Gender weighting of DSM-IV personality disorder criteria.

Melissa Hobbs

University of Windsor

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UMI
GENDER WEIGHTING OF DSM-IV PERSONALITY DISORDER CRITERIA

by
Melissa Hobbs

A Thesis
Submitted to the Faculty of Graduate Studies and Research
through Psychology
in Partial Fulfillment of the Requirements for
the Degree of Master of Arts at the
University of Windsor

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Abstract

The primary purpose of the current study was to determine the degree, if any, to which gender stereotypes are reflected within the criteria of DSM-IV Axis II Personality Disorders (PDs). Participants consisted of 73 university undergraduate students (33 males and 40 females), who were instructed to sort each of the 91 PD criteria, presented individually on index cards, along a dimension of masculine to feminine. A secondary aim was to determine if participants who were instructed to sort the cards into five piles ranked the criteria differently from those participants who were free to sort the criteria into as many piles as they felt were necessary to complete the task. Results revealed no significant gender weighting of PDs, but suggest trends towards rating Antisocial and Schizoid PDs as male-typed disorders and Dependent, Histrionic and Avoidant PDs as female-typed disorders. Implications and limitations of the current research are discussed.
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DEDICATION

I would like to take this opportunity to dedicate my thesis to my family, without whose support none of this would have been possible. Most particularly, I want to thank my husband, Shawn, for being my spouse, my partner and my best friend. Thanks, Shawn, for keeping me focused and for showing me the light at the end of the tunnel. Also, thank you to my son, Michael Thomas, who makes everything that I do worthwhile. I love you both dearly.

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Gender Weighting of DSM-IV Personality Disorder Criteria

General Theoretical Review

The last several decades have produced a noticeable increase in interest and research in sex/gender issues in mental health. A variety of theories have been posited to explain observed sex differences in mental health, or, to borrow the term from Mowbray, Lanir, and Hulce (1984), mental unhealth. Mowbray et al. use the term as a parallel to mental illness, thereby elucidating that the study of mental health differs from the study of mental unhealth (or mental illness). Theories provide the basis on which mental illness is defined and provide the structure for diagnosis, treatment and research. Mowbray et al. review three theories that attempt to explain sex differences in mental illness: psychoanalytic, biological/genetic and sociocultural.

It is important to note that much of the literature concerning theories of mental health has focused on why minority groups, such as women, seem to have higher prevalence rates of mental illness. Thus, the first part of this discussion will focus on how these theories apply to the mental health of women. However, there are also important implications for the incidence of mental illness in men. This issue will be addressed later in this section.

Psychoanalytic Theory. In general, psychological theories of mental illness view psychopathology as a result of a sickness or abnormality of the mind or psyche (Peterson, 1999). Specifically, according to psychoanalytic thought, adult mental health is a function of early life and developmental experiences. Mental illness is the result of “inner conflicts that overwhelm [their] defenses” (p. 109). These theories tend to emphasize “unconscious, irrational, and emotional processes” (p. 110).
According to Mowbray et al. (1984), the psychoanalytic theory that is most clearly shaped by gender stereotypes is the psychoanalytic theory of sex differences. Similarly, Miller (1984) notes that, rooted in traditional Freudian thought, psychoanalytic theory purports that “women are inherently passive, narcissistic and masochistic” (p. 29). It is the synthesis of these three characteristics that form the basic goal of women’s typical—though not particularly desirable—psychological development, and pathologies are the result of deviating from this basic goal. Miller contends that this line of thinking was the mainstay of psychological thought until about the mid 1970s. According to psychoanalytic formulations, “women are seen as more vulnerable to depression than men because of their early life experiences and ‘typical’ personality characteristics” (p. 8). Mowbray et al. note that there is very little empirical support for the link between life experiences or “typical” traits of women and the incidence of depression.

**Biological/Genetic Theory.** The biological/genetic theory assumes that a genetic basis exists to explain the sex differences and presence (or absence) of mental illness. Biological approaches to psychopathology view mental illness as “a disease of the brain” (Schwartz, 1999, p. 79), as opposed to a disease of the psyche (psychoanalytic theory) or a disease of society (sociological theory). According to Schwarz, however, diagnoses made from a biological perspective are imprecise in that for the most part, the etiology and pathophysiology of most psychiatric disorders is not known, and diagnoses are made based on clusters of symptoms and patterns of behaviors.

Women are seen as more vulnerable to mental illness as a result of their biological makeup, namely reproductive and endocrine systems. Mowbray et al. (1984) note, however, that in order to “prove” a biological basis for mental illness, researchers must
"link genetic transmission of mental illness to the X chromosome" (p. 8). There does not appear to be any such causal evidence in existence. In particular, Bernardez (1984) points to society and culture as underlying causes of symptomatic behavior. Bernardez (1984) also suggests that psychopharmacological therapies – which can be viewed as having a basis in biological/genetic theories and the medical model – focus on symptom reduction/alleviation, as opposed to determining and treating the cause of the symptoms. This presumed link between biological theory and psychopharmacological therapy rests on the premise that the medical model of mental illness is based on biological/genetic causal factors. Similarly, psychopharmacological treatment can also be viewed as having a medical – and thus biological – view of mental illness.

Sociocultural Theory. According to Thoits (1999), mental illness is viewed as "a breakdown in the face of overwhelming environmental stress" (p. 121). The main difference between this theory and the psychoanalytic and biological theories is that it places the locus of causation outside the individual, whereas the other two theories locate this causation inside the individual. The sociocultural perspective takes into account the many stressors in life that can have a negative impact on an individual's mental health. Some of the examples of stressors cited by Mowbray et al. (1984) include: "women's socialization, lowered social status, sex discrimination, stereotypic biases and discrepancies between rising expectations and actuality" (p. 9). Indeed, the notion that gender roles are culturally defined is an important one to keep in mind. Bernardez (1984) notes that "the problems of women vary with the culture and also vary with the times and situations during which the culture is being observed" (p. 17). She discusses four cultural factors affecting the mental health of women:
1) socialization of women: a culture prescribes what is and what is not acceptable and appropriate feminine behavior (and thus also masculine behavior, by extension);

2) social status of women: "second class citizenship...has implications for [women's] mental health" (p. 18);

3) discrimination against women: particularly in the sectors of employment and education, because a person's level of economic power has a direct influence on both the type of employment and type of education that a person receives;

4) biases that support inequality, both in the mental health field and the public.

Bernardez (1984) claims that "psychotherapies which do not closely examine the role of culture and the social context in which the woman lives obscure the problem, misdiagnose it, and mistreat the woman patient" (p. 23). Furthermore, she suggests that psychoanalytically-oriented psychotherapies place the locus of causality for mental problems within the individual, without giving any due to the possible influences of social factors. "The woman is thus made responsible...through a diagnosed deficiency, when her ailment is really a symptom of her adaptation to a world that has pathogenetic expectations about her" (pp. 22-23). Similarly, Marshall and Serin (1997) contend that "recent immigrants, or members of minority cultures, may be susceptible to misdiagnosis unless the diagnostician makes the effort to determine which attitudes and behaviors are appropriate for a person from a distinct culture" (p. 511). Furthermore, Lefton, Boyes and Ogden (2000) point out that "some disorders are culturally indigenous" (p. 527) or culturally specific.
In essence, sociocultural theory proposes that it is when women step outside of their gender-role, which is culturally defined and sanctioned, that they earn the label of mentally ill. In addition to the oppressive aspects of a patriarchal and discriminating culture, the female gender role prescribes more expression of their emotions than the male gender-role. This openness in expressing emotions itself may account in part for the apparent overrepresentation of women in the population defined as mentally ill.

**General Review of Gender and Mental Health**

Within the context of this paper, sex refers to one’s biological makeup (i.e., male or female), whereas gender orientation refers to whether one identifies oneself as masculine or feminine. Further, according to Lefton et al. (2000), “gender-role stereotypes [are] beliefs about gender-based behaviors that are strongly expected, regulated, and reinforced by society” (p. 383). This definition is consistent with the use of the terms sex-role stereotypes and gender-role stereotypes throughout the current discussion.

As noted, issues of sex and gender, while always latent in the field of mental health, have only become prevalent areas of research in the last couple of decades. Now, most researchers and clinicians have received at least minimal exposure to gender-sensitive training, both formally (e.g., through coursework) and informally (e.g., through practical experience). For example, Gilbert (1979) conducted a study with an undergraduate population in which the experimental group was a class that received specific instruction designed to raise their consciousness of gender-related issues; the control group, another class, received no such specific teaching. The researcher found that male participants endorsed more feminine traits at post-testing (i.e., the end of the course) than at the pre-testing (i.e., the beginning of the course). In fact, the Gilbert reported that participants in
the experimental group became more acutely aware of their own sex-related value systems and the judgements that they made based on those values. In other words, consciousness-raising training appears to have had an effect on judgements of sex-bias in future experiences of participants. Gilbert asserts “that many graduate students and professionals alike appear to have difficulty dealing with issues that stem from personal value systems regarding the attributes and behavior of women and men and this underscores the importance of continued teaching and research in this area” (p. 372). Therefore, gender sensitivity training seems to have had an ameliorative consciousness-raising effect.

It is generally believed that women are overrepresented as clients in the mental health care system. For example, in a meta-analysis of twenty-six studies looking at the relationship between gender and mental health, Bassoff and Glass (1982) found that participants who rated high on the expressive characteristics associated with the feminine sex-role exhibited higher levels of mental illness than those participants who were high on masculine instrumental characteristics or high on both (i.e., androgynous). In other words, femininity may be overrepresented in the descriptors (or criteria) that are associated with mental illness. They concluded that there is a “strong, positive association between masculinity and mental health” (p. 110). Moreover, Bassoff and Glass note that although androgyny appears to be positively related to mental health, “it is the masculine component of androgyny, rather than the integration of femininity and masculinity, that accounts for this... [and that] ...femininity appears to be a largely irrelevant component of androgyny at least on measures of mental health” (p. 110).

Similarly, Logan and Kaschak (1980), using a sample of undergraduate students, found that female participants scored higher on measures of anxiety and depression than
did male participants. Olfman (1994) hypothesizes that “growing up in almost any patriarchal culture with its attendant belief system has a profound effect on women’s mental health” (p. 259). She further asserts that “femininity is [incorrectly] conceptualized as damaged and derailed masculinity” (p. 261) and that biological sex differences have been equated with deficits in one sex (female). Similarly, Lips (1997) points out that “it is important to remember that sexist biases built into the diagnostic categories may well influence perceptions of whether women and men are psychologically healthy” (p. 277). Lips goes on to argue that the idea of diagnostic categories as reflections of an historically male dominated society, particularly in the field of psychiatry, “is certainly not inconceivable” (p. 277).

So what is it that accounts for this overrepresentation of women as consumers of mental health services? Possible variables that could contribute to such a phenomenon include, but are not limited to the following: 1) true gender differences in the prevalence of mental illness, (e.g., the biological or genetic model of gender differences, that proposes that mental illness is genetic in nature and that the very biological makeup of women makes them more vulnerable to mental illness; 2) biases in diagnosing mental illness; 3) differential treatment-seeking behaviors; and 4) differential referral into the mental health system. Furthermore, just as members of some cultures appear to display higher incidence of some disorders due to the influence of external factors such as socioeconomic status or geographical locale, external factors such as societal disadvantages likely play a role in the prevalence of mental illness stratified by sex. Mowbray et al. (1984) give a summary of the sociocultural approach to sex and gender differences in mental illness, citing factors such as “socialization, lowered social status, sex discrimination, stereotypic biases and
discrepancies between rising expectations and actuality" (p. 9) as contributing to the higher vulnerability of women to mental illness.

On the other hand, some authors (e.g., Hafner, 1986; Miller & Bell, 1996) suggest that men may indeed have a higher prevalence rate of mental illness than do women. Miller and Bell (1996) contend that the analogy of “women as ‘mad’ and men as ‘bad’” (p. 325) is misguided. They argue that ‘gender-blind’ mental health services do not “acknowledge the impact of inequalities on men’s mental health” (p. 318). Moreover, this lack of due process in regard to men’s mental health issues has significant consequences for men, women, and children alike. Miller and Bell suggest that the traditional view of masculinity and what it is to ‘be a man’ results in men prizing “the external world rather than the internal world, and predisposes men to control their emotional states by controlling the external environment. As an ideology [this] can set man against man as well as man against woman” (p. 319). The authors contend that men are pressured by social and cultural norms to shun feelings associated with being vulnerable and powerless, which in turn decreases their ability to cope with these negative affects. Men tend to satisfy their emotional needs with material things; this destructive pattern is reinforced in societal norms and expectations and also handed down to younger generations of males through a lack of non-traditionally masculine role-models who can “legitimize distress or soften the harsh injunctions of socialization” (p. 319). In other words, until non-traditional male role models are available, the traditional view of what it is to be masculine will perpetuate itself in future generations.

Hafner (1986) suggests that the mental health profession’s focus on overt symptomatology leads to an overrepresentation of women and a corresponding
underrepresentation of men in the estimated prevalence of mental disorder. Interested in why men have a higher mortality rate, Hafner looked at various data in the United Kingdom and concluded that “stereotypic male behavior makes a substantial contribution to men’s increased mortality” (p. 78). It is suggested that men are more likely than women to die by the following methods: murder, lung disease (including cancer), accidents (including motor vehicle accidents), cirrhosis of the liver and coronary heart disease (Hafner; Miller & Bell, 1996). Furthermore, it is the stereotypical behavior of men, claims Hafner, that leads to lifestyles which result in any of these instances. In fact, Hafner suggests that the “superiority of men’s mental health largely vanishes...if drug and alcohol abuse are included in measures of morbidity” (p. 78). Moreover, Hafner suggests that, if drug and alcohol abuse are included in our definitions of mental illness, then men report higher levels of mental illness than do women. Looking at married couples, Hafner (1986, p. 82) found that “physical manifestations of anxiety and depression [in men]...are more acceptable to all, including the medical profession...[which leaves] the real nature and origins of the disorder...obscured”. In a discourse analysis (whereas members of the research team discuss and agree on an interpretation of an item or event), Coyle and Morgan-Sykes (1998) reviewed non-academic magazine and newspaper articles and media advertisements depicting male behaviors. They found that although traditional and stereotypical masculine stereotypes are being portrayed as “problematic”, alternatives are “not constructed to appeal” (p. 273). Indeed, the authors contend that the alternatives are portrayed as effeminate and vain, suggesting homosexuality at the extreme.

In reviewing the literature, what is clear is that it is unclear whether women (e.g., Bassoff & Glass, 1982; Lips, 1997; Mowbray et al., 1984; Olfinan, 1994) or men (e.g.,
Coyle & Morgan-Sykes, 1998; Hafner, 1986; Miller & Bell, 1996) are overrepresented in the prevalence rates of mental illness. This lack of clarity calls attention to the need for further research in this area.

**Personality Disorders**

The Diagnostic and Statistical Manual – Fourth Edition (DSM-IV; American Psychiatric Association [APA], 1994) defines a personality disorder (PD) as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (APA, 1994, p. 629). Perhaps somewhat more clearly, Morrison (1995) defines personality traits as “well- ingrained ways in which individuals experience, interact with and think about everything that goes on around them. Personality disorders are collections of traits that have become [so] rigid...[that they] work to the individual’s disadvantage, to the point that they impair functioning or cause distress” (p. 460). Morrison further contends that PDs are “probably dimensional, not categorical [which] means that their components (traits) are present in normal people, but are accentuated in those with the disorders in question” (p. 461).

In general, the PDs fall into three broad clusters, based on similar symptomatology (APA, 1994; Kessler & Zhao, 1999; Morrison, 1995). Cluster A disorders are characterized by suspiciousness, oddity, irrationality, eccentricity, coldness, and withdrawal and include the Paranoid, Schizoid, and Schizotypal PDs. The second cluster, cluster B, includes the Antisocial, Borderline, Histrionic, and Narcissitic PDs and are characterized by “dramatic, emotional and attention-seeking [behaviors]...[and] labile and often shallow” moods and affect (Morrison, 1995, p. 459). Interpersonal/relationship
difficulties are also common in cluster B disorders. Finally, people with cluster C disorders can generally be described as “anxious and tense, and...often overcontrolled” (Morrison, 1995, p. 459). Cluster C disorders include: Avoidant, Dependent, and Obsessive-Compulsive PDs.

According to the DSM-IV (APA, 1994), there are six criteria that are common to all PDs. Criterion A asserts that at least two of the following areas must be affected by the person’s pattern of behavior/experience: cognitive, affective, interpersonal functioning and impulse control. Criterion B requires that the pattern be “inflexible and pervasive” spanning many areas of the person’s life. Criterion C states that the manifestations in A must lead to “clinically significant distress or impairment in social, occupational or other important areas of functioning” (APA, 1994, p. 630). Criterion D asserts that the behavior has been stable and has an onset in either adolescence or early adulthood. The manifestation(s) cannot be due to another mental disorder (Criterion E) or due to a general medical condition or substance use (Criterion F). The DSM-IV also points out that the traits associated with a PD are typically ego-syntonic, that is, the person exhibiting the traits usually does not see his/her behavior as dysfunctional or problematic.

The authors of the DSM-IV (APA, 1994) caution its users to be sensitive to personality traits that appear to be inconsistent with the client’s culture or origin. A diagnosis requires that the behavior or inner experience deviate “markedly” from the person’s cultural expectations. Thus, what appears to be deviant to a North American clinician may in fact be quite the norm when considering the client’s cultural background.

Noted in the DSM-IV (APA, 1994), PDs appear to be differentially diagnosed based on sex. The authors of the DSM-IV note that Antisocial PD appears to be
diagnosed more often in men, whereas women more often receive diagnoses for:
Borderline, Histrionic and Dependent PDs. As the manual is intended as a diagnostic tool,
however, it is atheoretical in nature. The authors contend that these sex-based differences
are probably valid but charge clinicians to be aware of these differences and to be
conscious of not over/under diagnosing PDs based on sex of the client and “social
stereotypes about typical gender roles and behaviors” (p. 362).

**Gender Issues and Personality Disorders**

Widiger (1998) notes six possible sources of sex bias, specifically in the diagnosis
of PDs. The first possible source is biased diagnostic constructs, which are the diagnostic
categories in which clinicians place clients (e.g., Antisocial, Borderline, or Histrionic PDs).
Widiger posits that the PD diagnostic categories/constructs are “sexist characterizations
of females or the female gender” (p. 96). That is, PD criteria encompass gender-related
traits in determining the presence (or absence) of a PD.

Indeed, another issue related to the usefulness and efficacy of these categories is
the very use of a categorical method of diagnosis itself. There is much debate and
discussion as to whether PDs are best defined as categorical constructs, or whether they
would be more accurately described and defined with a dimensional methodology (e.g.,
Livesley, 1991; Widiger, Trull, Hurt, Clarkin, & Frances, 1987; Wiggins & Pincus, 1989;).
Widiger et al. (1987) briefly review four dimensional models of personality in addition to
providing their own model. With the exception of the Interpersonal Circumplex model,
which suggests two dimensions to personality, the remaining models reviewed by Widiger
et al. each propose a three-factor dimensional model. As noted, the Interpersonal
Circumplex model (Wiggins, 1982) proposes that personality styles can be represented in
two dimensions: affiliation and power. These two themes are also evident in other models of personality styles. The DSM-III and DSM-IV propose three general clusters into which the various PDs can be placed. Each of these clusters, contend Widiger and his colleagues, may in fact represent fundamental personality dimensions. Specifically, the DSM-III and the DSM-IV propose the following three dimensions: odd/eccentric; dramatic/emotional/erratic; and anxious/fearful.

The second model reviewed by Widiger et al. (1987) encompasses Millon’s (1981) three dimensions of: self-other orientation; activity-passivity; and pleasure-pain. Widiger et al. then go on to discuss Eysenck’s (1985) three-dimensional model: neuroticism, psychoticism, and introversion-extroversion. Finally, Widiger et al. factor analyzed the 81 criteria in the DSM-III associated with PDs and identified the following three dimensions: desire for/degree of social interest; assertiveness; and a continuum from “internal anxious rumination to external behavioral ‘acting out’” (p. 560). It is not beyond the bounds of reason to suggest that, if a dimensional model is indeed an accurate way to represent PDs then gender stereotypes may in fact be one of those dimensions. Indeed, as will be discussed shortly, many researchers have found that there do seem to be differential PD diagnoses as a function of gender.

Widiger et al. (1987) note that much overlap exists between their three dimensions and the dimensions proposed in the other models reviewed. Indeed, they suggest that, regardless of the labels applied to the various dimensions, a dimensional approach has the potential to provide clinicians with a more comprehensive picture of their clients’ maladaptive and adaptive personality traits, which may then have significant effects on treatment decisions and outcomes. Indeed, the authors note that in addition to providing a
firm basis on which to judge one’s personality style, that an association between a
dimensional model and the PDs may provide a way to “evaluate normal and abnormal
personality traits along the same continuum” (p. 563). Widiger et al. further suggest that
this differential point may be “an arbitrary imposition of a categorical model on a
dimensional variable” (p. 563), and it is perhaps not possible to find a mutually agreeable
middle ground. The question still remains, regarding the point along the continuum at
which normal becomes abnormal, and abnormal becomes pathological. Currently, it is the
diagnosing clinician who determines this differential point, based on the criteria set out, for
example, in the DSM.

On the other hand, some argue that personality and PD assessment and diagnosis
should involve an interaction between the two systems of categorical and dimensional
conceptions. Wiggins and Pincus (1989) note that while it would be a difficult task to
marry the two concepts, it is not impossible. Indeed, they maintain that this union would
be preferable to adopting an either/or stance “because the current conceptions of
personality disorders are indeed related to dimensions of normal personality…[and] this…would obviate extensive reconceptualization of clinical phenomena” (p. 315).

In support of this unification argument, Widiger, Frances, Spitzer and Williams
(1988) note that the “boundaries between normal and abnormal personality styles and
between different personality disorders are to a large extent arbitrary” (p. 780). Indeed,
according to Widiger and Costa (1994), PDs “represent…maladaptive variants of traits
that are evident in all persons to varying degrees” (p. 78). This would seem to suggest,
then, that if these traits are common to all persons, the deviance is found not in the
presence or absence of the trait(s), but rather in the degree to which the trait(s) exists.
Moreover, although there is little empirical evidence to support the complete abandonment of the current polythetic categorical approach used in the DSM in favor of a completely dimensional approach, Livesley (1991) contends that the current system is also lacking in empirical validity. Hence, there appear to be advantages and disadvantages to both systems of classification, which itself may be suggestive that some sort of union between the two systems would be most beneficial to clients and clinicians alike.

A second source of bias can be found in diagnostic thresholds, i.e., the use of different thresholds for male-typed and female-typed PDs. Some authors suggest that less dysfunction is required to receive a female-type PD diagnosis than a male-type PD diagnosis. For example, Widiger (1998) posits that a “normal” woman may meet the criteria for Histrionic, and Dependent PDs (from the DSM-III). Similarly, Kaplan (1983a) suggests that “a healthy woman automatically earns the diagnosis of a Histrionic PD” (p. 789).

A third possible source of bias lies in the application of the diagnostic criteria. This area of bias, according to Adler, Drake, and Teague (1990), has received the most empirical support to date. If a clinician is biased in his or her application of diagnostic criteria, then they are more likely to give a diagnosis that is in line with their client’s gender. For example, a gender-biased clinician may diagnose a female with Borderline PD, which is more consistent with gender-stereotyped traits, when in fact she may meet the diagnostic criteria for Antisocial PD.

Another source of sex bias may be found within a sample of persons with a disorder. That is, the apparently higher prevalence of women exhibiting some disorder may be largely the result of the fact that women are overrepresented in clinical settings. In
other words, some researchers have found a positive correlation between sex and gender, and treatment-seeking behavior (e.g., Klerman & Weisman, 1980; Muller, 1990).

Bias may also be present in the actual assessment tools. According to Lindsay and Widiger (1995, p. 2), “an item [from a self-report inventory or a semistructured interview] would be considered sex biased if (a) it did not reflect dysfunction (i.e., it could easily result in false positives) and (b) it applied to one sex more than the other (i.e., it could lead to a differential sex prevalence of false positives)”. That is, the tools used by clinicians to assist in diagnosing PDs may be inherently sex biased themselves.

The sixth and final source of possible bias which is, according to Widiger, perhaps the most difficult to both identify and address, is bias in the diagnostic criteria themselves. Do the criteria for mental illness, particularly PDs, inherently include gender-specific stereotyped roles as a condition for obtaining a diagnosis? The current paper focuses on this last possible source of bias in examining differential prevalence rates of PDs in males and females. Whether or not gender plays a key role in the criteria, and ultimately the diagnosis, of PDs is a relevant issue that directly reflects upon accurate diagnosis and treatment of persons exhibiting PD symptomatology. If indeed the criteria are merely reflections of more macro-level social prescriptions of behavior, then persons diagnosed with a PD are, in essence, being labeled, treated and stigmatized for conformist-type behaviors, as opposed to actually having a mental illness or disease.

A number of researchers have found that a significant split exists between those PD diagnoses most commonly assigned to women and those most commonly assigned to men. For example, Ekselius, Bodlund, von Knorring, Lindstrom, and Kullgren (1996) administered a sample of 531 participants (including healthy volunteers and both
psychiatric inpatients and outpatients) a modified version of the Structured Clinical Interview for DSM-III-R screen questionnaire (SCID-II) in order to determine the prevalence of sex difference in PDs using DSM-III-R criteria. Using a chi-square method of statistical analysis, they found that Obsessive-Compulsive and Schizoid PDs occur more often in men, while Borderline and Self-Defeating PDs occur more often in women.

Gilbertson, Mcgraw, and Brown (1986-87) reviewed 19,000 records obtained from community health centers and state hospitals and identified 2,145 patients as diagnosed with a PD. The participants records were coded for sex of patient and sex of diagnosing clinician in order to determine if there was an interaction between the two variables. Gilbertson et al. found no significant interaction between sex of diagnosing clinician and sex of patient. However, irrespective of sex of diagnosing clinician, Borderline PD was more commonly diagnosed in women, along with Dependent and Histrionic PDs. In contrast, Adler et al. (1990) presented a 950-word clinical profile to 46 clinician raters, asking them to “assess the personality of the patient as having no trait, trait or disorder for each DSM-III personality disorder category” (p. 127). Their results suggest that Borderline PD was not related to sex, but that Narcissistic and Histrionic PDs were, as male-typed and female-typed disorders, respectively. Furthermore, Gilbertson et al. also found that Paranoid and Schizoid PDs were more likely to be diagnosed by male clinicians, and Dependent and Atypical PDs by female clinicians. The authors concluded that “male and female patients are diagnosed as evidencing specific personality disorders at differential rates” (p. 146).

A sample of 316 depressed patients at the Clinical Psychopharmacology Unit at Massachusetts General Hospital completed either or both of: SCID-II and Personality
Diagnostic Questionnaire-Revised (PDQ-R) prior to receiving treatment. Golomb, Fava, Abraham, and Rosenbaum (1995) found that Narcissistic, Antisocial and Obsessive-Compulsive PDs were more characteristic of men. However, since no PD was found to occur significantly more often in women, Golomb et al. concluded that “women tended to have fewer personality disorders” (p. 581). This finding challenges the general assumption that women are overrepresented in PD diagnoses. In a comprehensive review of gender and psychopathology, Al-Issa (1982) also asserts that “personality disorders tend to be consistently more prevalent among males than females” (p. 14). However, Widiger (1998) suggests that three of the current disorders are more prominent in female than in male patients: Dependent, Histrionic and Borderline.

Sprock, Blashfield, and Smith (1990) gave 50 undergraduate students 142 index cards, each containing one PD criteria from the DSM-III-R, and asked them to sort the cards along a continuum ranging from most characteristic of males to most characteristic of females. Participants were free to sort the cards into as many categories as they felt necessary in order to complete the task. In calculating mean ratings of the criteria as they related to the various PD disorders, they found that disorders most characteristic of men, using the DSM-III-R categories, included Sadistic, Antisocial and Schizoid PDs; female-typed disorders included Dependent, Histrionic and Avoidant PDs. They found that disorders which were neither more typical of males nor of females included “obsessive-compulsive, paranoid, self-defeating and schizotypal” (p. 588) PDs. The authors conclude that their results are indicative of “gender weighting in the DSM-III-R diagnostic criteria for personality disorders” (p. 590).
These differential prevalence rates are not what appear to be at the center of the PD debate; however, it is generally accepted that PD prevalence rates do in fact differ according to the sex of the client. What is less clear, however, is whether these differential prevalence rates are: a reflection of actual differences in the manifestations of mental illness; bias in the diagnostic criteria; or bias in the applications of those criteria. The question, then, concerns the root, or cause, of these differences.

One viable theory that has been posited to explain the differential prevalence rates of PD across gender was advanced by Landrine (1987, 1989). The Social Role Hypothesis states that “personality disorder categories as a whole represent the roles/role-stereotypes of both sexes” (1989, p. 326). The crux of this hypothesis is that diagnostic criteria and sex role stereotypes share many commonalities, which results in overlap between the two dimensions. Landrine (1989) notes that this raises the “question [of] why the gender-roles and stereotypes of both sexes might be reflected in the personality disorder categories [and that] if personality disorder categories are thereby a reflection of gender roles that serves to maintain gender stratification, then those categories are political” (p. 332). She goes on to point out that “if new categories – like the present ones – simply reproduce the gender status order, then the function of personality disorder language is to act as a lathe of a reality in which political or social analysis is precluded” (p. 332).

In looking at sex bias in PDs, as noted by Funtowicz and Widiger (1995), many researchers have confused the concept of clinician bias with that of criteria bias. Whereas criteria bias refers to bias inherent to the actual criteria associated with the categories of mental disorder (which will be discussed in greater detail shortly), clinician bias relates to the clinician’s own value/belief system and his or her adherence to culturally sanctioned
gender stereotypes. For example, Beckwith (1993) asked participants to describe: a healthy adult male; a healthy adult female; or a healthy adult (with unspecified sex). It was found that healthy adult females were described as more open with their emotions, less “blunt, rough and competitive” (p. 86) and liking math and science less than both healthy males and healthy adults with unspecified sex. It is interesting to note that these characteristics were also more closely associated with the sex-unspecified healthy adult, as opposed to the healthy male adult. This study suggests that not much has changed since Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) reported that healthy adult females and healthy adult males differed significantly in characteristics described by clinicians as indicating mental health.

In a similar study, Austad and Aronson (1987) asked various mental health professionals (including psychologists, psychiatrists and social workers) to review a case history, including portions of a taped therapy session and then rate the pseudopatient using the Broverman et al. (1970) Stereotype Questionnaire. The authors found that there was no significant difference between stereotype ratings of the male or female pseudopatient, although the female patient was viewed slightly more favorably. According to the authors, a bias against women, for example, in DSM criteria (regardless of edition), would be evident if women received a DSM diagnosis when exhibiting less dysfunction than it would take for men to receive the same diagnosis.

Funtowicz and Widiger (1995) found that “it might be relatively easier to obtain a male-typed personality disorder diagnosis than some female-typed personality disorder diagnoses (i.e., less dysfunction is necessary)” (p. 157). These authors examined bias within the DSM-III-R PD criteria and concluded that no sex bias existed in the diagnostic
criteria. Funtowicz and Widiger (1999) also evaluated the PD criteria contained in the DSM-IV (APA, 1994). They mailed a questionnaire to randomly selected members of Division 12 (Clinical Psychology) of the American Psychological Association. The questionnaire asked respondents to rate the DSM-IV PD criteria using a Likert-type scale, with a range of one (no dysfunction/distress) to seven (severe dysfunction/distress) for the following variables: social dysfunction, occupational dysfunction and subjective distress.

For the 134 responses received (out of 590 sent, a response rate of 23%), mean impairment ratings indicated no “bias against women in the threshold for a diagnosis of a PD” (Funtowicz & Widiger, 1999, p. 198). In fact, they found that male-typed disorders (i.e., antisocial, obsessive-compulsive and paranoid PDs) required the client to meet fewer of the diagnostic requirements than did the female-typed disorders, suggesting that less dysfunction is required in order to gain a male-typed diagnosis than a female-typed diagnosis, which is contrary to previous findings, and popular belief. In other words, it may be easier to be diagnosed with a disorder that is more common in males.

Kaplan (1983) offered very strong views about the bias associated with all versions of the DSM, namely that the diagnostic criteria are male-centered in nature. According to Kaplan, “masculine-biased assumptions about what behaviors are healthy and what behaviors are crazy are codified in diagnostic criteria [and that] these criteria then influence diagnosis and treatment rates and patterns” (p. 786). In her review, Kaplan drew from the work of Broverman et al. (1970), which, according to Kaplan, implies that “to be considered an unhealthy adult, women must act as women are supposed to act (conform too much to the female sex role stereotype); to be considered an unhealthy woman, women must act as men are supposed to act (not conform enough to the female sex role
stereotype)” (p. 788). Kaplan noted that this view of pathology places women in a double bind, or a Catch-22, in which a woman is likely to be diagnosed as mentally ill, whether she maintains a lifestyle that is consistent with her prescribed gender role or strays too far from that prescribed gender role. Indeed, Kaplan went far as to suggest that “behaving in a feminine stereotyped manner alone will earn a DSM-III diagnosis (e.g., Dependent or Histrionic Personality Disorder) [whereas] behaving in a masculine stereotyped manner alone will not” (p. 791). In other words, adherence to stereotypically masculine behaviors by women is seen as pathological, whereas the same adherence by men is seen as normal. It is the combination of masculine behaviors with female sex that influences the judgement of abnormality.

Contrary to Kaplan’s (1983) contention, however, Kass, Spitzer, and Williams (1983) found that once individuals entered into the treatment system for assessment, there did not appear to be any foundation for the concern over sex bias in diagnosing PDs. Specifically, the authors found “no overall tendency for a female patient to receive a personality disorder diagnosis more often than a male patient” (p. 801). While the authors found that, overall, there was no sex difference in diagnoses of PDs, they did find that sex played a role in which disorders were more likely to be assigned to patients. For example, they found that Histrionic and Dependent PDs were more representative of female patients, whereas Antisocial PD was more representative of male patients.

In summary, there appear to be many potential sources of sex bias within the field of mental health. Widiger (1998) reviews six of these potential sources of bias: biased diagnostic constructs; biased diagnostic thresholds; biased application of diagnostic criteria; biased sample of persons with a particular disorder; biased assessment tools; and
biased diagnostic criteria. Regardless of the source of sex bias, some researchers have indeed found that men and women seem to be more commonly diagnosed with different disorders (e.g., Al-Issa, 1982; Ekselius et al., 1996; Gilbertson et al., 1986-87; Golomb et al., 1995). Some authors contend that the diagnosis of PDs are more favorable to women (e.g., Funtowicz & Widiger, 1995), whereas others argue that the diagnostic criteria are more detrimental to women (e.g., Kaplan, 1983). Still others have found no difference (e.g., Kass et al., 1983). Clearly, this issue has not been settled and the review indicates a need for further study.

The purpose of the current study was to replicate research conducted by Sprock et al. (1990), using DSM-IV (APA, 1994) PD criteria, as opposed to the DSM-III-R criteria. It is necessary, then, to consider the changes that were implemented in revising the DSM. In developing the DSM-IV, the American Psychiatric Association established a number of workgroups to evaluate the efficacy of the various sections of the DSM-III-R. The Personality Disorders Workgroup was in charge of this process for Axis II disorders. As noted in Appendix D of the DSM-IV (APA, 1994), revisions to the PD categories and criteria were made “based on literature reviews, data reanalysis, and desire for compatibility with ICD-10 Diagnostic Criteria for Research” and therefore “items have been modified to increase clarity and specificity and to reduce possible gender bias” (p. 787). Specifically, the members of the PD Workgroup elected to remove the Passive-Aggressive PD category in the DSM-IV, in addition to removing two proposed categories: Sadistic PD and Self-Defeating PD. It is interesting to note, however, that the Passive-Aggressive PD has been included in the DSM-IV as a proposed category for PD diagnosis, along with Depressive PD. These same two proposed categories are also
included in the "Criteria Sets and Axes Provided for Further Study in Appendix B of the DSM-IV-TR", although Negativistic PD is suggested as an alternative name for the Passive-Aggressive PD (APA, 2000).

Another significant change between the DSM-III-R and the DSM-III is the inclusion of the general diagnostic criteria for a PD (items one to three in Appendix B), which suggests that a degree of similarity is present across PD categories. Changes that were enacted in the individual criteria representing the overall PD categories, as summarized in Appendix D of the DSM-IV (APA, 1994) can be found in Appendix A of the present study.

Consistent with this prior research, Sprock et al. (1990) operationalized gender weighting as: "the degree to which nonclinicians saw the behaviors described in the criteria as varying along a male-female dimension" (p. 587). The goal of the current research is to determine whether changes made in the DSM-IV's criteria are reflected in a difference in gender weighting of PD criteria. As there have been changes made to the criteria and the disorders between the DSM-III-R and the DSM-IV, this study is exploratory in nature. However, after reviewing the relevant literature, it does not seem unreasonable to expect some level of gender stereotyping to be incorporated into the DSM-IV PD diagnostic criteria.

There appears to be little, if any, research addressing the issue of prescribing the number of categories that a participant is to sort criteria into, versus a nonprescriptive sorting task. Therefore, a further purpose of this study was to determine if participants differ in their response patterns depending on whether they are given a predetermined set of categories or asked to generate their own.
Method

Participants

Participants consisted of 33 male and 40 female (N=73) undergraduate students from the University of Windsor. Thirty-seven participants (16 males and 21 females) were randomly assigned to Group 1 (unlimited-category-group), and thirty-six participants (17 males and 19 females) were randomly assigned to Group 2 (five-category-group). The mean age of participants was 22.11 years (22.78 years for group 1; 21.42 years for group 2). The majority of participants were of European-descent (80.8%), single (95.9%), and had declared majors in the Faculty of Arts and Social Sciences (72.6%).

All respondents were recruited through the Department of Psychology Participant Pool and were treated in accordance with the principles set forth by the Department of Psychology Ethics Committee. Participants received one bonus mark in exchange for taking part in this study.

Materials

Materials consisted of 91 index cards (3 x 5), each of which contained one of the DSM-IV criteria for each of the PDs (see Appendix B). The criteria in Appendix B were generated by this researcher to be consistent with Sprock et al.'s (1990) definition of a criterion: “any clause or phrase designated by a number or letter in the… [DSM-IV]… related to personality disorders, not including exclusionary criteria” (p. 587). As indicated, Sprock et al. used the DSM-III-R PD criteria, whereas the current research used the DSM-IV PD criteria.

Participants were further asked to complete the Marlowe-Crowne Social Desirability Scale ([MC-SDS] 1960, see Appendix C), in order to determine whether each
individual participant tended to respond in a socially desirable manner. The standard scoring procedure for the MC-SDS is to sum the responses that are scored in the socially desirable direction, as indicated in Appendix C. The mean level of desirability for the measure is 13.72, with a standard deviation of 5.78. For the purposes of the current study, a cut-off of 18 (approximately the mean plus one standard deviation) was used (i.e., a person who obtains a score greater than 18, is interpreted as responding in a socially desirable manner). The reliability of the measure, as reported by Crowne and Marlowe (1960) is .88, using the Kuder-Richardson formula. Furthermore, the MC-SDS appears to be the scale of social desirability that has been used most often since its inception in 1960.

Finally, participants filled out a basic demographic questionnaire, which included a manipulation check (see Appendix D). The manipulation check was an open-ended question in order to determine if the participants were consciously aware of the purpose of this study. According to Bordens and Abbott (1996), manipulation checks serve to “determine if the participants in your study perceive your experiment in the manner in which you intended” (p. 106). Therefore, if the participants in the current study indicate an accurate awareness of the purpose of the study, then this adds to the validity of the data. On the other hand, if participants have misinterpreted the purpose of the study (e.g., to study self-esteem), then this would call into question the validity of the data. Ancillary material included an informed consent form, an instruction sheet, and a written debriefing (see Appendix D).

Procedure

Participants were recruited by obtaining a list of randomly selected names and telephone numbers from the Department of Psychology Participant Pool. The pool
consisted of undergraduate students registered in psychology courses who voluntarily
signed up to take part in psychology research. The researcher contacted each of the
prospective participants by phone and provided a brief description of the study. If the
participant agreed to take part, a time was then set up for his or her participation.
Participation was voluntary and participants could withdraw at any time during the course
of their participation.

Upon arrival on the specified day and time, participants completed the written
consent form. The researcher answered any questions at this time. Participants were then
given the index cards, each card containing one criterion, to sort at their own pace. Each
index card had a different DSM-IV (1994) PD diagnostic criterion printed on it and each
participant received the criteria in a randomized order. At this time, participants were also
given an instruction sheet (see Appendix D), which asked them to sort the cards “along a
dimension of gender from features most characteristic of men to those most typical of
women” (Sprock et al., 1990, p. 587). Participants in Group 1 were able to sort the cards
into as many categories as they felt necessary to complete the task, whereas participants
in Group 2 were asked to sort the criteria into five categories using a Likert-type scale,
where one represented male-typed criteria and five represented female-typed criteria (see
Appendix D).

For Group 1, upon completion, the cards in each separate pile created by the
participant were collected with an elastic around each pile. The categories were then
coded on a continuum of 0 (zero) to 1 (one), with zero representing the male stereotype
and one representing the female stereotype. The endpoints of each participant’s piles were
the only ones preset at zero or one; the piles between these two endpoints were assigned a
number between zero and one, based on the number of piles the participant created. For example, three piles were assigned values of 0, .5 and 1; for four piles: 0, .33, .66, 1; for five piles: 0, .25, .50, .75, 1, and so on. There were different numbers of cards per category and different number of categories per participant. In addition, the number of categories created by each participant was also recorded.

For participants in Group 2, upon completion, the cards in each of the five piles were collected with an elastic around each pile. The five categories were then also coded on a continuum of 0 (zero) to 1 (one), with zero representing the male stereotype and one representing the female stereotype. In this group, however, each of the piles had a preset value of: 0, .25, .5, .75 or 1.0, whereas in Group 1, only the endpoints were preset. Therefore, for Group 2, there were a different number of cards per category but the same number of categories (five) per participant.

In the original study, Sprock et al. (1990) set the cut off scores for participant ratings as 0.20 for the male stereotype and 0.80 for the female stereotype. No explanation was given in Sprock et al. (1990) for setting the specific cutoffs, and personal communication with J. S. Sprock (August 6, 2001) revealed that they were indeed arbitrarily set, seemingly on the basis of the data. In other words, the authors set the cutoffs ad hoc, after they had collected and had begun analyzing the data. Sprock noted that “…[using] the top and bottom quarters of the scale…was too broad and would have too many of the criteria…[whereas]…few of the criteria were rated at the very top (.9 or higher) or very bottom (.1 or lower). Therefore, the structure of the data also played a role in our selection” (J. S. Sprock, personal communication, August 6, 2001).
In order to maintain consistency with the original study by Sprock et al. (1990), the current research used the same cut-off scores in order to determine if PD criteria and disorders are weighted according to gender. Therefore, those mean criteria and disorder ratings that fell below 0.20 were considered to be representative of the male stereotype; those mean criteria and disorder ratings greater than 0.80 represented the female stereotype. The decision to maintain the same cutoff scores was made in order to facilitate comparisons between DSM-III-R and DSM-IV PD criteria and categories. However, because these cutoffs were arbitrarily set, ad hoc, the current study also looked at more (<0.15 and >0.85) and less (<0.25 and >0.75) conservative cutoffs for the purpose of comparison in relation to the overall PD categories. It is hoped that these comparisons will provide some information as to the usefulness of Sprock et al.'s arbitrarily set cutoffs.

Immediately after completing the sorting task, each participant was asked to complete the 33-item MC-SDS (Appendix C), followed by the demographic questionnaire, which included the manipulation check (see Appendix D). A manipulation check was included on the demographics questionnaire, which was administered after participants completed the other tasks. The manipulation check was in the form of the following question: "In one sentence, what do you think was the purpose of this study?". The purpose of the question was to determine if participants were consciously aware that the focus of the research was their notions of gender/sex differences in various behaviors (that is, the 91 criteria that were sorted). Participants' responses were coded as either "yes" (aware of research interest) or "no" (not aware of research interest). The use of keywords and/or phrases, such as "gender roles," "gender/sex stereotypes," "characteristics of men and women," and "attitudes and traits of [the] genders" indicated a "yes" coding to these
responses. Examples of answers that were coded “no” include: “to study people’s self-esteem,” “to assess empathy,” and “comparing aggressiveness to personality traits”.

Finally, each participant was given a written debriefing (Appendix D), explaining the purpose of the study. Any additional questions and/or concerns were addressed at this time.

In addition, although the current study did not measure the effect of response latency on the validity of participant responses, a brief review of this topic can be found in Appendix E. Similarly, a brief review of the relevance of gender orientation to the study of mental health can be found in Appendix F.

Results

Manipulation Check

Analysis of responses to the manipulation check revealed that the majority of participants (83.6%) were aware of the general area of interest of the research. In the present study, in contrast to studies in which the true purpose must be concealed, the fact that a high number of participants were aware of its purpose increases confidence in the validity of the data. An analysis of variance indicated no significant difference in responding to the manipulation check as either a function of sex ($F(1, 72) = 2.73, p = 0.10$) or group ($F(1, 72) = 0.52, p = 0.47$).

Marlowe-Crown Social Desirability Scale

Three participants were not included in the analyses of the Marlowe-Crown Social Desirability Scale (MC-SDS) as they did not complete the entire measure, therefore $n=70$ for this scale. A univariate analysis of variance (ANOVA) revealed no significant difference in pattern of responding either as a function of sex ($F(1,69) = 0.66, p = 0.42$),
or of group \( F(1, 69) = 0.72, p = 0.40 \). There was no significant interaction between sex and group \( F(1, 69) = 0.02, p = 0.89 \). The overall mean of responses was \( M = 14.91 \) (SD = 5.76). Females scored slightly higher (\( M = 15.49 \), SD = 5.91) than did male participants (\( M = 14.34 \), SD = 5.64), but this difference was not significant.

The overall mean response (\( M = 14.91 \)), was less than the preset cutoff of \( M = 18 \). Correlational analyses revealed no significant relationship (\( r = 0.18, p = 0.14 \)) between MC-SDS scores and participants' ratings of the criteria. In addition, there was no relationship (\( r = 0.01, p = 0.97 \)) between MC-SDS scores and the number of categories created by participants in Group 1. Therefore, as a group, participants did not appear to respond in a socially desirable manner. Therefore, on the basis of representing oneself in a socially desirable manner, participants were assumed to have responded accurately and the data are viewed as a valid reflection of participants' views with respect to rating the criteria.

**Group 1 (Unlimited-Category Group)**

There were 37 participants in the group that was instructed to sort the criteria into as many categories as they felt necessary to complete the task (Group 1). The mean number of categories used by participants in Group 1 was 3.70 (SD = 1.62), ranging from two to seven categories. The modal response was to sort the cards into two categories (most representative of males and most representative of females). Statistical analysis revealed no significant difference (\( t = -0.26, p = 0.80 \)) in the number of categories into which participants sorted the criteria as a function of the sex of the participant. In other words, male and female respondents in Group 1 did not sort the individual criteria into a different number of piles or categories.
Individual Criteria

Statistical analyses revealed high correlations (a range of: \( r = 0.82 \) to \( r = 0.87 \)) between the mean criteria responses for both sex (male and female) and group (1 and 2). Therefore, it was not necessary to analyze the individual criteria as a function of either sex or group. Tabachnick and Fidell (1996) note that in some situations in which multiple ANOVAs are performed and data (dependent variables or DVs) are not correlated, a Bonferroni type adjustment is used. However, as noted, in the present study, the DVs (i.e., mean ratings for each criterion) are highly correlated. According to Tabachnick and Fidell, “the problem with reporting univariate Fs for correlated DVs is inflation of Type I error rate; with correlated DVs, the univariate Fs are not independent and no straightforward adjustment of the error rate is possible” (p. 402). In other words, conducting 91 consecutive ANOVAs (one for each of the 91 criteria) would significantly increase the chance of finding a significant difference by chance alone (i.e., Type I error).

Mean responses were obtained for each of the 91 criteria by summing each participant’s rating for a criterion and dividing by the number of participants (N=73). Those criteria with a mean rating of less than 0.20 were considered to be most representative of males and those criteria with a mean rating of greater than 0.80 were considered most characteristic of females. Eight of the 91 criteria (8.79%) met one of these predetermined cutoffs (see Table 1). It is interesting to note that of the eight criteria that met the “most-characteristic-of” cut-off, six were sorted to represent the male stereotype, four of which are criteria for a diagnosis of Antisocial PD. The other male-type criteria were from the Borderline and Narcissistic PDs. The only criteria ranked as being most characteristic of females were from the Histrionic PD.
Personality Disorders by Categories

As noted previously, analyses on individual criteria were neither necessary (due to the high correlations reported above) nor recommended (due to the high likelihood of Type I error). However, a number of analyses were conducted on the mean ratings of the overall PD categories.

Mean ratings for the overall PDs are found in Table 2. The data in this table are rank ordered according to mean ratings for each PD (that is, the mean of each PD category collapsed across sex and group). None of the overall means for any of the PD categories met either the less than 0.20 or greater than 0.80 cutoffs for most characteristic of males or females, respectively. However, as can be seen by looking at the rankings (Table 2), Antisocial \( M = 0.22, \ SD = 0.14 \), Schizoid \( M = 0.38, \ SD = 0.14 \), and Narcissistic \( M = 0.42, \ SD = 0.15 \) PDs were rated as most characteristic of males, whereas Avoidant \( M = 0.65, \ SD = 0.16 \), Dependent \( M = 0.64, \ SD = 0.16 \), and Histrionic \( M = 0.60, \ SD = 0.11 \) PDs were rated as most characteristic of females.

Indeed, while there was no difference in these trends if more conservative cutoff scores were employed (i.e., \(<0.15\) for males and \(>0.85\) for females), if less conservative criteria (i.e., \(<0.2\) for males and \(>0.75\) for females) are used, Antisocial PD \( M = 0.22 \) then falls into the critical cutoff area in order to represent male stereotypical behaviors. This finding is consistent in both Groups 1 and 2. Therefore, while it seems that Sprock et al. (1990) did use arbitrary cutoff points, designated ad hoc, more or less conservative cutoffs do not, generally, make substantial differences to the interpretation of the ratings made by participants in the current study.
Statistical analyses were also conducted on each of the PD categories in order to determine if there was any difference in overall mean ratings as a function of either sex or group (see Table 2). ANOVAs revealed that there was no difference in mean ratings by men and women for any of the PD categories. Neither were there significant differences between the two groups of participants (unlimited-category and 5-category groups) in how they rated the overall PDs, with one exception. The one exception is with the Obsessive-Compulsive PD, which showed a significant difference in overall mean ratings as a function of group ($F(1,72) = 4.41, p = 0.04$). That is, participants in Group 1 (unlimited-category group) ranked the criteria associated with Obsessive-Compulsive PD as significantly more representative of males than did Group 2 (5-category group).

Discussion

The purpose of the current study was twofold. The primary purpose was to determine whether gender weighting does indeed exist within the diagnostic criteria for personality disorders (Axis-II) in the DSM-IV. This was investigated by replicating a study conducted by Sprock et al. (1990). Recall that Sprock et al. asked their participants to sort DSM-III-R Axis II PD criteria along a continuum of masculine to feminine (a summary of the differences between the DSM-III-R and DSM-IV criteria can be found in Appendix A). Their participants were asked to complete the same sorting task as were the participants in Group 1 (unlimited category group) in the present study. In the current research, none of these overall PD categories met the preset cutoff for representing male-typed ($< 0.20$) versus female-typed ($> 0.80$) disorders.

Consistent with prior research (e.g., Ekselius, et al., 1996; Golomb et al., 1995; Sprock et al., 1990), Dependent, Histrionic and Avoidant PDs were rated as most
characteristic of women in terms of absolute numbers, whereas Antisocial and Schizoid PDs were rated as most representative of men. However, consistent with Kass et al. (1983) showing no differences, none of the differences in the present study were significant or even marginally significant, in large part due to the wide variations in response as evidenced by the large standard deviations for each category. The replication of these findings in future studies could provide clear evidence that PDs are not reflections of gender stereotypes.

Furthermore, male and female participants in the current study rated the criteria similarly. One possible explanation for this result is that men and women have been socialized to have the same sex-based stereotypes, and therefore see the typical behaviors presented in the criteria in a consistent manner. This explanation would be consistent with Landrine’s (1987, 1989) Social Role Hypothesis, which contends that diagnostic criteria are parallel to, indeed perhaps even reflective of, sex-role stereotypes. If this is the case, then Landrine’s proposal that PDs actually represent a medical screen to a political issue is a valid one. On the other hand, an compelling notion would be that males and females in fact are more similar than they are different (in terms of the behaviors described within the criteria), which would reflect a change in society’s views of the sexes. Regardless, however, response patterns suggest the need for further study in order to adequately address the question of whether gender weighting is present within the DSM-IV criteria for personality disorders.

A secondary research question in this study was to determine whether participants sorted the criteria differently as a function of what instruction group they were assigned to. Recall that participants in Group 1 (unlimited-category group) were free to sort the
criteria into as many categories as they wanted (consistent with Sprock et al.’s 1990 original study), whereas participants in Group 2 (5-category group) were instructed to sort the criteria into five categories. In general, group membership did not have an overall effect on how the criteria were sorted, as indicated by the high correlations reported in the previous section. However, when the criteria were then grouped according to disorder, Obsessive-Compulsive PD was ranked as significantly more male-typed by participants in Group 1 than by participants in Group 2. It is unclear as to why this difference was found, but the result does suggest a need for future research in this area. Given that only this one disorder out of the eleven possible overall PDs (including the superordinate generic criteria) had a significant effect for group membership, there may be other extraneous variables that were not accounted for in the analyses. Alternatively, the significant finding may be due to chance. That ten out of eleven disorders were not ranked differently as a function of group membership suggests that group membership would not have an overall effect on participant ratings and that there was no significant difference between the groups to account for this finding. It is also possible, however, that there is something inherent in the Obsessive-Compulsive PD itself that is substantially different from the other disorders which has resulted in this finding. Again, further research in this area may be warranted.

Although the current research may provide some insight into how men and women view a prescribed set of behaviors (i.e., the criteria), an obvious limitation is the use of a nonclinician sample. Typically, it is clinicians who apply these (and other) criteria in order to make a diagnosis of a PD and it is unknown if a clinician sample would rate the criteria in a significantly different way than did the university student nonclinician sample. Similar
research using a clinician sample is indicated in order to determine the generalizability of the results to a population that is more likely to make such diagnoses. More simply put, the generalizability of the current study is limited to a nonclinician undergraduate population.

One weakness of the current study and other research is failure to examine the role of the evaluator's own gender role orientation (masculine, feminine, androgynous) in the application of gender stereotypes. A related area of interest might be the evaluator's sexual orientation (gay, lesbian, bisexual, transgendered). Future research may benefit from examining the role of the clinician's gender and sexual orientations in the application of gender stereotypes in the diagnosis and treatment of mental illness.

Another issue to consider within the current research was briefly discussed at the beginning of this section; specifically, the differences between the two groups. A recent literature search revealed no prior research investigating whether people who are free to sort stimuli into an unlimited number of categories (Group 1) do so in a significantly different way than those people who are instructed to sort stimuli into a specified number of categories (Group 2). Although no overall differences were found in the current study, with the possible exception of Obsessive-Compulsive PD, future research will need to address this issue in order to determine if the finding is replicable.

In conclusion, although some nonsignificant trends in sorting the criteria were evident, statistical analyses failed to find significant differences indicating gender weighting within the criteria for DSM-IV Axis II PDs. It would be interesting to determine whether the same results would occur for a non-clinician sample identified according to their own gender-role orientation or a clinician sample categorized in the same way. It could be the
case that studies employing this more fine-grained analysis would support a dimensional view of PDs with gender being one of the relevant dimensions. It is important that clinicians and others who work with people who have either been diagnosed with a PD or are exhibiting symptoms of such a disorder, be familiar with any patterns of bias that may be inherent in the disorders themselves, such as biased criteria. Awareness of the patterns discussed empowers the clinician, thus enabling them to provide the best care and treatment possible to their clients.
References


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<tr>
<th>Criteria</th>
<th>Mean</th>
<th>SD</th>
<th>Disorder</th>
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<td>#29: Pervasive pattern of disregard for and violation of the rights of</td>
<td>0.17</td>
<td>0.18</td>
<td>Antisocial</td>
</tr>
<tr>
<td>others occurring since age of 15 years</td>
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<td></td>
<td></td>
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<td>as indicated by repeatedly performing acts that are grounds for arrest</td>
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<td>#33: Irritability and aggressiveness, as indicated by repeated physical</td>
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<td>fights or assaults.</td>
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<td>#34: Reckless disregard for safety of self or others.</td>
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<td>#45: Inappropriate, intense anger or difficulty controlling anger (e.g.</td>
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<td>0.81</td>
<td>Borderline</td>
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<td>frequent displays of temper, constant anger, recurrent physical fights.</td>
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<td></td>
</tr>
<tr>
<td>#47: Pervasive pattern of excessive emotionality and attention-seeking.</td>
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<tr>
<td>#51: Consistently uses physical appearance to draw attention to self.</td>
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<td>Histrionic</td>
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<td>#65: Shows arrogant, haughty behaviors or attitudes.</td>
<td>0.17</td>
<td>0.25</td>
<td>Narcissistic</td>
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</table>

dimension scale: 0.00 = characteristic of males; 1.00 = characteristic of females
Table 2

Mean Ratings and Analysis of Variance for Each DSM-IV Personality Disorders By Sex and Group

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<tr>
<th>Personality Disorder</th>
<th>Mean and SD*</th>
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<th>P</th>
<th>F</th>
<th>P</th>
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<td>Antisocial</td>
<td>Mean = 0.22</td>
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<td>0.66</td>
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<td>Schizoid</td>
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<td>4.04</td>
<td>0.05</td>
<td>1.02</td>
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<tr>
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<td>SD = 0.14</td>
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<td>Narcissistic</td>
<td>Mean = 0.42</td>
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<td>0.83</td>
<td>1.48</td>
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<td>Obsessive-COMPULSIVE</td>
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<td>0.40</td>
<td>4.41</td>
<td>0.04**</td>
<td>0.72</td>
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<td>General Criteria</td>
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<td>1.13</td>
<td>0.29</td>
<td>0.07</td>
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<tr>
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<td>Borderline</td>
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<td>0.80</td>
<td>2.32</td>
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<tr>
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<td>Histrionic</td>
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<td>Dependent</td>
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<td>Avoidant</td>
<td>Mean = 0.65</td>
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Personality disorders are ranked according to mean rating.
*overall mean ratings, where on the continuum 0.00 = male-type; 1.00 = female-type
**indicates significant at the 0.05 level (α = 0.05)
APPENDIX A

Annotated Listing of Changes in DSM-IV
(DSM-IV, p. 787)
Based on literature reviews, data reanalysis, and desire for compatibility with ICD-10 Diagnostic Criteria for Research, items have been modified to increase clarity and specificity and to reduce possible gender bias.

**Antisocial Personality Disorder.** Based on literature review, data reanalyses, and field-trial results, the criteria has been condensed, simplified, and slightly altered: two items (irresponsible parenting and failure to sustain a monogamous relationship) have been deleted; two items tapping consistent irresponsibility (failure to sustain consistent work behavior or honor financial obligations) have been collapsed into one item; and Criterion C (specifying the relationship to Conduct Disorder) has been simplified.

**Borderline Personality Disorder.** An additional item for transient, stress-related paranoid ideation or severe dissociative symptoms has been added in DSM-IV.

**Passive-Aggressive Personality Disorder.** This disorder has been deleted from the Classification. A revised version has been moved to Appendix B, “Criteria Sets and Axes Provided for Further Study.”
APPENDIX B

DSM-IV Personality Disorder Criteria
1. An enduring pattern of inner experience and behavior that deviates markedly from
the expectations of the individual's culture. This pattern is manifested in two (or
more) of the following areas: cognition (i.e., ways of perceiving and interpreting
self, other people, and events); affectivity (i.e., the range, intensity, lability, and
appropriateness of emotional response); interpersonal functioning; or impulse
control

2. An enduring pattern that is inflexible and pervasive across a broad range of
personal and social situations

3. An enduring pattern that leads to clinically significant distress or impairment in
social, occupational, or other important areas of functioning.

4. A pervasive distrust and suspiciousness of others such that their motives are
interpreted as malevolent

5. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving
him or her

6. Preoccupied with unjustified doubts about the loyalty or trustworthiness of friends
or associates

7. Reluctant to confide in others because of unwarranted fear that the information
will be used maliciously against him or her

8. Reads hidden demeaning or threatening meanings into benign remarks or events

9. Persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights

10. Perceives attacks on his or her character or reputation that are not apparent to
others and is quick to react angrily or to counterattack
11. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

12. Pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings

13. Neither desires nor enjoys close relationships, including being part of a family

14. Almost always chooses solitary activities

15. Has little, if any, interest in having sexual experiences with another person

16. Takes pleasure in few, if any, activities

17. Lacks close friends or confidants other than first-degree relatives

18. Appears indifferent to the praise or criticism of others

19. Shows emotional coldness, detachment, or flattened affectivity

20. Pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior

21. Ideas of reference (excluding delusions of reference)

22. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or “sixth sense”; bizarre fantasies or preoccupations)

23. Unusual perceptual experiences, including bodily illusions

24. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)

25. Suspiciousness or paranoid ideation

26. Inappropriate or constricted affect
27. Behavior or appearance that is odd, eccentric, or peculiar

28. Excessive social anxiety that does not diminish with familiarity and tends to be
   associated with paranoid fears rather than negative judgments about self

29. Pervasive pattern of disregard for and violation of the rights of others occurring
   since age 15 years

30. Failure to conform to social norms with respect to lawful behaviors as indicated by
   repeatedly performing acts that are grounds for arrest

31. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for
   personal profit or pleasure

32. Impulsivity or failure to plan ahead

33. Irritability and aggressiveness, as indicated by repeated physical fights or assaults

34. Reckless disregard for safety of self or others

35. Consistent irresponsibility, as indicated by repeated failure to sustain consistent
   work behavior or honor financial obligations

36. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt,
   mistreated, or stolen from another

37. Pervasive pattern of instability of interpersonal relationships, self-image, and
   affects and marked impulsivity

38. Frantic efforts to avoid real or imagined abandonment

39. Pattern of unstable and intense interpersonal relationships characterized by
   alternating between extremes of idealization and devaluation

40. Identity disturbance: markedly and persistently unstable self-image or sense of self
41. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)

42. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

43. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

44. Chronic feelings of emptiness

45. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

46. Transient, stress-related paranoid ideation or severe dissociative symptoms

47. Pervasive pattern of excessive emotionality and attention seeking

48. Uncomfortable in situations in which he or she is not the center of attention

49. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior

50. Displays rapidly shifting and shallow expression of emotions

51. Consistently uses physical appearance to draw attention to self

52. Has a style of speech that is excessively impressionistic and lacking in detail

53. Shows self-dramatization, theatricality, and exaggerated expression of emotion

54. Suggestible, i.e., easily influenced by others or circumstances

55. Considers relationships to be more intimate than they actually are

56. Pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy
57. Grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

58. Preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love

59. Believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)

60. Requires excessive admiration

61. Sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations

62. Interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends

63. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others

64. Often envious of others or believes that others are envious of him or her

65. Shows arrogant, haughty behaviors or attitudes

66. Pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation

67. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection

68. Unwilling to get involved with people unless certain of being liked

69. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed

70. Preoccupied with being criticized or rejected in social situations
71. Inhibited in new interpersonal situations because of feelings of inadequacy

72. Views self as socially inept, personally unappealing, or inferior to others

73. Unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

74. Pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation

75. Difficulty making everyday decisions without an excessive amount of advice and reassurance from others

76. Needs others to assume responsibility for most major areas of his or her life

77. Difficulty expressing disagreement with others because of fear of loss of support or approval (NOTE: do not include realistic fears of retribution)

78. Difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)

79. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant

80. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself

81. Urgently seeks another relationship as a source of care and support when a close relationship ends

82. Unrealistically preoccupied with fears of being left to take care of himself or herself

83. Pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency
84. Preoccupied with details, rules, lists, order, organization or schedules to the extent that the major point of the activity is lost

85. Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)

86. Excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)

87. Overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

88. Unable to discard worn-out or worthless objects even when they have no sentimental value

89. Reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things

90. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes

91. Shows rigidity and stubbornness
APPENDIX C

Marlowe-Crowne Social Desirability Scale
Personal Reaction Inventory

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

1. Before voting I thoroughly investigate the qualifications of all the candidates.
2. I never hesitate to go out of my way to help someone in trouble.
3. It is sometimes hard for me to go on with my work if I am not encouraged.
4. I have never intensely disliked anyone.
5. On occasion I have had doubts about my ability to succeed in life.
6. I sometimes feel resentful when I don’t get my way.
7. I am always careful about my manner of dress.
8. My table manners at home are as good as when I eat out in a restaurant.
9. If I could get into a movie without paying and be sure I was not seen I would probably do it.
10. On a few occasions, I have given up doing something because I thought too little of my ability.
11. I like to gossip at times.
12. There have been times when I felt like rebelling against people in authority even though I knew they were right.
13. No matter who I’m talking to, I’m always a good listener.
14. I can remember “playing sick” to get out of something.
15. There have been occasions when I took advantage of someone.
16. I’m always willing to admit it when I make a mistake.
17. I always try to practice what I preach.

18. I don’t find it particularly difficult to get along with loud mouthed, obnoxious people.

19. I sometimes try to get even rather than forgive and forget.

20. When I don’t know something I don’t at all mind admitting it.

21. I am always courteous, even to people who are disagreeable.

22. At times I have really insisted on having my own way.

23. There have been occasions when I felt like smashing things.

24. I would never think of letting someone else be punished for my wrong-doings.

25. I never resent being asked to return a favor.

26. I have never been irked when people expressed ideas very different from my own.

27. I never make a long trip without checking the safety of my car.

28. There have been times when I was quite jealous of the good fortune of others.

29. I have almost never felt the urge to tell someone off.

30. I am sometimes irritated by people who ask favors of me.

31. I have never felt that I was punished without cause.

32. I sometimes think when people have a misfortune they only got what they deserved.

33. I have never deliberately said something that hurt someone’s feelings.
## Scoring of Marlowe-Crowne Social Desirability Scale

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APPENDIX D

Ancillary Material
Demographic Questionnaire

1. Sex: [ ] male
   [ ] female

2. Age: _____ Date Of Birth ________________

3. Race:  [ ] White  [ ] Black  [ ] Other (please specify)_________
   [ ] Native Indian  [ ] Asian

4. Marital Status:  [ ] single
   [ ] spouse/partner
   [ ] divorced

5. University Major: ________________ Year: _____

6. In one sentence, what do you think was the purpose of this study?
Informed Consent

I am a graduate student in Clinical Psychology and am currently conducting a study in order to complete my Master’s Thesis. This study is designed to assess how certain statements are ranked along a dimension of gender. The research is being conducted under the direction of Dr. Cheryl Thomas, from the Department of Psychology at the University of Windsor. As noted above, for this study, you will be asked to sort a number of statements along a gender dimension.

Please understand that your participation in the study is totally voluntary and that you are free to stop your participation at any time without penalty. You may also choose not to answer any question(s) without penalty. All of your responses will be held in strict confidence by the researcher. At no time will your identity (e.g., name or student number) be reported with your results. All results will be added to those of other participants and reported in group form.

This research has been approved by the University of Windsor’s Ethics Committee. If you have any complaints about the research, you may contact Dr. Stewart Page, Chair of the Psychology Department’s Ethics Committee (253-4232 ext. 2243).

After you have participated in the study, the researcher will discuss it further with you. Also, if you have any additional questions, please feel free to contact either myself by leaving a note in my mailbox in the Psychology Department Mail Room/Lounge or Dr. Cheryl Thomas (ext. 2252). The results of this study will be available at the end of June, 2001. Please let me know if you are interested in receiving further information about the findings of this study. Thank you for your participation.

Please sign the Consent Form at the bottom of this page, detach it, and give it to the researcher. You may keep the top portion for your records.

Consent Form

I have read the above Informed Consent information regarding this study about gender. I understand the information provided and give my consent to participate with my signature below.

Name ___________________________ Signature ___________________________ Date ________________

Student Number: ___________________________
Instructions (Group 1)

The cards that you have just been given each contain one statement. The statements may be about an action, a thought, a feeling, or a combination of any of these. Your task is to sort the cards along a dimension of gender from features most characteristic of men to those most typical of women. Please place the card(s) most characteristic of men towards your left and those most characteristic of women towards your right (see diagram below). You can use as many categories as you feel are necessary in order to complete the task.

Cards most characteristic of males

Cards most characteristics of females

You can create as many categories or piles of cards as you feel are necessary in order to sort the cards into the above dimension.

Remember, your task is to sort the cards into a continuum of male-female characteristics

If you have any questions, please feel free to ask the researcher at this time.
Instructions (Group 2)

The cards that you have just been given each contain one statement. The statements may be about an action, a thought, a feeling, or a combination of any of these. Your task is to sort the cards into five (5) categories or piles according to the scale below. Please place the card(s) most characteristic of men towards your left and those most characteristic of women towards your right (see diagram below).

<table>
<thead>
<tr>
<th>Cards most characteristic of males</th>
<th>Neither male nor female</th>
<th>Cards most characteristics of females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Please sort the cards into the five categories or piles as shown above using the following scale:

1 = definitely male characteristic
2 = somewhat male characteristic
3 = neither male nor female characteristic
4 = somewhat female characteristic
5 = definitely female characteristic

Remember, your task is to sort the cards into a continuum of male-female characteristics

If you have any questions, please feel free to ask the researcher at this time.
Debriefing

The present study is concerned with assessing how a variety of statements are perceived along a dimension of gender. The statements were taken from the criteria that are required in order to diagnose a client with a personality disorder. The primary purpose of the study is to determine the extent to which gender stereotypes are present, if at all, in these criteria and the personality disorders as a whole.

If you have any comments or concerns about the present study, please feel free to contact myself, Melissa Hobbs, by either leaving a note in my mailbox in the Psychology Lounge, leaving a message with one of the secretaries in the Psychology Department, or by email at: hobbs4@uwindsor.ca. Alternately, you may contact Dr. Cheryl Thomas (253-4232, ext. 2252), my research supervisor.

Thank you again for your participation.

Melissa C. Hobbs
APPENDIX E

Response Latencies
Response Latencies

Measuring response latency involves measuring the amount of time it takes for a participant to respond to each item with which they are presented. Although this definition is somewhat terse, it follows logically that the most reliable means of obtaining measurements of response latency involves computer-administration of test items. Without the aide of a computer, there is much room for error in recording how long it takes for participants to respond to each item on any given measure. For these reasons it seems impractical to measure response latencies within the scope of the present study. For the interest of the reader, however, the following is a brief review of findings with respect to response latencies and the validity of responses.

Tetrick (1989) looked at response latencies in computer-administered version of the Marlowe-Crowne Social Desirability Scale using two separate data sets. Both data sets consisted of undergraduate students, in Psychology and Business. Tetrick proposed that the more difficult a task, the longer it would take participants to respond or make a decision. Results suggested that responding false to a socially desirable statement took the longest amount of time, even after controlling for reading speed (which can account for up to 50% of the variance in response latencies). Similarly, Brunetti, Schlottman, Scott, and Hollrah (1998) computer-administered the Minnesota Multiphasic Personality Inventory – Second Edition (MMPI-2) to three groups of undergraduate student (N=120). The first group was asked to respond to the questions honestly, whereas the second and third groups were instructed to “fake” their responses, either by underreporting or overreporting pathology. They expected that those participants in either of the “faker”
groups would have longer response latencies than those participants who were instructed to respond honestly. Indeed, they concluded that “subjects responded more quickly when accepting schema-related items and more slowly when rejecting them” (p. 151).

Holden (1995) conducted a series of experiments (involving both an undergraduate sample and an unemployed adult sample) in order to test the general model of lying (i.e., it takes more time to answer a question falsely than it takes to answer it honestly) and its generalizability to personnel testing. He hypothesized that “schema-congruent responses should be relatively faster than noncongruent answers” (P. 352). For both samples of participants, he used a computer to administer various items from a number of personnel and employment questionnaires. Participants were told to imagine that they were applying for a “sensitive government position” (p. 346) and were randomly assigned to either answer the items honestly or to fake their answers in order to obtain the position. In both samples, the faking groups had longer response latencies, particularly when endorsing items that corresponded to delinquency (such as drug and alcohol use). Holden and Hibbs (1995) and Holden, Woermke, and Fekken (1993) found similar results in subsequent research in which they looked at the interaction of a participant’s self-schema and the content of test items on various personality measures. That is, “differential response latencies reflect the interaction of an individual’s schema with test item content” (Holden et. al., 1993, p. 1). From the review conducted, it seems reasonable to expect that validity of responses may be measured, at least to some degree, through simultaneous measurement of response latencies. If the proper equipment and time are available, evaluation of response latencies may indeed add a measure of response validity to the study of psychological phenomenon.
APPENDIX F

Gender Orientation
Gender Orientation

A related issue to the study of sex and gender stereotypes is the concept of gender orientation or gender identity. According to Lips (1997), gender orientation “is the individuals’ private experience of his or her gender: the concept of the self as male or female” (p. 145). On the other hand, sexual orientation is defined as “the degree of erotic responsiveness to the other sex (heterosexuality) or to one’s own sex (homosexuality)” (Lips, 1997, p. 150). In reviewing the recent literature in this area, it appears that there have been a number of studies looking at the sex and gender orientations of clients and the effects of such orientations on the therapeutic relationship. For example, Biaggio, Roades, Staffelbach, Cardinali, and Duffy (2000) asked 422 clinicians to read a case vignette and then provide a diagnosis and assess the client’s level of functioning. The vignette described a client with symptoms consistent with a diagnosis of a Major Depressive Episode. The vignettes given to the clinicians differed only as to the client’s “gender, sexual orientation (heterosexual or gay/lesbian), and gender role (traditional or nontraditional occupation)” (p. 1660). The authors concluded that there does appear to be evidence of clinician bias in both the diagnosis and assessment of functioning based on the client’s gender, gender role and sexual orientation. Specifically, “gay/lesbian clients were rated as functioning better in their significant relationships, were seen as more motivated for therapy, and were viewed as having a higher need for medication” (p. 1165). The authors go on to suggest that perhaps clinicians have lower expectations (e.g., of relationship stability and thresholds of dysfunction) for gay/lesbian clients than for heterosexual clients, which would account for the seeming higher functioning ratings given to the gay/lesbian clients.
In another study, Cheng (1999) investigated the influences of gender-role and social support in incidence of depression. His measures included: the Short Form of the Bem Sex-Role Inventory (S-BSRI; Bem, 1974, 1981) to assess gender-role/gender orientation; the Inventory of Socially Supportive Behaviors (ISSB; Barrera, Sandler, & Ramsay, 1981) to assess social support; and the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) as a measure of depression. Cheng concluded that higher rates of femininity were associated with higher rates of depression, whereas the relationship between high levels of masculinity and depression is negatively correlated.

Taking a different perspective, Wisch and Mahalik (1999) assessed the effect, if any, of the male clinician's gender role conflict on their clinical judgements of their male clients. In order to provide some answers to this question, Wisch and Mahalik invited 539 male clinicians (recruited via membership in the APA, Division of Psychotherapy) to take part in the study. The response rate was 36% (i.e., 196 out of 539 perspective participants completed and returned the measures). In addition to each participating clinician completing the Gender Role Conflict Scale (GRCS; O’Neil, Helms, Gable, David, & Wrightsman, 1986), participants were each provided with one vignette and a client rating scale. The client rating scale was to assess the clinician's level of: liking, empathy, comfort, willingness to see, adjustment and prognosis towards the client. The researchers found that as the clinician's gender conflict increased, their positive reactions to the client in the vignette decreased. That is, there was a negative correlation between the clinician's gender conflict and the clinician's positive reactions towards the client.

Although gender orientation was not the focus of the current study, the above review of recent literature is intended to make the reader aware that gender orientation, of
both the client and the clinician, is an issue that is relevant to the study of gender and mental health in general. This brief review is indicative of future research needs in this area.
VITA AUCTORIS

Melissa Hobbs was born in Ottawa, Ontario in 1972. She obtained a General B.A. in October 1998 and an Honours B.A. with thesis in Psychology in 1999, both from the University of Windsor. She is currently a candidate for the Master's degree in Clinical Psychology and hopes to graduate in the Fall of 2001. She is continuing her education at the Ph.D. level in Clinical Psychology at the University of Windsor.