured SDO variable. This approach revealed that higher SDO scores predicted stronger medicalization beliefs, which in turn predicted greater overpathologizing tendencies. Although the manipulation failed to produce between-group differences in SDO, the indirect pathway from measured SDO to overpathologizing via medicalization beliefs was statistically supported, mirroring the hypothesis mechanism in the correlational nature.

This analytic approach follows Hauser et al.'s (2018) recommendation that when experimental manipulations fail, manipulation check scores can be analyzed as naturally varying individual differences to test the theoretical pathways in a correlational framework. Similar "internal analyses" have been applied in classic studies, such as Schachter's (1959) research on anxiety and affiliation, where self-reported anxiety scores supported the hypothesized pathway despite null experimental effects.

Because the manipulation did not achieve its intended effect, these findings should not be interpreted as evidence about malleability of SDO. Instead, they provide preliminary, correlational support for the proposed mediating mechanism - higher SDO predicting stronger medicalization beliefs, which predict greater overpathologizing. Although exploratory, this result underscores the importance of testing this pathway with stronger and more contextually salient manipulations to establish causal validity.

5.4.1. *Limitations*

A key methodological limitation concerns the limited impact of the experimental manipulation. The status-based priming was implemented through the inclusion of a “life coach” detail at the end of the vignette, with its salience reinforced by a subsequent question about the benefit the client had gained from this prior support. While this follow-up question was intended to draw attention back to the status cue, placing this critical information at the very end of a relatively lengthy vignette may have reduced its effectiveness, particularly in an online, self-administered format where sustaining participant attention is challenging. Without an explicit attention check to verify that the vignette was read in full, it is possible that some participants skimmed or skipped the final portion, thereby missing or under-processing the manipulation.

Prior research has shown that vignettes that are lengthy or that present essential manipulations late in the scenario are especially vulnerable to reduced engagement and incomplete processing in online contexts where reading behavior is not monitored (Aguinis & Bradley, 2014). In online experiments more broadly, the lack of environmental control and real-time monitoring limits the researcher’s ability to ensure that participants fully process the intended stimulus, a limitation that is particularly critical for context-sensitive manipulations such as status cues.

A further limitation relates to the professional composition of the sample. Although the study recruited individuals with relevant mental health training or degrees, the sample was disproportionately composed of psychologists. Such professional homogeneity may lead to a shared set of conceptual frameworks and interpretive strategies shaped by similar training and disciplinary norms, potentially reducing the range of perspectives applied to clinical reasoning (Borrell-Carrió et al., 2004). This lack of diversity may have reduced variability in key constructs, thereby limiting the ability to detect differences.

In addition, when participants belong to occupational groups with clearly defined normative standards, they may be more motivated to present themselves in ways consistent with those standards. This tendency toward socially desirable responding can reflect genuine pressure to conform to professionally sanctioned values and behaviors, especially in ethically sensitive judgment contexts, and may mask individual differences in clinical reasoning or decision-making (Richman et al., 1999). Given the predominance of psychologists in the sample, the findings may therefore be more reflective of the professional norms and decision-making tendencies of this subgroup, limiting their generalizability to other segments of the mental health profession.

Another limitation concerns the measurement instruments. The MBS was developed specifically for this study and underwent its initial psychometric evaluation in the present sample. Although analyses indicated acceptable reliability and a coherent factor structure, validation in independent samples is needed to establish stability and generalizability (Boateng et al., 2018). Similarly, the ATPQ was administered in a translated and adapted form, with item selection tailored to the study's focus. Although it may be considered acceptable according to Taber (2018), a Cronbach's alpha of .63 still requires cautious interpretation due to its moderate internal consistency. Additionally, as with the MBS, its performance has not been examined in other populations or cultural contexts. Translation and cultural adaptation

may introduce semantic or conceptual shifts, which can affect measurement equivalence if not evaluated through multi-stage, cross-sample validation (Beaton et al., 2000).



6. GENERAL DISCUSSION

We set out to examine how social dominance orientation (SDO) and medicalizing beliefs intersect to shape overpathologizing tendencies in psychotherapy. Across two complementary studies, we combined the ecological validity of naturalistic data with the causal inference afforded by experimental design. Study 1, based on organically occurring client complaints, offered real-world evidence that overpathologizing is not merely a theoretical concern but a tangible pattern in therapeutic practice. Study 2 extended this by testing whether hierarchical orientations predict overpathologizing tendencies, and whether medicalizing beliefs function as the mediating psychological mechanism. Together, these studies represent a rare integration of observational and experimental evidence, enabling us to assess the robustness of our theoretical model across distinct methodological contexts.

A central strength our work lies in its sequential, mixed-method design. By aligning qualitative patterns from client complaints with the quantitative testing of a mediation model, we were able to triangulate findings (Greene et al., 1989) and enhance the interpretive significance of our conclusions (Collins et al., 2006). In doing so, we not only confirmed that overpathologizing is present in actual clinical encounters but also clarified the structural process that may sustain it; specifically, the role of medicalization as an ideologically driven bias linked to preferences for social hierarchy.

Our findings contribute to a literature that often frames clinical judgment bias as either cognitive error or expressions of prejudice toward particular social groups (Kvaale et al., 2013; Lopez, 1989; Metzl, 2009). While these accounts remain valuable, they tend to underplay the institutional authority dimension; how the normative power of medicine extends beyond illness treatment to define social norms and regulate everyday life (Conrad, 2007; Horwitz, 2002). From this perspective, overpathologizing is not just a misjudgment but a structural tendency rooted in the professional authority to determine what counts as “normal” or “pathological.”

This reframing has important implications. Overpathologizing can erode therapeutic trust, foster unnecessary illness identities, and direct clients toward inappropriate interventions (Leventhal et al., 1980; Suhr & Wei, 2017). At a systemic level, it can contribute to misallocation of resources, perpetuate inequalities in access to care, and reinforce existing social hierarchies (Suhr & Johnson, 2022; Wakefield, 2016). By showing that medicalization beliefs predict overpathologizing - and that these beliefs are linked, at least correlationally linked to SDO-E we identify a potential pathway through which ideological orientations may indirectly shape the fairness and quality of mental health care.

The present research advances this discussion by identifying medicalization as a robust predictor of overpathologizing and linking it to SDO as a potential antecedent. This connection shifts the focus from viewing overpathologizing solely as a case-by-case clinical misjudgment to recognizing it as a bias structurally sustained by ideological orientations toward hierarchy and medical authority.

Addressing these mechanisms requires interventions that target not only explicit prejudices but also the normative and relational dimensions of therapeutic authority. Embedding power-awareness training into ethics curricula, supervision practices, and continuing professional development could help practitioners critically reflect on how their institutional roles shape their interpretations of clients' experiences (Comas-Díaz & Brown, 2016). Revising ethical guidelines to explicitly address the risks of overpathologizing, particularly when medicalization tendencies are reinforced by hierarchical orientations, would expand bias-mitigation strategies beyond demographic prejudice to encompass structural-ideological influences. Such measures would strengthen the ethical foundations of psychotherapy and promote more client-centered, socially aware practice.

Future research should extend this work in several directions. First, experimental manipulations of hierarchical cues should be made more salient, emotionally engaging, and ecologically valid. While vignette-based designs offer control, they are vulnerable to reduced realism and attentional limitations, particularly in online settings (Aguinis & Bradley, 2014). Future studies could employ face-to-face or immersive role-play methods, using ideologically charged, contextually rich scenarios, such as explicit status competition or visible inequality, which have been shown to more effectively activate hierarchy-relevant orientations (Levin et al., 2012).

Second, the Medicalization Beliefs Scale (MBS) and Adapted Therapist Pathologizing Questionnaire (ATPQ) developed in this thesis represent early-stage tools for operationalizing the constructs central to the model. While initial results indicate acceptable reliability and conceptual coherence, more advanced refinement could improve measurement precision, cultural adaptability, and predictive validity, thereby enhancing their utility in both research and applied contexts (Boateng et al., 2018).

Third, research should situate overpathologizing within broader debates in mental health practice. Scholars have raised concerns about the expansion of diagnostic criteria (Lakeman, 2013), the medicalization of normative distress (Horwitz, 2002), and the neglect of structural and contextual determinants of suffering (Metzl & Hansen, 2014). Investigating these dynamics would clarify how clinical bias intersects with shifts in diagnostic boundaries, the blurring of normality and pathology, and the individualization of socially rooted distress (Wakefield, 2016).

Finally, replication across more professionally diverse samples and in cultural contexts, along with longitudinal designs, could examine whether changes in hierarchical orientations and medicalization beliefs correspond to shifts in overpathologizing tendencies. Intervention studies could also test whether reflective training, power-awareness workshops, and ethics-focused modules can effectively reduce such biases. Pursuing these directions would both refine our theoretical model

and inform strategies for a more ethically grounded, socially aware, and equitable psychotherapy practice.



7. APPENDICES

7.1. APPENDIX 1: Psychometric Properties of MBS

The MBS was initially developed with 9 items grouped into three theoretically grounded factors: biogenetic explanations, social control and social norms. These factors were informed by the multidimensional framework of medicalization proposed by Van Dijk et al. (2020), capturing both ideological and institutional facets of medical authority.

However, initial psychometric evaluations revealed problematic reliability and factor structure in the 3-factor configuration. As shown in the reliability tables below, the biogenetic explanations factor showed particularly poor internal consistency ($\alpha = 0.252$), with second item which is reverse code exhibiting a negative item-total correlation. Furthermore, exploratory factor analysis (EFA) did not support a clear three-factor solution and suggested a better fit for a unidimensional structure. As a result, the scale was revised to a 6-item unidimensional model to enhance both internal consistency and theoretical clarity.

Initial reliability testing of the 9-item, three-factor configuration revealed suboptimal internal consistency, particularly for the biogenetic explanations factor ($\alpha = 0.252$). The second item, which was reverse-coded, showed a negative item-total correlation ($r = -0.040$), indicating potential conceptual or wording issues. The social control ($\alpha = 0.682$) and social norms ($\alpha = 0.636$) factors demonstrated borderline acceptable reliability but remained below conventional thresholds for robust internal consistency (Nunnally & Bernstein, 1994). The total scale α was 0.761, indicating acceptable reliability at the scale level but problematic factor-level coherence.

Table 7.1.1. Item–Total Correlations and Cronbach’s Alpha if Item Deleted by Factor for the MBS

Factors	Items	Item-Total Correlations	Cronbach’s α If Item Deleted	Cronbach’s α
Biogenetic	1	0.312	-0.220	0.252
	2	-0.019	0.447	
	3	0.144	0.176	
Social Control	4	0.416	0.685	0.682
	5	0.588	0.460	
	6	0.511	0.566	
Social Norms	7	0.513	0.439	0.636
	8	0.536	0.408	
	9	0.303	0.725	
Total				0.761

Notes. Item–total correlations indicate the association of each item with its respective factor score (excluding that item). Cronbach’s α if item deleted reflects the reliability of the factor if the respective item were removed. Cronbach’s α at the factor level is reported in the last column, and the overall α for the full scale is presented in the “Total” row.

An exploratory factor analysis (EFA) using the minimum residual extraction method with oblimin rotation suggested a single dominant factor rather than the intended three-factor model. This factor explained 30.3% of the variance, with the strongest loadings observed for Items 5 ($\lambda = 0.803$), 7 ($\lambda = 0.774$), and 8 ($\lambda = 0.657$). Several items, particularly Items 1, 2, and 9, showed low or negligible loadings, supporting their removal from the scale. These findings suggested that the MBS items were better conceptualized as indicators of a unidimensional construct rather than distinct subdimensions.

Table 7.1.2. Exploratory Factor Analysis Factor Loadings and Uniqueness for MBS

Item	Factor 1 Loading	Uniqueness
5	0.803	0.355
7	0.774	0.400
8	0.657	0.568
6	0.580	0.663
4	0.477	0.772
3	0.468	0.781
9	—	0.860
1	—	0.874
2	—	0.998

Notes. 1) Loadings represent standardized factor loadings from the exploratory factor analysis. Uniqueness indicates the proportion of variance in the item not explained by the factor. Factor loadings below .40 are typically considered weak and are shown here for completeness. Items 1, 2, and 9 did not load substantially on the factor.

Based on the item performance and factor loadings, the MBS was refined to a 6-item unidimensional model comprising Items 3, 4, 5, 6, 7, and 8. This revision improved internal consistency ($\alpha = 0.761$) and produced item-total correlations ranging from 0.394 to 0.691, indicating that each item contributed meaningfully to the overall construct.

Table 7.1.3. Item–Total Correlations and Cronbach’s Alpha if Item Deleted for the Revised MBS

Item	Item-Total Correlation	Cronbach's α if Deleted
3	0.411	0.743
4	0.394	0.746
5	0.691	0.691
6	0.480	0.732
7	0.667	0.698
8	0.588	0.713
Total	-	0.761

Notes. 1) Item–total correlation indicates the correlation of each item with the overall scale score (excluding that item). Cronbach’s α if deleted shows the internal consistency of the scale if the respective item were removed.

Confirmatory factor analysis (CFA) of the revised model yielded acceptable model fit indices: RMSEA = 0.070 (90% CI [.028, .106]), TLI = 0.903, and BIC = –87.2. Although the chi-square statistic was statistically significant, $\chi^2(27) = 44.2$, $p = .020$, this is not uncommon in moderately sized samples (Bentler & Bonett, 1980). Overall, these indices supported the adequacy of the unidimensional structure.

Table 7.1.4. Confirmatory Factor Analysis Fit Indices for the MBS

RMSEA	90% CI	TLI	BIC	χ^2	df	p
0.070	[.028, .106]	0.903	-87.2	44.2	27	0.020

Notes. 1) RMSEA = Root Mean Square Error of Approximation; CI = confidence interval; TLI = Tucker–Lewis Index; BIC = Bayesian Information Criterion; χ^2 = chi-square goodness-of-fit statistic; df = degrees of freedom; p = significance level.

The psychometric evaluation indicated that while the original 9-item, three-factor model had theoretical appeal, empirical evidence favored a shorter, unidimensional configuration with stronger internal consistency and a more coherent factor structure. This refined version was therefore adopted for subsequent analyses in the present study.

7.2. APPENDIX 2: Psychometric Properties of ATPQ

The internal consistency of the four-item ATPQ was assessed using Cronbach's alpha. The overall reliability coefficient was $\alpha = 0.629$, indicating borderline internal consistency for research purposes. Item-total correlations ranged from 0.295 to 0.498. The " α if item deleted" values showed that removing *item 4* would marginally increase alpha to 0.630. However, this item was retained due to its theoretical relevance in representing the prognosis dimension of overpathologizing tendencies.

Table 7.2.1. Item–Total Correlations and Cronbach’s Alpha if Item Deleted for the ATPQ

Items	Item–Total Correlation	Cronbach’s α if Item Deleted
1	0.489	0.533
2	0.473	0.521
4	0.295	0.630
5	0.498	0.535
Overall scale	—	0.629

Notes. 1) Item–total correlation refers to the correlation of each item with the total scale score (excluding that item). Cronbach’s α if deleted indicates the reliability of the scale if the respective item were removed. The “Overall scale” row represents the Cronbach’s α for the full scale ($\alpha = .63$).

Assumption checks indicated the data were factorable. Bartlett’s test of sphericity was significant, $\chi^2(6) = 80.10$, $p < .001$, and the KMO value was 0.666, which is considered mediocre but acceptable for exploratory purposes. The eigenvalues confirmed the one-factor solution, with only the first factor exceeding the threshold of 1 (1 factor = 1.3915, 2 factor = 0.1831).

An exploratory factor analysis (EFA) was performed using the minimum residual extraction method and oblimin rotation. Results indicated a single-factor solution, with loadings ranging from 0.316 to 0.684. The eigenvalue for the first factor was 1.39, while all other factors were below the Kaiser criterion threshold.

Table 7.2.2. Exploratory Factor Analysis Factor Loadings and Uniqueness for the ATPQ

Item	Factor 1	Uniqueness
1	0.684	0.533
2	0.680	0.538
4	0.316	0.900
5	0.602	0.638

Notes. 1) Factor loadings represent standardized coefficients from the exploratory factor analysis. Uniqueness indicates the proportion of item variance not explained by the factor. Items with loadings below .40 are considered weak and should be interpreted with caution.

Model fit indices for the one-factor model indicated a less-than-optimal fit (RMSEA = 0.131, 90% CI [0.026, 0.251], TLI = 0.817, $\chi^2(2) = 6.50$, $p = .039$), suggesting that while the items measure a common construct, some variance remains unexplained.

Table 7.2.3. Confirmatory Factor Analysis Fit Indices for the ATPQ

RMSEA	90% CI Lower	TLI	BIC	χ^2	df	p
0.131	[0.025, 0.251]	0.817	-3.24	6.50	2	.039

Notes. 1) RMSEA = Root Mean Square Error of Approximation; CI = confidence interval; TLI = Tucker–Lewis Index; BIC = Bayesian Information Criterion; χ^2 = chi-square goodness-of-fit statistic; df = degrees of freedom; p = significance level.

The ATPQ demonstrated borderline internal consistency ($\alpha = 0.629$) but maintained theoretical coherence across items. EFA supported a unidimensional structure, although Item 4 showed lower factor loading and item–total correlation. Despite less-than-optimal model fit indices, the scale was deemed suitable for use as a composite measure of overpathologizing tendencies in this study, given its theoretical alignment and acceptable psychometric adequacy for research purposes.



7.3. APPENDIX 3: Full Experimental Materials and Measures

Bilgilendirilmiş Onam Formu

Araştırmanın Yürütücüsü: Mehmet Ali Sevim (xxxx) AGU Veri Bilimi Bölümü

Danışman: Doç. Dr. Ahmet Çoymak (xxxx) AGU Psikoloji Bölümü

Araştırmaya İlişkin Bilgiler: Bu araştırma, Abdullah Gül Üniversitesi Veri Bilimi Yüksek Lisans öğrencisi Mehmet Ali Sevim tarafından, Doç. Dr. Ahmet Çoymak danışmanlığındaki yüksek lisans tezi kapsamında yürütülmektedir. Bu form, sizi araştırma koşulları hakkında bilgilendirmek için hazırlanmıştır.

Araştırmanın Amacı Nedir?

Bu araştırma, ruh sağlığı alanında çalışan bireylerin, mesleki durumlara yaklaşımları ile insan psikolojisine dair görüşleri arasındaki ilişkide kısa süreli bellek süreçlerinin aracı rolünü incelemeyi amaçlamaktadır.

Araştırmaya Kimler Katılabilir?

Bu çalışmaya aşağıdaki gruplardan kişiler katılabilir:

- Psikoloji veya Psikolojik Danışmanlık ve Rehberlik (PDR) lisans öğrencileri, (psikopatoloji, klinik psikoloji veya klinik görüşme derslerinden en az birini almış),
- Psikolog ve psikolojik danışmanlar,
- Ruh sağlığı ve hastalıkları uzmanları (psikiyatristler),
- Ruh sağlığı ve hastalıkları uzmanlığı araştırma görevlileri (psikiyatri asistanları),
- Çocuk ve ergen ruh sağlığı ve hastalıkları uzmanları (çocuk ve ergen psikiyatristleri),
- Çocuk ve ergen ruh sağlığı ve hastalıkları uzmanlığı araştırma görevlileri (çocuk ve ergen psikiyatrisi asistanları)

Katılımcılardan Ne Yapmaları Beklenmektedir?

Bu araştırmaya katılmayı kabul ederseniz bir okuma görevini, 2 adet anketi ve demografik bilgi formunu tamamlamanız beklenmektedir. Lütfen verilen bilgileri ve ölçeklerin başındaki açıklamaları dikkatlice okuyarak size en uygun gelen cevabı işaretleyiniz. Bu çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Herhangi bir yaptırıma maruz kalmadan çalışmaya katılmayı reddedebilir veya çalışmayı yarıda bırakabilirsiniz.

Çalışma Ne Kadar Sürecektir?

Çalışmada süre kısıtlaması olmayıp yaklaşık 5 dakika sürmesi beklenmektedir.

Verilerin Gizliliği Nasıl Sağlanacak?

Çalışmada kimlik belirleyici hiçbir bilgi talep edilmeyecektir. Bu çalışma kapsamında sağladığınız bilgiler anonim olarak saklanacak ve diğer katılımcıların verileri ile birleştirilerek bütün halinde analize dahil edilecektir. Verileriniz yalnızca bilimsel çalışmalar kapsamında kullanılacak ve Açık Bilim etik prensiplerine uygun bir biçimde yalnızca test edilen modele ait veriler açık erişim platformlarında (örn. OFS) bilimsel amaçlarla paylaşılabilir, ancak bu paylaşımında anonimliğin devamlılığı garantimiz altındadır.

Katılımın Riskleri Var mıdır?

Çalışmada genel olarak kişisel rahatsızlık verecek herhangi bir ayrıntı öngörülmemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz çalışmayı yarıda bırakabilir, yukarıdaki iletişim bilgileri kullanılarak bize ulaşabilir veya etik kurulla xxxx iletişime geçebilirsiniz.

Aşağıda seçeneklerden "Çalışmaya katılmayı onaylıyorum" seçeneğini işaretleyerek bu araştırmanın amacı ve verdiğiniz cevapların nasıl kullanılacağı ve saklanacağı hakkındaki Bilgilendirme ve Gönüllü Katılım Formunu okumuş olduğunuzu onaylıyorsunuz. Aynı zamanda bu onayla beraber araştırmaya katılımın zorunlu olmadığı, araştırmadan istediğiniz zaman hiçbir neden göstermeksizin

çekilebileceği bilgisine sahip olduğunuzu ifade etmiş olmaktadır. Bu bilgiler doğrultusunda araştırmaya katılmayı kabul ediyorsanız lütfen "Çalışmaya katılmayı onaylıyorum" seçeneğini işaretleyiniz.

- Çalışmaya katılmayı onaylıyorum.
- Çalışmaya katılmayı onaylamıyorum.

Onam formunu okuyarak anladığınızdan emin olabilmemiz için lütfen cümledeki boşluğa ne gelmesi gerektiğini aşağıya yazınız. "Çalışmada süre kısıtlaması olmayıp yaklaşık ____ dakika sürmesi beklenmektedir."

Bu çalışmaya yalnızca belirli bir akademik ve mesleki geçmişe sahip katılımcılar katılabilmektedir. Aşağıdaki soruyu, çalışma için uygunluk durumunuzu belirleyebilmemiz amacıyla yöneltiyoruz.

Aşağıdaki unvanlardan hangisi sizi en iyi tanımlar?

- Psikolojik Danışmanlık ve Rehberlik (PDR) Lisans Öğrencisiyim (Psikopatoloji, klinik psikoloji veya klinik görüşme derslerinden en az birini aldım)
- Psikoloji Lisans Öğrencisiyim (Psikopatoloji, klinik psikoloji veya klinik görüşme derslerinden en az birini aldım)
- Psikolojik Danışmanım
- Psikoloğum
- Uzman Psikoloğum (Klinik psikoloji hariç, psikolojinin diğer alanlarında yüksek lisans veya doktora yaptım)
- Uzman Psikolojik Danışmanım (PDR bölümünde yüksek lisans veya doktora yaptım)
- Uzman Klinik Psikoloğum (Klinik psikoloji yüksek lisans veya doktora yaptım)
- Ruh Sağlığı ve Hastalıkları Uzmanıyım (Psikiyatristim)
- Ruh Sağlığı ve Hastalıkları Uzmanlığı Araştırma Görevlisiyim (Psikiyatri Asistanıyım)
- Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları Uzmanıyım (Çocuk ve Ergen Psikiyatristiyim)

○ Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları Uzmanlığı Araştırma Görevlisiyim (Çocuk ve Ergen Psikiyatrisi Asistanıyım) ○ Hiçbiri	
Bu bölümde, kısa süreli bellek ve danışan öyküsü ilişkisi ölçümlenecektir. Bu nedenle mesleki pratikte karşılaşılabilecek türden bir danışan öyküsü örneği okuyacaksınız. Lütfen metni dikkatlice okuyunuz ve ardından yöneltilecek sorulara kendi profesyonel yargınızı kullanarak yanıt veriniz. Metni okumadan önce veya okumayı tamamladıktan sonra not almanıza gerek yoktur. Sorular, okuma sırasında aklınızda kalan bilgiler ve genel izlenimler üzerinden cevaplanacaktır. İyi çalışmalar dileriz.	
Danışan Öyküsü	
Vinyet A (Deney Koşulu) Deniz, geldiğinde gergin ve sinirli hissettiğini belirtmiştir. Gün içinde birkaç saat süren çökkün duygudurumlara girdiğinden, konsantre olmakta ve işine uyum sağlamakta zorlandığından bahsetmiştir. Düşüncelerini odaklayamadığını, bazen mide bulantısı hissettiğini ve belirli bir düşünceye odaklanmayan, içerik olarak değişkenlik gösteren tekrarlayan düşüncelere sahip olduğunu ifade etmiştir. Yaşamın birçok alanında kaygı hissettiğini, özellikle geceleri kaygılarının arttığını söylemiştir. Deniz ayrıca uykuya dalmakta zorlandığını ve uykusunun en fazla birkaç saat	Vinyet B (Kontrol Koşulu) Deniz, geldiğinde gergin ve sinirli hissettiğini belirtmiştir. Gün içinde birkaç saat süren çökkün duygudurumlara girdiğinden, konsantre olmakta ve işine uyum sağlamakta zorlandığından bahsetmiştir. Düşüncelerini odaklayamadığını, bazen mide bulantısı hissettiğini ve belirli bir düşünceye odaklanmayan, içerik olarak değişkenlik gösteren tekrarlayan düşüncelere sahip olduğunu ifade etmiştir. Yaşamın birçok alanında kaygı hissettiğini, özellikle geceleri kaygılarının arttığını söylemiştir. Deniz ayrıca uykuya dalmakta zorlandığını ve uykusunun en fazla birkaç saat

sürdüğünü belirtmiştir. Zaman zaman iyi hissetmek için kısa yürüyüşler yaptığını da eklemiştir. Terapi sırasında şaka yollu olarak Tourette Sendromuna sahip olup olmadığını merak ettiğini söylemiştir. Bazen yanında bulunan kişilerin saçından bir tutam koparmak gibi alışılmadık dürtüler hissettiğini, ancak bu dürtülere karşı koyabildiğini belirtmiştir. Deniz, sosyalleşebildiğini ancak yakın hissettiği çok az arkadaşı olduğunu söylemiştir. Kişisel eşyalarını başkalarıyla paylaşmaktan çekindiğini, insanlara yük olmaktan korktuğunu söylemiştir. Sonuç olarak, derin duygularını paylaşabileceği kimsesinin olmadığını ifade etmiştir. İş performansından genel olarak memnun olduğunu ancak son zamanlarda çalışırken konsantrasyonunu sürdürmekte zorlandığını belirtmiştir. Haftada ortalama bir gün içki içtiğini, bu süreçte dört ila beş saat boyunca yaklaşık üç bira tükettiğini söylemiştir. Akrabaları arasında babasının alkolik olduğu söylenmektedir. Deniz, duygusal veya fiziksel olarak hiçbir zaman tacize uğramadığını belirtmiştir.	sürdüğünü belirtmiştir. Zaman zaman iyi hissetmek için kısa yürüyüşler yaptığını da eklemiştir. Terapi sırasında şaka yollu olarak Tourette Sendromuna sahip olup olmadığını merak ettiğini söylemiştir. Bazen yanında bulunan kişilerin saçından bir tutam koparmak gibi alışılmadık dürtüler hissettiğini, ancak bu dürtülere karşı koyabildiğini belirtmiştir. Deniz, sosyalleşebildiğini ancak yakın hissettiği çok az arkadaşı olduğunu söylemiştir. Kişisel eşyalarını başkalarıyla paylaşmaktan çekindiğini, insanlara yük olmaktan korktuğunu söylemiştir. Sonuç olarak, derin duygularını paylaşabileceği kimsesinin olmadığını ifade etmiştir. İş performansından genel olarak memnun olduğunu ancak son zamanlarda çalışırken konsantrasyonunu sürdürmekte zorlandığını belirtmiştir. Haftada ortalama bir gün içki içtiğini, bu süreçte dört ila beş saat boyunca yaklaşık üç bira tükettiğini söylemiştir. Akrabaları arasında babasının alkolik olduğu söylenmektedir. Deniz, duygusal veya fiziksel olarak hiçbir zaman tacize uğramadığını belirtmiştir.
---	---

Babasının kendisine ve iki küçük kız kardeşine destek olduğunu da eklemiştir. Babasıyla genel olarak iyi bir ilişkisi olduğunu ancak alkol almasa çok daha iyi olacağını düşündüğünü ifade etmiş, bu konuyu babasına sarhoşken dile getirdiğinde ise babasının öfkesiyle karşılaştığını eklemiştir. Deniz’in annesi ise son altı yıldır depresyon tedavisi görmektedir. Deniz, gelmeden önce psikolojik sıkıntılarını azaltmak için sertifikalı bir yaşam koçundan bir yıl boyunca destek almayı denemiştir. Bu yaşam koçu ona, her sabah meditasyon yapmasını, olumsuz düşüncelerden uzak durmasını ve kendisini iyi hissettiren şeylerle meşgul olmasını önermiştir. Yaşam koçu ile bu süreçte düzenli olarak görüştüğünü de belirtmiştir.	Babasının kendisine ve iki küçük kız kardeşine destek olduğunu da eklemiştir. Babasıyla genel olarak iyi bir ilişkisi olduğunu ancak alkol almasa çok daha iyi olacağını düşündüğünü ifade etmiş, bu konuyu babasına sarhoşken dile getirdiğinde ise babasının öfkesiyle karşılaştığını eklemiştir. Deniz’in annesi ise son altı yıldır depresyon tedavisi görmektedir.
Danışan öyküsünü okudunuz. Şimdi, bellek görevi ve mesleki yaklaşım anketine geçeceğiz. Bu bölümler, dikkatli düşünmenizi ve kendi yorumunuzu belirtmenizi gerektirecektir. Eğer hazır değilseniz önceki bölüme dönüp danışan öyküsünü tekrar gözden geçirebilirsiniz. Devam etmek için aşağıdaki “Bir sonraki adıma geç” butonuna tıklayabilirsiniz. ○ Danışan öyküsüne geri dön ○ Bir sonraki adıma geç	
Bellek Görevi ve Mesleki Yaklaşım Anketi Şimdi, az önce okuduğunuz danışan öyküsü ile ilgili bazı sorulara yanıt vermeniz istenecektir. Bu sorular, hem metinde yer alan bilgileri ne ölçüde hatırladığınızı hem de danışan hakkındaki genel izlenimlerinizi değerlendirmeyi	

amaçlamaktadır. Lütfen her soruyu dikkatlice okuyarak kendi değerlendirmenize göre cevaplayınız. Unutmayınız, doğru ya da yanlış cevaplar yoktur; önemli olan kendi profesyonel yargınızı kullanmanızdır.

Deniz'in daha önce psikolojik sıkıntılarını azaltmak için denediği yöntemlerden ne düzeyde fayda gördüğünü düşünüyorsunuz?

1 Hiç fayda görmemiştir – 7 Çok fayda görmüştür

Lütfen aşağıdaki seçeneklerden okuduğunuz metin içinde geçtiğini düşündüğünüz ifadeleri işaretleyiniz.

- ☐ Otizm
- ☐ Kuantum
- ☐ Tourette Sendromu
- ☐ Asperger
- ☐ Hipokrat
- ☐ Depresyon
- ☐ Kişisel eşyalar

1. Genel Rahatsızlık Düzeyi

Lütfen Deniz'in genel rahatsızlık düzeyini derecelendiriniz.

1 (Hiç rahatsız değil) - 7 (Yüksek Düzeyde Rahatsız)

2. Müdahalenin Aciliyeti

Lütfen Deniz için gereken müdahalenin aciliyetini derecelendiriniz.

1 (Hiç acil değil) – 7 (Çok acil)

3. Psikoterapi Seans Sayısı

Lütfen Deniz'in ihtiyaç duyacağı tahmini psikoterapi seansı sayısını seçiniz.

- ☐ 1-6
- ☐ 7-12
- ☐ 13-18
- ☐ 19-24
- ☐ 25-30

- 31-36
- 36 ve üstü

4. Rahatsızlığın seyri

Lütfen Deniz'in terapi sürecinin tamamlanmasından sonraki muhtemel rahatsızlık seyrini derecelendiriniz.

1 (İyileşmiş) - 7 (Ağır devam eden)

5. Farmakoterapi desteği

Lütfen Deniz'in psikoterapiye ek olarak farmakoterapi desteğine ne düzeyde ihtiyaç duyduğunu derecelendiriniz.

1 (Düşük ihtiyaç) - 7 (Yüksek ihtiyaç)

6. İçgörü

Lütfen Deniz'in sahip olduğu içgörüyü derecelendiriniz.

1 (Düşük içgörü) - 7 (Yüksek içgörü)

7. Ego gücü

Lütfen Deniz'in sahip olduğu ego gücünü (hayal kırıklığı, engellenme gibi acı veren duyguları taşıyabilme yetisi) derecelendiriniz.

1 (Düşük ego gücü) - 7 (Yüksek ego gücü)

İnsan Psikolojisine Dair Görüşler Anketi

Aşağıda bir kısa süreli bellek sorusu ve insan psikolojisinin doğasına dair görüşlerinizi içeren bir dizi soru bulunmaktadır. Bu bölümün ardından geriye doldurmanız gereken sadece birkaç sorudan oluşan demografik bilgi formu kalacak.

Lütfen aşağıdaki seçeneklerden okuduğunuz metin içinde geçtiğini düşündüğünüz ifadeleri işaretleyiniz.

- ☐ Zaman zaman iyi hissetmek için kısa yürüyüşler yaptığını da eklemiştir.

- ☐ Deniz, babasının kendisini hiçbir zaman desteklemediğini söylemiştir.
- ☐ Deniz, gece uykularının genellikle kesintisiz sürdüğünü ifade etmiştir.
- ☐ Deniz, düşüncelerini odaklamakta zorlanmadığını belirtmiştir.
- ☐ Deniz, annesinin alkol problemi olduğunu ifade etmiştir.

1. Bireylerin yaşadığı psikolojik stresin kaynağı çoğunlukla biyolojik/kalıtımsaldır.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

2. Bireylerin yaşadığı psikolojik stresin kaynağı çoğunlukla bağlamsaldır (içinde bulunduğu mevcut çevresel koşullara bağlıdır).

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

3. Bireylerin yaşadığı psikolojik stresin kaynağı, tanı sistemlerinde yer alan bir psikopatolojiye sahip olmalarıdır.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

4. Bireylerin yaşadığı psikolojik stresler, toplumsal düzenin korunması açısından öncelikli olarak ruh sağlığı uzmanları tarafından ele alınmalıdır.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

5. Ruh sağlığı alanı, bireylerin toplumsal kurallara uygun davranmalarını sağlamak için düzenleyici bir rol üstlenmelidir.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

6. Psikolojik destek süreçlerinde karar verme yetkisi bireyin inisiyatifinden çok, ruh sağlığı alanının yönlendirmesiyle şekillenmelidir.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

7. Ruh sağlığı alanı, bireylerin hangi davranış ve düşüncelerinin normal ya da anormal olarak tanımlanacağında etkin bir rol oynamalıdır.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

8. Ruh saęlıęı alanı, toplumda hangi davranıřların saęlıklı kabul edilmesi gerektięini belirlemelidir.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

9. řiddet, saldırganlık gibi toplumsal kuralları ihlal eden davranıřların psikiyatrik bir durumla açıklanması, bu kiřilerin cezalandırılmak yerine tedavi edilmesini saęlar.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

Meslek ve Mesleki Kurumsallařma

Bu bölümde Türkiye'deki meslekler ve kurumsallařmayla ilgili genel düşüncelerinize yönelik sorular yer almaktadır. Lütfen bu ifadelere ne düzeyde katıldığınızı derecelendiriniz.

1. Toplumda bazı meslek grupları elbette dięerlerinden daha alt konumdadır.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

2. Bazı meslek gruplarının toplumdaki konumlarının deęiřmemesi, düzenin korunması açısından önemlidir.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

3. İdeal bir toplumda, bazı meslek gruplarının daha üst konumda, bazılarının ise daha alt seviyede yer alır.

1 (Hiç katılmıyorum) - 7 (Kesinlikle katılıyorum)

Demografik Bilgi Formu

Son olarak, bu formda çalışmanın analiz sürecine katkı saęlaması amacıyla sizden bazı temel demografik bilgiler talep edilecek ve araştırma sonlanacaktır.

Yaşınız

Cinsiyetiniz

- ☐ Erkek
- ☐ Kadın
- ☐ Diğer _____

Sosyoekonomik düzeyiniz

1(En düşük) – 5 (En yüksek)

Aldığınız en yüksek dereceli eğitimin düzeyini belirtiniz.

- ☐ Lisans (Öğrenci)
- ☐ Lisans
- ☐ Yüksek Lisans
- ☐ Tıpta uzmanlık
- ☐ Doktora

Aldığınız en yüksek dereceli eğitimin alanını belirtiniz.

- ☐ Psikolojik Danışmanlık (Lisans)
- ☐ Psikoloji (Lisans)
- ☐ Ruh Sağlığı ve Hastalıkları Uzmanlığı
- ☐ Klinik Psikoloji
- ☐ Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları Uzmanlığı
- ☐ Diğer Psikoloji Alanları (Sosyal, Bilişsel, Deneysel, Gelişim, Nöropsikoloji vs.)
- ☐ Diğer PDR Alanları
- ☐ Tıp
- ☐ Diğer _____

Tercih ettiğiniz veya kendinizi yakın hissettiğiniz kuramsal terapi yöntemini yazınız.

- Bilişsel Davranışçı Ekol (Maruz bırakma, Şema terapi, Mindfulness)
- Psikanalitik ve Psikodinamik Ekol
- Hümanistik Ekol (Varoluşçu, pozitif, duygu-odaklı, kişi-odaklı ve Gestalt terapi)
- Eklektik Yaklaşım
- Diğer _____

Psikoterapistlik tecrübenizi yıl olarak aşağıya yazınız. (Eğer 1 yıldan az ise 1 değeri girebilirsiniz)

Zaman ayırdığınız için teşekkür ederiz.

Araştırmamıza katılmamayı tercih ettiğiniz için herhangi bir işlem yapmanız gerekmemektedir.

Dilerseniz bu sayfayı kapatabilir veya araştırmanın yürütücüsü Mehmet Ali Sevim (xxxx) ile iletişime geçebilirsiniz.

Zaman ayırdığınız için teşekkür ederiz.

Bu araştırma yalnızca belirli bir akademik ve mesleki geçmişe sahip katılımcılarla yürütülmektedir. Yanıtınız, çalışma kapsamına uygun olmadığınızı göstermektedir.

Araştırma ilgili herhangi bir sorunuz olması halinde dilerseniz araştırmanın yürütücüsü Mehmet Ali Sevim (xxxx) ile iletişime geçebilirsiniz.

Katkı sağlamak için ayırdığınız zaman ve ilginiz için teşekkür ederiz.

Katılımınız için teşekkür ederiz.

Bu çalışmaya zaman ayırarak, araştırma sürecine ve bilimsel bilgi birikimine katkı sundunuz.

Yanıtlarınız, yalnızca akademik düzeyde değil, aynı zamanda alandaki uygulama pratiklerine dair önemli fikirler elde edilmesine de yardımcı olacaktır.

Deney Sonrası Bilgilendirme Formu

Değerli katılımcı,

Araştırmamıza katıldığınız için teşekkür ederiz. Bu çalışma, psikoterapistlerin sosyal baskınlık yöneliminin aşırı patolojize etme davranışına etkisini incelenmek amacıyla tasarlanmıştır. Çalışmanın amacı hakkında başlangıçta size kısıtlı bilgi sunduğumuz için üzgünüz.

Yapılan çalışmanın gerçek amacını size en başta söylemenin sizi yönlendirebileceğini ve sonuçlara olumsuz etki edeceğini düşündüğümüz için çalışmanın gerçek amacını sizden gizledik. Çalışmanın gerçek amacını sizden gizlememizin sizi rahatsız etmediğini ve araştırmamıza sunmuş olduğunuz katkıyı sürdürmeye devam etmek istediğinizi umuyoruz.

Eğer verdiğiniz yanıtların analiz sürecine dahil edilmesini istemiyorsanız aşağıda belirtilen link aracılığıyla yanıtlarınızın araştırmanın veri setinden çıkarılmasını sağlayabilirsiniz. Bu durumda size herhangi bir soru ya da neden sunmanız istenmeyecek, verileriniz imha edilecek ve kayıt altına alınmayacaktır.

Şu anda desteğinizi sunmuş olsanız bile daha sonraki zamanlarda bu durumun sizi rahatsız ettiğini düşünüyor veya bununla ilgili olumsuz duygular hissediyor olursanız size destek olmak için elimizden geleni yapacağımızı bildirmek isteriz. Gelecekte sizi bu deneyle ilgili rahatsız eden bir şey olduğunu düşündüğünüzde

ltfen bizlerle, Mehmet Ali Sevim (xxxx) veya Do. Dr. Ahmet oymak ile (xxxx) iletiřime gemekten ekinmeyiniz. Ayrıca olası rahatsızlıđınızı Abdullah Gl niversitesi etik kurula xxxx dilediđiniz zaman iletebileceđinizi de bildirmek isteriz. Bu durumla ilgili daha fazla destek almak iin ařađıda iletiřim bilgileri sunulan AG Psikolojik Danıřma ve Rehberlik Ofisine de dilediđiniz zaman destek alabileceđinizi de belirtmek isteriz.



7.4. APPENDIX 4: The English Version of the Materials and Measures

Informed Consent Form

Principal Investigator:

Mehmet Ali Sevim (xxxx), Abdullah Gül University, Department of Data Science

Advisor:

Assoc. Prof. Ahmet Çoyamak (xxxx), Abdullah Gül University, Department of Psychology

Research Information:

This study is conducted by Mehmet Ali Sevim, a master's student in Data Science at Abdullah Gül University, under the supervision of Assoc. Prof. Ahmet Çoyamak, as part of his master's thesis. This form has been prepared to inform you about the conditions of the study.

Purpose of the Study:

This study aims to examine the mediating role of short-term memory processes in the relationship between mental health professionals' approaches to occupational situations and their views on human psychology.

Eligibility Criteria:

The following groups are eligible to participate in this study:

- Undergraduate students in Psychology or Guidance and Psychological Counseling (GPC) who have taken at least one of the following courses: Psychopathology, Clinical Psychology, or Clinical Interview
- Psychologists and psychological counselors
- Medical Specialists in Mental Health and Diseases (psychiatrists)

- Residents in Mental Health and Diseases (psychiatry residents)
- Medical Specialists in Child and Adolescent Mental Health and Diseases (child and adolescent psychiatrists)
- Residents in Child and Adolescent Mental Health and Diseases (child and adolescent psychiatry residents)

Participant Tasks:

If you agree to participate, you will be asked to complete a reading task, two questionnaires, and a demographic information form. Please read the provided information and the instructions at the beginning of each scale carefully and mark the answers that best represent your views. Participation is entirely voluntary. You may refuse to participate or withdraw from the study at any time without penalty.

Duration:

The study has no time limit and is expected to take approximately 5 minutes.

Confidentiality:

No personally identifying information will be requested. The information you provide will be stored anonymously and combined with the responses of other participants for analysis. Your data will be used solely for scientific purposes and may be shared on open-access platforms (e.g., OSF) in accordance with Open Science ethical principles, but always in a way that ensures anonymity.

Risks:

No details expected to cause personal discomfort are anticipated in this study. However, if you feel uncomfortable for any reason during participation, you may withdraw from the study at any time, contact us using the information above, or reach out to the ethics committee at xxxx.

By selecting “I agree to participate,” you confirm that you have read the Information and Voluntary Participation Form, that you understand the purpose of this research and how your responses will be used and stored, and that you know participation is voluntary and you may withdraw without giving a reason.

- ☐ I agree to participate.
- ☐ I do not agree to participate.

To ensure you have read and understood the consent form, please fill in the blank: “There is no time limit for the study, and it is expected to take approximately ____ minutes.”

Only participants with a specific academic and professional background are eligible to participate in this study. We are asking the following question to determine your eligibility for the study.

Which of the following titles best describes you?

- ☐ Undergraduate student in GPC (completed at least one of: Psychopathology, Clinical Psychology, or Clinical Interview)
- ☐ Undergraduate student in Psychology (completed at least one of: Psychopathology, Clinical Psychology, or Clinical Interview)
- ☐ Psychological Counselor
- ☐ Psychologist
- ☐ Specialist Psychologist (Master’s or PhD in other fields of psychology excluding clinical psychology)
- ☐ Specialist Psychological Counselor (Master’s or PhD in GPC)
- ☐ Specialist Clinical Psychologist (Master’s or PhD in Clinical Psychology)
- ☐ Specialist in Mental Health and Diseases (Psychiatrist)
- ☐ Resident in Mental Health and Diseases (Psychiatry Resident)
- ☐ Specialist in Child and Adolescent Mental Health and Diseases (Child and Adolescent Psychiatrist)
- ☐ Resident in Child and Adolescent Mental Health and Diseases (Child and Adolescent Psychiatry Resident)
- ☐ None of the above

In this section, the relationship between short-term memory and client history will be measured. Therefore, you will read an example of a client history that might be encountered in professional practice.

Please read the text carefully and then answer the questions using your professional judgment. There is no need to take notes before or after reading the text. Questions will be answered based on the information and overall impressions you retained during the reading. We wish you continued success.

Vignette

Vignette A (Experimental Condition)

Deniz stated that he felt tense and irritable upon arrival. He mentioned experiencing depressive moods lasting several hours during the day, having difficulty concentrating, and struggling to adapt to his work. He reported being unable to focus his thoughts, sometimes feeling nauseous, and having recurring thoughts that did not center on any particular topic and varied in content. He expressed feeling anxiety in many areas of life, noting that his anxiety increased especially at night. Deniz also stated that he had difficulty falling asleep and that his sleep lasted a few hours at most. He added that he occasionally took short walks to feel better.

During therapy, he jokingly wondered whether he might have Tourette's Syndrome. He mentioned sometimes experiencing unusual urges, such as pulling a strand of hair from

Vignette B (Control Condition)

Deniz stated that he felt tense and irritable upon arrival. He mentioned experiencing depressive moods lasting several hours during the day, having difficulty concentrating, and struggling to adapt to his work. He reported being unable to focus his thoughts, sometimes feeling nauseous, and having recurring thoughts that did not center on any particular topic and varied in content. He expressed feeling anxiety in many areas of life, noting that his anxiety increased especially at night. Deniz also stated that he had difficulty falling asleep and that his sleep lasted a few hours at most. He added that he occasionally took short walks to feel better.

During therapy, he jokingly wondered whether he might have Tourette's Syndrome. He mentioned sometimes experiencing unusual urges, such as pulling a strand of hair from

someone nearby, but that he could resist these urges. Deniz said he was able to socialize but had very few close friends. He expressed reluctance to share his personal belongings with others and a fear of being a burden to people. As a result, he stated that he had no one with whom he could share his deep feelings. He reported being generally satisfied with his work performance but recently struggled to maintain concentration. He stated that he drank alcohol about one day a week, during which he consumed around three beers over a four-to-five-hour period. Among his relatives, it is said that his father has alcoholism. Deniz stated that he had never experienced emotional or physical abuse. He added that his father supported him and his two younger sisters. While he generally had a good relationship with his father, he thought it would be much better if his father did not drink alcohol. He mentioned that when he brought up this issue to his father while his father was	someone nearby, but that he could resist these urges. Deniz said he was able to socialize but had very few close friends. He expressed reluctance to share his personal belongings with others and a fear of being a burden to people. As a result, he stated that he had no one with whom he could share his deep feelings. He reported being generally satisfied with his work performance but recently struggled to maintain concentration. He stated that he drank alcohol about one day a week, during which he consumed around three beers over a four-to-five-hour period. Among his relatives, it is said that his father has alcoholism. Deniz stated that he had never experienced emotional or physical abuse. He added that his father supported him and his two younger sisters. While he generally had a good relationship with his father, he thought it would be much better if his father did not drink alcohol. He mentioned that when he brought up this issue to his father while his father was
--	--

drunk, he was met with anger. Deniz's mother has been receiving treatment for depression for the past six years. Before coming, Deniz tried to alleviate his psychological distress by receiving support from a certified life coach for a year. This life coach advised him to meditate every morning, avoid negative thoughts, and engage in activities that made him feel good. Deniz stated that he met with the life coach regularly during this process.	drunk, he was met with anger. Deniz's mother has been receiving treatment for depression for the past six years.
You've read the client's story. Now, we'll move on to the memory task and the professional approach questionnaire. These sections will require careful thought and your own interpretation. If you're not ready, you can return to the previous section and review the client's story. Click the "Continue to the next step" button below to continue. ○ Return to vignette ○ Next step	
Memory Task and Professional Approach Questionnaire You will now be asked to answer some questions about the client's story you just read. These questions are intended to assess both your recall of the information in the text and your overall impression of the client. Please read each question carefully and answer based on your own assessment. Remember, there are no right or wrong answers; the important thing is to use your own professional judgment. To what extent do you think Deniz benefited from the methods she previously tried to reduce her psychological distress?	

1 (No benefit) – 7 (Many benefit)

Please tick the expressions you think are in the text you read from the options below.

- ☐ Autism
- ☐ Quantum
- ☐ Tourette's syndrome
- ☐ Asperger
- ☐ Hippocrate
- ☐ Depression
- ☐ Belongings

1. Severity

Please rate the distress severity of Deniz.

1 (Low severity) - 7 (High severity)

2. Urgency

Please rate the urgency of the intervention required for Deniz.

1 (Not urgent at all) – 7 (Extremely urgent)

3. Session Number

Please select the estimated number of psychotherapy sessions Deniz will need.

- ☐ 1-6
- ☐ 7-12
- ☐ 13-18
- ☐ 19-24
- ☐ 25-30
- ☐ 31-36
- ☐ 36 and above

4. Prognosis

Please rate the likely course of Deniz's psychological distress after the completion of therapy.

1 (Recovered) - 7 (Severe ongoing)

5. Pharmacotherapy Support

Please rate the extent to which Deniz would need pharmacotherapy in addition to psychotherapy.

1 (Low need) - 7 (High need)

6. Insight

Please rate the level of Deniz's insight.

1 (Low insight) - 7 (High insight)

7. Ego Strength

Please rate Deniz's ego strength (the ability to tolerate distressing emotions such as frustration or feeling blocked).

1 (Low ego strength) - 7 (High ego strength)

Human Psychology Beliefs Questionnaire

Below is a short-term memory question followed by a series of questions regarding your views on the nature of human psychology. After this section, only a few demographic questions will remain for you to complete.

Please check the statements you believe appeared in the text you have read.

- ☐ He also mentioned occasionally taking short walks to feel better.
- ☐ Deniz said that his father had never supported him.
- ☐ Deniz stated that his night sleep was generally uninterrupted.
- ☐ Deniz stated that he did not have difficulty focusing his thoughts.
- ☐ Deniz stated that his mother had an alcohol problem.

1. The source of psychological distress experienced by individuals is mostly biological/genetic.
1 (Strongly disagree) - 7 (Strongly agree)
2. The source of psychological distress experienced by individuals is mostly contextual (depending on current conditions).
1 (Strongly disagree) - 7 (Strongly agree)
3. The source of psychological distress experienced by individuals is having a psychopathology listed in diagnostic systems.
1 (Strongly disagree) - 7 (Strongly agree)
4. Psychological distress should primarily be addressed by mental health professionals in order to maintain social order.
1 (Strongly disagree) - 7 (Strongly agree)
5. The mental health field should play a regulatory role in ensuring individuals comply with social rules.
1 (Strongly disagree) - 7 (Strongly agree)
6. Decision-making authority in psychological support processes should be shaped more by the mental health field than by the individual's own initiative.
1 (Strongly disagree) - 7 (Strongly agree)
7. The mental health field should play an active role in determining which behaviors and thoughts are considered normal or abnormal.
1 (Strongly disagree) - 7 (Strongly agree)
8. The mental health field should determine which behaviors are considered healthy in society.
1 (Strongly disagree) - 7 (Strongly agree)

9. Explaining socially unacceptable behaviors such as violence and aggression as psychiatric conditions ensures that such individuals are treated instead of punished.

1 (Strongly disagree) - 7 (Strongly agree)

Profession and Professional Institutionalization

This section contains questions about your general thoughts on professions and institutionalization in Türkiye. Please rate your level of agreement with these statements.

- 1 Certainly, some professional groups in society are in a lower position than others.

1 (Strongly disagree) - 7 (Strongly agree)

- 2 It is important for the preservation of order that the positions of some professional groups in society do not change.

1 (Strongly disagree) - 7 (Strongly agree)

- 3 In an ideal society, some occupational groups would be at a higher level and some at a lower level.

1 (Strongly disagree) - 7 (Strongly agree)

Demographic Information Form

Finally, in this form, you will be asked to provide some basic demographic information to contribute to the analysis process of the study. After this, the study will be completed.

Age

Gender

- ☐ Male
- ☐ Female
- ☐ Other _____

Socioeconomic level

1(Low) – 5 (High)

Please indicate the field of your highest degree

- ☐ Bachelor's (Student)
- ☐ Bachelor's
- ☐ Master's
- ☐ Medical Specialty
- ☐ Doctorate

Please indicate the field of your highest degree:

- ☐ Guidance and Psychological Counseling (Bachelor's)
- ☐ Psychology (Bachelor's)
- ☐ Mental Health and Diseases Specialty
- ☐ Clinical Psychology
- ☐ Child and Adolescent Mental Health and Diseases Specialty
- ☐ Other Psychology Fields (Social, Cognitive, Experimental, Developmental, Neuropsychology, etc.)
- ☐ Other GPC Fields
- ☐ Medicine
- ☐ Other _____

Please indicate your preferred or most closely aligned therapeutic approach.

- Cognitive Behavioral Approach (Exposure, Schema Therapy, Mindfulness)
- Psychoanalytic and Psychodynamic Approach
- Humanistic Approach (Existential, Positive, Emotion-Focused, Person-Centered, Gestalt)
- Eclectic Approach
- Other _____

Years of experience as a psychotherapist (Enter “1” if less than one year)

Thank you for your time.

Since you have chosen not to participate in our research, no further action is required on your part.

You may close this page or, if you wish, contact the principal investigator, Mehmet Ali Sevim (xxxx).

Thank you for your time.

This research is conducted only with participants who have a specific academic and professional background. Your response indicates that you do not meet the eligibility criteria for this study.

If you have any questions regarding the research, you may contact the principal investigator, Mehmet Ali Sevim (xxxx).

Thank you for the time and interest you have devoted to contributing.

Thank you for your participation.

By taking the time to engage in this study, you have contributed to the research process and to the accumulation of scientific knowledge.

Your responses will help generate valuable insights not only at the academic level but also for practical applications in the field.

Post-Experiment Debriefing Form

Dear Participant,

Thank you for taking part in our research. This study was designed to examine the effect of psychotherapists' social dominance orientation on their tendency to overpathologizing. We apologize for providing you with limited information about the purpose of the study at the outset.

We withheld the true purpose of the study at the beginning because we believed that revealing it might influence your responses and negatively affect the results. We hope that concealing the true purpose did not cause you any discomfort and that you wish to continue contributing your data to our research.

If you do not want your responses to be included in the analysis, you may request the removal of your data from the dataset through the link provided below. In this case, you will not be asked for any explanation, your data will be destroyed, and no record will be kept.

Even if you are currently willing to contribute, if at any point in the future you feel uncomfortable about your participation or experience negative feelings related to it, please know that we will do our best to support you. Should you have any concerns about this experiment in the future, please feel free to contact Mehmet Ali Sevim (xxxx) or Assoc. Prof. Ahmet Çoymak (xxxx). You may also contact the Abdullah Gül University Ethics Committee at xxxx at any time.

If you wish to receive further support on this matter, please note that you may also contact the AGU Psychological Counseling and Guidance Office at any time, using the details provided below:

For support applications: xxxx



7.5. APPENDIX 5: AI Transparency Statement

In line with Abdullah Gül University's Artificial Intelligence (AI) Policy, generative AI tools were selectively used to support the writing process of this thesis. Specifically, I used OpenAI's (2024) ChatGPT (GPT-4o) for improving the clarity, coherence, and academic tone of English-language text; Elicit (Ought, 2025) for identifying relevant academic sources during the literature review process. These tools were employed solely to enhance the linguistic quality and accessibility of the written content. They were not used for generating scientific content, formulating hypotheses, analyzing data, or interpreting results. All theoretical reasoning, methodological decisions, and analytical interpretations remain the sole responsibility of the author. This statement is provided in accordance with the AGU AI Policy to ensure transparency and uphold ethical academic standards.

7.6. APPENDIX 6: Data Transparency

This statement is made in accordance with open science principles to ensure transparency, reproducibility, and ethical data sharing. The thesis comprises two empirical studies that rely on distinct forms of data and analytical procedures. Study 1 involved the collection and computational classification of organically occurring client complaints, while Study 2 employed an online experimental design with self-report measures. The details of each study's data collection and analysis process are described in their respective method sections of Study 1 and Study 2.

For Study 1, publicly available client complaints were extracted from Şikayetvar.com platform using Python-based tools (Selenium, BeautifulSoup, Pandas). Duplicates and irrelevant pages (e.g., firm profiles) were removed during preprocessing. Complaints were then classified using a prompt-based zero-shot method with Llama 4 Maverick (Meta AI, 2025), an open-source large language model. Due to copyright restrictions, the full texts of the complaints cannot be made publicly available. However, anonymized metadata, classification outputs, and thematic labels uploaded to the Open Science Framework (OSF) repository.

For Study 2, data were collected via an online survey hosted on Google Forms. The survey included a vignette-based manipulation, scales (e.g., MBS, ATPQ, SDO-E), and a demographic form. All responses were collected anonymously, and no personally identifiable information was requested at any stage of the study. Statistical analyses, including reliability testing, exploratory factor analysis, and mediation modeling, were conducted using Jamovi (2024), an open-source statistical software built on the R environment.

All anonymized datasets, survey materials, classification outputs, and analysis-related files have been uploaded to the OSF project created for this thesis. The repository is publicly available and can be accessed via the link below:

OSF project link: <https://osf.io/np48r/>



8. REFERENCES

- [1] Aaron, D. (2012). *Therapists' experiences of therapeutic mistakes*. [Doctoral Dissertation, University of Leeds]. <https://etheses.whiterose.ac.uk/id/eprint/2923/>
- [2] Aguinis, H., & Bradley, K. J. (2014). Best practice recommendations for designing and implementing experimental vignette methodology studies. *Organizational research methods*, 17(4), 351-371. <https://doi.org/10.1177/1094428114547952>
- [3] Auster, C. J., & Ohm, S. C. (2000). Masculinity and femininity in contemporary American society: A reevaluation using the Bem Sex-Role Inventory. *Sex roles*, 43(7), 499-528. <https://doi.org/10.1023/A:1007119516728>
- [4] Bargh, J. A., & Chartrand, T. L. (2000). The mind in the middle: A practical guide to priming and automaticity research. *Handbook of research methods in social and personality psychology*, 2000, 253-285.
- [5] Barker, K., & Galardi, T. R. (2015). Diagnostic domain defense: Autism spectrum disorder and the DSM-5. *Social Problems*, 62(1), 120-140. <https://doi.org/10.1093/socpro/spu001>
- [6] Beaton, D. E., Bombardier, C., Guillemin, F., & Ferraz, M. B. (2000). Guidelines for the process of cross-cultural adaptation of self-report measures. *Spine*, 25(24), 3186-3191. <https://doi.org/10.1097/00007632-200012150-00014>
- [7] Bentler, P. M., & Bonett, D. G. (1980). Significance tests and goodness of fit in the analysis of covariance structures. *Psychological bulletin*, 88(3), 588. <https://doi.org/10.1037/0033-2909.88.3.588>
- [8] Billieux, J., Schimmenti, A., Khazaal, Y., Maurage, P., & Heeren, A. (2015). Are we overpathologizing everyday life? A tenable blueprint for behavioral addiction research. *Journal of behavioral addictions*, 4(3), 119-123. <https://doi.org/10.1556/2006.4.2015.009>
- [9] Birnbaum, M. H. (2004). Human research and data collection via the Internet. *Annu. Rev. Psychol.*, 55(1), 803-832. <https://doi.org/10.1146/annurev.psych.55.090902.141601>
- [10] Blanchard, M., & Farber, B. A. (2020). "It is never okay to talk about suicide": patients' reasons for concealing suicidal ideation in psychotherapy. *Psychotherapy Research*, 30(1), 124-136. <https://doi.org/10.1080/10503307.2018.1543977>
- [11] Blanco, C., & Surman, C. B. (2024). Diagnosing and treating ADHD in adults: balancing individual benefits and population risks. *JAMA psychiatry*, 81(12), 1169-1170. <https://doi.org/10.1001/jamapsychiatry.2024.3228>

- [12] Brown, C. (2007). Situating knowledge and power in the therapeutic alliance. *Narrative therapy: Making meaning, making lives*, 3-22. <https://doi.org/10.4135/9781452225869>
- [13] Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quinonez, H. R., & Young, S. L. (2018). Best practices for developing and validating scales for health, social, and behavioral research: a primer. *Frontiers in public health*, 6, 149. <https://doi.org/10.3389/fpubh.2018.00149>
- [14] Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 83–111). American Psychological Association. <https://doi.org/10.1037/12075-003>.
- [15] Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. *The Annals of Family Medicine*, 2(6), 576-582. <https://doi.org/10.1370/afm.245>
- [16] Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosenkrantz, P. S., & Vogel, S. R. (1970). Sex-role stereotypes and clinical judgments of mental health. *Journal of Consulting and Clinical Psychology*, 34(1), 1–7. <https://doi.org/10.1037/h0028797>
- [17] Brubaker, S. J. (2007). Denied, embracing, and resisting medicalization: African American teen mothers' perceptions of formal pregnancy and childbirth care. *Gender & Society*, 21(4), 528-552. <https://doi.org/10.1177/0891243207304972>
- [18] Bryant, R. A. (2013). Is pathological grief lasting more than 12 months grief or depression?. *Current opinion in psychiatry*, 26(1), 41-46. <https://doi.org/10.1097/YCO.0b013e32835b2ca2>
- [19] Chapman, L. J., & Chapman, J. P. (1969). Illusory correlation as an obstacle to the use of valid psychodiagnostic signs. *Journal of abnormal psychology*, 74(3), 271-272. <https://doi.org/10.1037/h0027592>
- [20] Clarke, A. E., & Shim, J. (2010). Medicalization and biomedicalization revisited: technoscience and transformations of health, illness and American medicine. In *Handbook of the sociology of health, illness, and healing: A blueprint for the 21st century* (pp. 173-199). Springer New York. https://doi.org/10.1007/978-1-4419-7261-3_10
- [21] Cohen, J. (2013). *Statistical power analysis for the behavioral sciences*. Routledge. <https://doi.org/10.4324/9780203771587>
- [22] Collins, K. M. T., Onwuegbuzie, A. J., & Jiao, Q. G. (2006). Prevalence of mixed-methods sampling designs in social science research. *Evaluation & Research in Education*, 19(2), 83–101. <https://doi.org/10.2167/eri421.0>
- [23] Comas-Díaz, L., & Brown, L. S. (2016). Multicultural theories. In J. C. Norcross, G. R. VandenBos, D. K. Freedheim, & B. O. Olatunji (Eds.), *APA handbook*

of clinical psychology: Theory and research (pp. 241–272). American Psychological Association. <https://doi.org/10.1037/14773-009>

[24] Conrad, P. (1992). Medicalization and social control. *Annual review of Sociology*, 18(1), 209-232. <https://doi.org/10.1146/annurev.so.18.080192.001233>

[25] Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders* (Vol. 14, p. 204). Johns Hopkins University Press. <https://doi.org/10.1400/93208>

[26] Conrad, P. (2013). Medicalization: Changing contours, characteristics, and contexts. In *Medical sociology on the move: new directions in theory* (pp. 195-214). Springer Netherlands. https://doi.org/10.1007/978-94-007-6193-3_10

[27] Crosby, J. P., & Sprock, J. (2004). Effect of patient sex, clinician sex, and sex role on the diagnosis of antisocial personality disorder: Models of underpathologizing and overpathologizing biases. *Journal of clinical psychology*, 60(6), 583-604. <https://doi.org/10.1002/jclp.10235>

[28] Cumming, G. (2014). The new statistics: Why and how. *Psychological science*, 25(1), 7-29. <https://doi.org/10.1177/0956797613504966>

[29] Dawes, R. M., Faust, D., & Meehl, P. E. (1989). Clinical versus actuarial judgment. *Science*, 243(4899), 1668-1674. <https://doi.org/10.1126/science.2648573>

[30] De Varis, J. (1994). The dynamics of power in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 31(4), 588. <https://doi.org/10.1037/0033-3204.31.4.588>

[31] Dowling, J. F., & Graham, J. R. (1976). Illusory correlation and the MMPI. *Journal of Personality Assessment*, 40(5), 531-538. https://doi.org/10.1207/s15327752jpa4005_12

[32] Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral sciences*, 5(4), 565-575. <https://doi.org/10.3390/bs5040565>

[33] Duckitt, J., & Sibley, C. G. (2010). Personality, ideology, prejudice, and politics: A dual-process motivational model. *Journal of personality*, 78(6), 1861-1894. <https://doi.org/10.1111/j.1467-6494.2010.00672.x>

[34] Efron, B., & Tibshirani, R. J. (1993). *An introduction to the bootstrap*. Chapman & Hall/CRC. <https://doi.org/10.1201/9780429246593>

[35] Field, A., Miles, J., & Field, Z. (2012). *Discovering statistics using R*. Sage.

[36] Finch, J. (1987). The vignette technique in survey research. *Sociology*, 21(1), 105-114. <https://doi.org/10.1177/0038038587021001008>

[37] Findor, A. (2017). *Detecting and reducing intergroup bias: Using vignettes in experimental research*. Univerzita Komenského v Bratislave.

https://fses.uniba.sk/fileadmin/fsev/uesmv/dokumenty_2017_2018/Textbook_30_1.pdf

[38] Fors, M. (2021). *Power issues in psychotherapy: Reflections on psychoanalytic theory and clinical cases*. [Doctoral Dissertation, University of Oslo].

[39] Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972–1977* (C. Gordon, Ed.). Pantheon Books. (Original work published 1977)

[40] Franklin, D. L. (1985). Differential clinical assessments: The influence of class and race. *Social Service Review*, 59(1), 44-61. <https://doi.org/10.1086/644261>

[41] French, J. R., & Raven, B. (1959). The bases of social power. In D. Cartwright (Ed.), *Studies in social power* (pp. 150–167). University of Michigan, Institute for Social Research.

[42] Fritz, C. O., Morris, P. E., & Richler, J. J. (2012). Effect size estimates: Current use, calculations, and interpretation. *Journal of Experimental Psychology: General*, 141(1), 2-18. <https://doi.org/10.1037/a0024338>

[43] Gammell, D. J., & Stoppard, J. M. (1999). Women's experiences of treatment of depression: Medicalization or empowerment?. *Canadian Psychology/Psychologie canadienne*, 40(2), 112. <https://doi.org/10.1037/h0086831>

[44] Gerber, M. (2012). *A dual-process motivational model of punitive attitudes: The effects of right-wing authoritarianism and social dominance orientation on public punitiveness* [Doctoral dissertation, London School of Economics and Political Science].

[45] Ghasemi, A., & Zahediasl, S. (2012). Normality tests for statistical analysis: a guide for non-statisticians. *International journal of endocrinology and metabolism*, 10(2), 486. <https://doi.org/10.5812/ijem.3505>.

[46] Gonzalez, J. M., Alegría, M., Prihoda, T. J., Copeland, L. A., & Zeber, J. E. (2011). How the relationship of attitudes toward mental health treatment and service use differs by age, gender, ethnicity/race and education. *Social psychiatry and psychiatric epidemiology*, 46(1), 45–57. <https://doi.org/10.1007/s00127-009-0168-4>

[47] Gonzalez, L., & Nielsen, A. (2024). An integrative review of teaching strategies to support clinical judgment development in clinical education for nurses. *Nurse education today*, 133, 106047. <https://doi.org/10.1016/j.nedt.2023.106047>

[48] Gosling, S. D., Vazire, S., Srivastava, S., & John, O. P. (2004). Should we trust web-based studies? A comparative analysis of six preconceptions about internet questionnaires. *American psychologist*, 59(2), 93. <https://doi.org/10.1037/0003-066X.59.2.93>

[49] Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational evaluation and policy analysis*, 11(3), 255-274. <https://doi.org/10.3102/01623737011003255>.

- [50] Guimond, S., Dambrun, M., Michinov, N., & Duarte, S. (2003). Does social dominance generate prejudice? Integrating individual and contextual determinants of intergroup cognitions. *Journal of personality and social psychology*, 84(4), 697. <https://doi.org/10.1037/0022-3514.84.4.697>
- [51] Hauser, D. J., Ellsworth, P. C., & Gonzalez, R. (2018). Are manipulation checks necessary?. *Frontiers in psychology*, 9, 998. <https://doi.org/10.3389/fpsyg.2018.00998>
- [52] Haw, C., Collyer, J., & Sugarman, P. (2010). Patients' complaints at a large psychiatric hospital: can they lead to better patient services?. *International journal of health care quality assurance*, 23(4), 400-409. <https://doi.org/10.1108/09526861011037452>
- [53] Hayes, A. F. (2018). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach* (2nd ed.). Guilford Press.
- [54] Hieger, B. (2007). *The influence of diagnostic clarity and prejudicial attitudes on clinical judgment biases*. [Doctoral Dissertation, The Pennsylvania State University]
- [55] Hislop, J., & Arber, S. (2003). Understanding women's sleep management: beyond medicalization-healthicization?. *Sociology of health & illness*, 25(7), 815-837. <https://doi.org/10.1046/j.1467-9566.2003.00371.x>
- [56] Ho, A. K., Sidanius, J., Cuddy, A. J., & Banaji, M. R. (2013). Status boundary enforcement and the categorization of black-white biracials. *Journal of Experimental Social Psychology*, 49(5), 940-943. <https://doi.org/10.1016/j.jesp.2013.04.010>
- [57] Ho, A. K., Sidanius, J., Kteily, N., Sheehy-Skeffington, J., Pratto, F., Henkel, K. E., Foels, R., & Stewart, A. L. (2015). The nature of social dominance orientation: Theorizing and measuring preferences for intergroup inequality using the new SDO-7 scale. *Journal of personality and social psychology*, 109(6), 1003. <https://doi.org/10.1037/pspi0000033>
- [58] Ho, A. K., Sidanius, J., Pratto, F., Levin, S., Thomsen, L., Kteily, N., & Sheehy-Skeffington, J. (2012). Social dominance orientation: Revisiting the structure and function of a variable predicting social and political attitudes. *Personality and Social Psychology Bulletin*, 38(5), 583-606. <https://doi.org/10.1177/0146167211432765>
- [59] Horwitz, A. V. (2002). *Creating mental illness*. University of Chicago Press.
- [60] Huang, L. L., & Liu, J. H. (2005). Personality and social structural implications of the situational priming of social dominance orientation. *Personality and Individual Differences*, 38(2), 267-276. <https://doi.org/10.1016/j.paid.2004.04.006>
- [61] Hughes, R. (1998). Considering the vignette technique and its application to a study of drug injecting and HIV risk and safer behaviour. *Sociology of health & illness*, 20(3), 381-400. <https://doi.org/10.1111/1467-9566.00107>

- [62] Illich, I. (1975). The medicalization of life. *Journal of medical ethics*, 1(2), 73-77. <https://doi.org/10.1136/jme.1.2.73>
- [63] Jonas, A. D., & Jonas, D. F. (1975). An evolutionary context for schizophrenia. *Schizophrenia Bulletin*, 1(12), 33. <https://doi.org/10.1093/schbul/1.12.33>
- [64] Kaplan, A. G. (1979). Toward an analysis of sex-role related issues in the therapeutic relationship. *Psychiatry*, 42(2), 112-120. <https://doi.org/10.1080/00332747.1979.11024014>
- [65] Kaynak, B. D., Kaynak Malatyalı, M., & Hasta, D. (2021). Yeni sosyal baskınlık yönelimi ölçeği'nin (SBY7) türkçeye uyarlanması. *Studies in psychology*, 41(1), 301-330. <https://doi.org/10.26650/SP2020-0108>.
- [66] Krantz, J. H., & Dalal, R. (2000). *Validity of web-based psychological research. In psychological experiments on the internet*. Academic Press. <https://doi.org/10.1016/B978-012099980-4/50003-4>
- [67] Kuckartz, U., & Rädiker, S. (2024). Integrating artificial intelligence (ai) in qualitative content analysis. *Qualitative content analysis: Methods, practice and using software*. <https://qca-method.net/documents/Kuckartz-Raediker-2024-Integrating-AI-in-Qualitative-Content-Analysis.pdf>
- [68] Kugler, M. B., Cooper, J., & Nosek, B. A. (2010). Group-based dominance and opposition to equality correspond to different psychological motives. *Social Justice Research*, 23(2), 117-155. <https://doi.org/10.1007/s11211-010-0112-5>
- [69] Kvaale, E. P., Haslam, N., & Gottdiener, W. H. (2013). The 'side effects' of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. *Clinical psychology review*, 33(6), 782-794. <https://doi.org/10.1016/j.cpr.2013.06.002>
- [70] Lakeman, R. (2013). *Saving normal: an insider's revolt against out-of-control psychiatric diagnosis, dsm-5, big pharma, and the medicalization of ordinary life*. William Morrow. <https://doi.org/10.1080/17522439.2013.830642>
- [71] Lakens, D. (2022). Sample size justification. *Collabra: psychology*, 8(1), 33267. <https://doi.org/10.1525/collabra.33267>
- [72] Lampropoulos, D., & Apostolidis, T. (2018). Social dominance orientation and discrimination against people with schizophrenia: Evidence of medicalization and dangerousness beliefs as legitimizing myths. *The Spanish Journal of Psychology*, 21, E37. <https://doi.org/10.1017/sjp.2018.46>
- [73] Lee, E., & Bhuyan, R. (2013). Negotiating within whiteness in cross-cultural clinical encounters. *Social Service Review*, 87(1), 98-130. <https://doi.org/10.1086/669919>

- [74] Legha, R. K., & Miranda, J. (2020). An anti-racist approach to achieving mental health equity in clinical care. *Psychiatric Clinics*, 43(3), 451-469. <https://doi.org/10.1016/j.psc.2020.05.002>
- [75] Leventhal, H., Meyer, D., & Nerenz, D. (1980). The common sense model of illness danger. In S. Rachman (Ed.), *Medical Psychology* (Vol. 2, pp. 7–30). Pergamon.
- [76] Levin, S., Matthews, M., Guimond, S., Sidanius, J., Pratto, F., Kteily, N., & Dover, T. (2012). Assimilation, multiculturalism, and colorblindness: Mediated and moderated relationships between social dominance orientation and prejudice. *Journal of Experimental Social Psychology*, 48(1), 207-212. <https://doi.org/10.1016/j.jesp.2011.06.019>
- [77] Lilienfeld, S. O. (2017). Clinical psychological science: Then and now. *Clinical Psychological Science*, 5(1), 3-13. <https://doi.org/10.1177/2167702616673363>
- [78] Lindgren, A., & Rozental, A. (2022). Patients' experiences of malpractice in psychotherapy and psychological treatments: A qualitative study of filed complaints in Swedish healthcare. *Ethics & Behavior*, 32(7), 563-577. <https://doi.org/10.1080/10508422.2021.1948855>
- [79] López-Aybar, L., & Gonzales, L. (2024). Prosumers' experiences of witnessed discrimination and internalized stigma: A moderated mediation. *Psychological Services*, 21(4), 982–992. <https://doi.org/10.1037/ser0000837>
- [80] Lopez, S. R. (1989). Patient variable biases in clinical judgment: conceptual overview and methodological considerations. *Psychological Bulletin*, 106(2), 184. <https://doi.org/10.1037/0033-2909.106.2.184>
- [81] Lupton, D. (2012). *Medicine as culture: Illness, disease and the body*. Sage Publications
- [82] MacKinnon, D. P., Lockwood, C. M., & Williams, J. (2004). Confidence limits for the indirect effect: Distribution of the product and resampling methods. *Multivariate Behavioral Research*, 39(1), 99–128. https://doi.org/10.1207/s15327906mbr3901_4
- [83] Meehl, P. E. (1954). *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*. University of Minnesota Press. <https://doi.org/10.1037/11281-000>.
- [84] Mendel, R., Traut-Mattausch, E., Jonas, E., Leucht, S., Kane, J. M., Maino, K., & Hamann, J. (2011). Confirmation bias: why psychiatrists stick to wrong preliminary diagnoses. *Psychological medicine*, 41(12), 2651-2659. <https://doi.org/10.1017/S0033291711000808>
- [85] Meta AI. (2025, April 18). *The Llama 4 herd: The beginning of a new era of natively multimodal AI innovation*. Meta AI. <https://ai.meta.com/blog/Llama-4-multimodal-intelligence/>

- [86] Metzl, J. M. (2010). *The protest psychosis: How schizophrenia became a black disease*. Beacon Press.
- [87] Metzl, J. M., & Hansen, H. (2014). Structural competency: theorizing a new medical engagement with stigma and inequality. *Social science & medicine*, 103, 126-133. <https://doi.org/10.1016/j.socscimed.2013.06.032>
- [88] Miller, C. L., & Cummins, A. G. (1992). An examination of women's perspectives on power. *Psychology of Women Quarterly*, 16(4), 415-428. <https://doi.org/10.1111/j.1471-6402.1992.tb00265.x>
- [89] Moreira, T. (2006). Sleep, health and the dynamics of biomedicine. *Social Science & Medicine*, 63(1), 54-63. <https://doi.org/10.1016/j.socscimed.2005.11.066>
- [90] Morgan, H. (2002). Exploring racism. *Journal of Analytical Psychology*, 47, 567-581. <https://doi.org/10.1111/1465-5922.00347>
- [91] Morrill, Z. S. (2021). *Power dynamics in psychotherapy: Eminent therapists' experiences navigating power from humanistic-existential and feminist-multicultural perspectives* [Doctoral dissertation, University of Massachusetts Boston].
- [92] Mounet, O. O., Mizock, L., Cornelius, A., & Hopwood, R. (2024). Misdiagnosis of borderline personality disorder in transgender and gender nonbinary populations. *International Journal of Transgender Health*, 1-16. <https://doi.org/10.1080/26895269.2024.2447783>
- [93] Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). New York: McGraw-Hill.
- [94] OpenAI. (2024). *ChatGPT (GPT-4o)* [Large language model]. <https://chat.openai.com/chat>
- [95] Osborne, J. W., & Waters, E. (2002). Four assumptions of multiple regression that researchers should always test. *Practical assessment, research, and evaluation*, 8(1). <https://doi.org/10.7275/r222-hv23>
- [96] Ought. (2024). *Elicit* [AI research assistant]. <https://elicit.com>
- [97] Polifroni, E. C. (2010). Power, right, and truth: Foucault's triangle as a model for clinical power. *Nursing Science Quarterly*, 23(1), 8-12. <https://doi.org/10.1177/0894318409353811>
- [98] Pratto, F., Sidanius, J., Stallworth, L. M., & Malle, B. F. (1994). Social dominance orientation: A personality variable predicting social and political attitudes. *Journal of personality and social psychology*, 67(4), 741. <https://doi.org/10.1037/0022-3514.67.4.741>
- [99] Preacher, K. J., & Hayes, A. F. (2004). SPSS and SAS procedures for estimating indirect effects in simple mediation models. *Behavior Research Methods, Instruments, & Computers*, 36(4), 717-731. <https://doi.org/10.3758/BF03206553>

- [100] Rafalovich, A. (2013). Attention deficit-hyperactivity disorder as the medicalization of childhood: Challenges from and for sociology. *Sociology Compass*, 7(5), 343-354. <https://doi.org/10.1111/soc4.12034>
- [101] Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica*, 114(5), 303-318. <https://doi.org/10.1111/j.1600-0447.2006.00824.x>
- [102] Reips, U. D. (2002). Standards for Internet-based experimenting. *Experimental psychology*, 49(4), 243. <https://doi.org/10.1026/1618-3169.49.4.243>
- [103] Richman, W. L., Kiesler, S., Weisband, S., & Drasgow, F. (1999). A meta-analytic study of social desirability distortion in computer-administered questionnaires, traditional questionnaires, and interviews. *Journal of applied psychology*, 84(5), 754. <https://doi.org/10.1037/0021-9010.84.5.754>
- [104] Rieker, P. P., & Bird, C. E. (2005). Rethinking gender differences in health: why we need to integrate social and biological perspectives. *The journals of gerontology. Series B, Psychological sciences and social sciences*, 60, 40-47. https://doi.org/10.1093/geronb/60.special_issue_2.s40
- [105] Roberts, M. (2005). The production of the psychiatric subject: power, knowledge and Michel Foucault. *Nursing Philosophy*, 6(1), 33-42. <https://doi.org/10.1111/j.1466-769X.2004.00196.x>
- [106] Robiner, W. N. (1987). An experimental inquiry into transference roles and age. *Psychology and Aging*, 2(3), 306. <https://doi.org/10.1037/0882-7974.2.3.306>
- [107] Rosenthal, D. A. (2004). Effects of client race on clinical judgment of practicing European American vocational rehabilitation counselors. *Rehabilitation Counseling Bulletin*, 47(3), 131-141. <https://doi.org/10.1177/00343552040470030201>
- [108] SeleniumHQ. (2024). *Selenium WebDriver* [Computer software]. <https://www.selenium.dev/>
- [109] Schachter, S. (1959). The psychology of affiliation: Experimental studies of the sources of gregariousness. Stanford Univer. Press. <https://doi.org/10.1086/222700>
- [110] Seabold, S., & Perktold, J. (2010). Statsmodels: econometric and statistical modeling with python. *SciPy*, 7(1), 92-96. <https://doi.org/10.25080/Majora-92bf1922-011>
- [111] Sidanius, J., & Pratto, F. (2001). *Social dominance: An intergroup theory of social hierarchy and oppression*. Cambridge University Press.
- [112] Sidanius, J., Cotterill, S., Sheehy-Skeffington, J., Kteily, N., Carvacho, H., Sibley, C. G., & Barlow, F. K. (2016). *Social dominance theory: Explorations in the*

psychology of oppression. Cambridge University.
<https://doi.org/10.1017/9781316161579.008>

[113] Skär, L., & Söderberg, S. (2012). Complaints with encounters in healthcare—men's experiences. *Scandinavian Journal of Caring Sciences*, 26(2), 279-286.
<https://doi.org/10.1111/j.1471-6712.2011.00930.x>

[114] Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American journal of public health*, 93(2), 239-243.
<https://doi.org/10.2105/AJPH.93.2.239>

[115] Snyder, J. (2021). *Your mind online: The influence of contingent self-esteem on confirmation bias* [Master's thesis, DePaul University].

[116] Spitzer, R. L. (1981). The diagnostic status of homosexuality in DSM-III: a reformulation of the issues. *The American Journal of Psychiatry*, 138(2), 210-215.
<https://doi.org/10.1176/ajp.138.2.210>

[117] Sue, S., & Sue, D. W. (1971). Chinese-American personality and mental health. *Amerasia Journal*, 1(2), 36-49. <https://doi.org/10.17953/amer.1.2.n6680j28804v3g61>

[118] Suhr, J. A., & Johnson, E. E. (2022). First do no harm: Ethical issues in pathologizing normal variations in behavior and functioning. *Psychological Injury and Law*, 15(3), 253-267. <https://doi.org/10.1007/s12207-022-09455-z>

[119] Suhr, J., & Wei, C. (2017). Attention deficit/hyperactivity disorder as an illness identity: Implications for neuropsychological practice. In *Neuropsychological evaluation of somatoform and other functional somatic conditions* (pp. 251-273). Routledge. <https://doi.org/10.4324/9781315266992-9>

[120] Taber, K. S. (2018). The use of Cronbach's alpha when developing and reporting research instruments in science education. *Research in science education*, 48(6), 1273-1296. <https://doi.org/10.1007/s11165-016-9602-2>

[121] The jamovi project (2024). *jamovi*. (Version 2.6) [Computer Software]. Retrieved from <https://www.jamovi.org>.

[122] Turner, J. C., & Reynolds, K. J. (2003). Why social dominance theory has been falsified. *British Journal of Social Psychology*, 42(2), 199-206.
<https://doi.org/10.1348/014466603322127184>

[123] Van Dijk, W., Meinders, M. J., Tanke, M. A., Westert, G. P., & Jeurissen, P. P. (2019). Medicalization defined in empirical contexts—a scoping review. *International journal of health policy and management*, 9(8), 327.
<https://doi.org/10.15171/ijhpm.2019.101>

[124] Wakefield, J. C., Horwitz, A. V., & Schmitz, M. F. (2005). Are we overpathologizing the socially anxious? Social phobia from a harmful dysfunction perspective. *The Canadian Journal of Psychiatry*, 50(6), 317-319.
<https://doi.org/10.1177/070674370505000604>

- [125] Wen, Z., & Fan, X. (2015). Monotonicity of effect sizes: Questioning kappa-squared as mediation effect size measure. *Psychological methods*, 20(2), 193. <https://doi.org/10.1037/met0000029>
- [126] Westfall, R. E., & Benoit, C. (2004). The rhetoric of “natural” in natural childbirth: childbearing women's perspectives on prolonged pregnancy and induction of labour. *Social science & medicine*, 59(7), 1397-1408. <https://doi.org/10.1016/j.socscimed.2004.01.017>
- [127] White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W. W. Norton & Company.
- [128] Wilcox, R. R. (2011). *Introduction to robust estimation and hypothesis testing*. Academic press.
- [129] Wisch, A. F., & Mahalik, J. R. (1999). Male therapists' clinical bias: Influence of client gender roles and therapist gender role conflict. *Journal of Counseling Psychology*, 46(1), 51. <https://doi.org/10.1037/0022-0167.46.1.51>
- [130] Yako, L. (2023). *On the Great Resignation: Interrogating the Neoliberal Narrative*. CounterPunch.
- [131] Yalom, I. D. (1980). *Existential psychotherapy*. Basic Books.
- [132] Zhang, Y., Wang, M., Ren, C., Li, Q., Tiwari, P., Wang, B., & Qin, J. (2024). Pushing the limit of LLM capacity for text classification [Preprint]. *arXiv*. <https://doi.org/10.48550/arXiv.2402.07470>.
- [133] Zhang, Y., Zou, C., Lian, Z., Tiwari, P., & Qin, J. (2024). Towards evaluating large language models on sarcasm understanding. *arXiv e-prints*, 2408. <https://doi.org/10.48550/arXiv.2408.11319>
- [134] Zimmerman, D. W. (1998). Invalidation of parametric and nonparametric statistical tests by concurrent violation of two assumptions. *Journal of Experimental Education*, 67(1), 55–68. <https://doi.org/10.1080/00220979809598344>
- [135] Zola, I. K. (1972). Medicine as an institution of social control. *The sociological review*, 20(4), 487-504. <https://doi.org/10.1111/j.1467-954X.1972.tb00220.x>
- [136] Zur, O. (2014). Power in psychotherapy and counseling. *The Zur Institute*. <https://drzur.com/power-in-therapy/>