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Tracy Dyer
University of Toronto Scarborough

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Tracy Dyer*

The degree to which gender bias is present in the clinical diagnosis of personality disorders has been a subject of substantial interest in the realm of clinical psychology. This review explores the existence, causes and solutions of gender bias in the diagnosis of personality disorders. The existence and causes of gender bias within the Diagnostic and Statistical Manual of Mental Disorders (DSM) and various diagnostic tools is first examined through the lens of social constructivism as well as through critically analyzing various past studies on the topic. This revealed a significant finding: that gender bias is, in fact, present in both the DSM criteria itself as well as within various other diagnostic measures. In addition, extant research showing that clinicians themselves are not immune to gender bias is critically examined. Finally, a variety of options that may help decrease the impact of gender bias in the diagnosis of personality disorders are briefly reviewed.

In 1978, following the release of the third version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the coding of personality disorders as distinct from Axis I disorders served to highlight immense sex ratio differences within the diagnostic rates of specific personality disorders (Strain, 2003). As a result, research within the field of clinical psychology began to center around gender differences and suspected gender bias contained within these diagnoses (Strain, 2003). Since the late 1970's, much research has concluded that although differential prevalence rates may represent authentic gender differences to a certain extent, gender bias does, in fact, exist and affect the diagnoses of personality disorders. Furthermore, it has become evident that gender bias exists within the DSM criteria itself—a notion which can be analyzed through the lens of social constructivism. Likewise, gender bias also presents itself within other diagnostic instruments such as self-report measures. It is additionally evident that clinicians themselves are not immune to holding gender bias which may affect the accuracy of their diagnostic decision-making. Fortunately, however, there are many viable options for the future DSM, diagnostic instruments and for clinicians themselves to help decrease the influence of gender bias on the diagnosis of personality disorders. Overall, there is much evidence for the existence of gender bias within the realm of personality disorder diagnosis and has its roots both within the DSM and amongst diagnostic instruments and diagnostic decision-making; however, there are many steps that can be taken by both clinicians and academics to reduce its influence.

Numerous studies have concluded that several personality disorders tend to be distributed quite consistently by gender. Borderline, Histrionic and Dependent Personality Disorders are more frequently diagnosed in female clients while Antisocial, Narcissistic, Obsessive-Compulsive and Cluster A Personality Disorders—Schizoid, Schizotypal and Paranoid—Personality Disorders tend to be more frequently diagnosed in males (APA, 2000; Donohue, Fowler, & Lilienfeld, 2007). Currently, it is undetermined to what extent the mentioned differential prevalence rates actually represent the base rates of disorders in the real

* Initially submitted for PSYD32H3 at University of Toronto Scarborough. For inquiries regarding the article, please e-mail the author at *tracy.dyer@mail.utoronto.ca*.

world. Until the true prevalence rates of these disorders can be determined in community samples by eliminating sampling bias in research, the answer still remains unclear (Bjorklund, 2007). Some argue that the root of these gender discrepancies in clinical judgment is that clinicians diagnose in accordance to the base rates of these disorders and are thus not necessarily depicting gender bias (Becker & Lamb, 1994). However, other researchers argue that clinician diagnoses form the foundation for the base rates of particular personality disorders and those base rates may be utilized by clinicians to "rationalize bias" in diagnostic decision-making (Becker & Lamb, 1994). Furthermore, even if clinicians are, in fact, influenced by formerly established base rates of personality disorders, if they over-diagnose a specific disorder in females versus in males because it is thought to be more prevalent in females than in males, the result is an amplified effect of gender bias on existing base rates (Becker & Lamb, 1994).

When addressing the question as to why and how gender bias exists within the realm of clinical psychology, researchers often look to the "root" of clinical psychology—in this case, the DSM. Phil Brown is a professor of sociology and health science specializing in the notion of social constructivism as it relates to patterns in medical diagnoses. Brown (1995) offers a unique commentary on social constructivism as it relates to diagnosis saying, "it is quite possible to believe that biomedical components are important, while still emphasizing social forces as well as people's interactive definition-making... We are, after all, talking about phenomena which occur in people's bodies" (p. 37). They key phrases in Brown's quotation include "social forces" and "definition-making" which both apply to the categorization of the various personality disorders. In essence, social constructivism is defined a school of thought that emphasizes the collaborative and interactive nature of learning and definition-making—including the categorization of definitions of the various personality disorders (Brown, 1995). Hence, as DSM categories—in this case, personality disorders—are the result of human social forces, social constructivism can be used as a lens to critique the DSM as a source of flawed human definition-making and thus of human gender bias.

To clarify further, Brown (1995) argues that there are three main "versions" of social constructivism that are most relevant to the area of medical diagnoses. First, social problems such as the dysfunctional behaviors of a patient diagnosed with a specific personality disorder are purely matters of social definition (Brown, 1995). Personality disorders are thus essentially "unreal" from an objective standpoint but rather are intended to be "social labelers and problem finders" (p. 35). Because they are purely left up to social definition, they are thus products of flawed human definition-making which encompasses our many biases and prejudices such as gender bias. Secondly, Brown (1995) argues that the language and symbols that characterize a certain entity, such as a specific personality disorder, must be deconstructed and analyzed to depict how the knowledge of that category is formed. In other words, we must deconstruct the categorization of personality disorders in order to understand how biased human definition-making has been ingrained into the very definitions of these categorizations. Finally, Brown (1995) makes mention of the concept of "science in action" (p. 36)—in other words, that the construction of scientific facts is the result of an ongoing process in which our definitions of specific personality disorders are constantly changing. Thus, although bias is prevalent in the diagnostic criteria for many disorders within the DSM, there is always room for research, problem-solving and thus, improvement. All three aspects of Brown's (1995) dissemination can apply both to

criticisms of the DSM as well as criticisms of associated diagnostic tools.

In relation to Brown's (1995) social constructivist viewpoints, Landrine (1989) argues that "if every woman is somewhat histrionic or dependent, and every man is somewhat compulsive, paranoid, or antisocial, the reason may be that gender-role categories and personality disorder categories are simply flip sides of the same stereotyped coin*"* (p. 332). Landrine (1989) came to this conclusion after conducting a study in which undergraduates attributed descriptions of each personality disorder to various social factors such as gender or social status. Moreover, in the second part of the study, Landrine (1989) found that the Sadistic Personality Disorder of the DSM-3 was often attributed to white males and the Self-Defeating Personality Disorders of the DSM-3 were attributed to middle-class females. Thus, although personality disorders are exemplified by extreme, and thus maladaptive behaviors, the DSM has been criticized for falsely pathologizing individuals who are overt exemplifiers of the stereotypical sex roles—both male and female (Donohue, Fowler, & Lilienfeld, 2007). Many healthy individuals who conform to these roles may account for the observed patterns of sex differences in personality disorder diagnosis (Donohue, Fowler, & Lilienfeld, 2007; Caplan, 1987; Landrine, 1989). For instance, males who are more "masculine" and thus exhibit more antisocial behavior than typically seen in females are more likely to actually attain a diagnosis of Antisocial Personality Disorder as per DSM criteria—regardless of whether nor not their behavior meets the criteria of being definably dysfunctional or not. Similarly, females who exhibits overtly "feminine" traits such as that of histrionic behavior may be more likely to be given a diagnosis of Histrionic Personality Disorder as per DSM criteria regardless of whether or not their behavior is truly dysfunctional or not. From Brown's (1995) social constructivist lens, it can be argued that the current definitions of personality disorders within the DSM has given rise to this unfair patholigization of individuals who are extreme examples of their respective stereotypical sex roles. The criteria that was used in order to categorize and diagnose these personality disorders must be re-evaluated to account for healthy individuals merely express more traits associated with their masculinity or femininity, respectively.

Another important critique of the DSM is the evidence of gender differences that exist in the expression of personality traits in males versus in females. One such example is the evidence of gender differences in the expression of antisocial behavior (Dolan & Volm, 2009). In males, antisocial behavior tends to be expressed as irritability, aggressiveness and recklessness; while in females, antisocial behavior tends to be expressed as financial irresponsibility, failure to plan ahead, impulsivity and lack of remorse (Dolan & Volm, 2009). Dolan and Volm (2009) also found that key personality traits associated with offending behavior are expressed quite differently in males versus in females. For instance, impulsivity may be expressed primarily as self-harming behavior in females but as violence against others in males. Currently, the DSM does not make mention of these significant differences in expression of pathological behaviors and may be one of the reasons why disorders such as Antisocial Personality Disorder is more commonly diagnosed in males than in females than disorders such as Borderline Personality Disorder—in which self-harming behavior is a criterion—more commonly diagnosed in females than in males. From the realm of social constructivism, Brown's (1995) second version of social constructivism most effectively illustrates this particular criticism of the DSM—the language and symbols which were used to define DSM

categories must be further specified in order to combat gender bias. In this case it is the definition of words such as "impulsivity" or "recklessness" that needs further clarification within the DSM criteria to account for gender differences in the expression of these traits.

Similar to the biases associated with the DSM, much research has looked into the various flaws of diagnostic instruments such as diagnostic screening tests. One such example was observed in a study conducted by Lindsay, Sankis & Widiger (2000), where it was concluded that the Millon Clinical Multiaxial Inventory (MCMI)-3 and MCMI-2 may be particularly biased in misperceiving behaviors that are more "masculine" in nature as indicative of maladaptive, pathological narcissism. Additionally, Dolan & Volm (2009) mentioned, the expression of antisocial behavior within females as differing from that of males. Females tend to express antisocial behavior as financial irresponsibility, failure to plan ahead, impulsivity and lack of remorse while score higher on items of irritability, aggressiveness and recklessness (Dolan & Volm, 2009). However, the Factor 2 Psychopathy Checklist—revised (PCL-R) items tend to focus on male antisocial behaviors (Dolan & Volm, 2009). Once again, through the lens of social constructivism, the language and symbols—such as the definition of "antisocial behavior"—which were used to construct these diagnostic instruments much be reconsidered and further specified to account for gender differences.

In addition to constructive flaws within the DSM and associated diagnostic instruments, clinicians themselves are susceptible to making vast flaws in diagnostic decisions as a result of gender bias. In 1978, the year of the release of the DSM-3 and the coding of personality disorders as distinct from Axis I disorders, Dr. Phil Warner performed a well-known study which formed a precedent for further research (Warner, 1978). Two groups of clinicians were given identical patient profiles that were descriptive of a patient with Histrionic Personality Disorder (Warner, 1978). When told the patient was a female, the majority of clinicians accurately provided a diagnosis of Histrionic Personality Disorder; however, when told the patient was a male, clinicians tended to diagnose the patient as having Antisocial Personality Disorder (Warner, 1978). Since Warner's initial study in 1978, many other researchers have replicated his results with similar experimental methods—that is, two different groups of clinicians were provided with identical patient profiles except for the designation of the patient's gender. Studies have concluded that clinicians tend to make different diagnoses when the patient is male versus when the patient is female and vice versa. For instance, Adler (1990) performed a study in which clinicians were given identical patient profiles—excluding gender—describing a patient who met the DSM-3's diagnostic criteria for Histrionic, Narcissistic, Borderline and Dependent Personality Disorder. Akin to the results of Warner's original study, men were more likely to be rated as narcissistic while females were more likely to be rated as histrionic (Adler, 1990). Interestingly, Adler (1990) also found that Narcissistic Personality Disorder was largely overlooked when the patient was described as female while histrionic personality disorder was largely overlooked when the patient was described as a male. In another variation of Warner's original study, Becker & Lamb (1994) presented clinicians with three sets of different, randomly-assigned, patient profiles detailing a female patient with both borderline personality disorder and post-traumatic stress disorder symptomatology as well as three matching sets of male patient profiles. Once again, it was found that when the patient was presented as a female, clinicians tended to diagnose the patient with Borderline Personality Disorder and less so when the

patient was signified as being a male (Becker & Lamb, 1994). These studies, as well as the many other variations of Warner's original study depict how clinicians tend to favor the more prototypically "male" personality disorders when the client is a male and more prototypically "female" personality disorders when the client is a female.

Adler (1990) has suggested that at the root of these diagnostic errs is the fact that clinicians are just as likely as others to make causal attributions based on perceptually salient information—regardless of whether such information is related to diagnostic criteria or not. In this case, gender constitutes a piece of salient information which determines a significant "pattern" or "set" that clinicians utilize to comprehend behavior (Adler, 1990). Specifically, according to Adler (1990), such information can be exemplified as sex role categorization—which allows clinicians to reduce a large amount of information into a "more manageable typology" (p. 130). In addition, both Strain (2003) and Adler (1990) make mention of the fact that the influence of gender on personality affects both male and female clinicians equally with no known interaction effects. Such a finding led Adler (1990) to conclude that the gender stereotype process is the result of the culture as opposed to flaws on the part of individual clinicians. Strain (2003), also agreed that gender bias occurs almost automatically, in a "rapid, effortless and unconscious manner" by adulthood (p. 4). The concept of a "cultural gender bias" impacting diagnostic decision-making is supported by various studies in child psychology depicting how behaviors of children are viewed differently depending on whether the observer believes the subject is a boy versus a girl (Adler, 1990). In the future, clinicians need to take these such findings into awareness when making diagnostic decisions.

As always within the realm of science, where there are problems there are plenty of solutions that address combating bias within the DSM itself, within diagnostic instruments and within diagnostic decision-making. For starters, the DSM itself must clarify the threshold at which behaviors become maladaptive for questions of gender bias to thoroughly be examined and thus countered (Widiger and Spitzer, 1991). This could help reduce the number of healthy individuals, who are extreme examples of their respective gender roles yet are pathologized under DSM criteria. Second, both the DSM and associated diagnostic instruments, such as the Factor 2 PCL-R items, need to clarify the definitions of traits that are expressed differently in males and females. For example, as there is evidence that the trait of impulsivity is expressed differently in males versus in females, the DSM needs to make note of such differences in expression and clarify what behaviors constitute "impulsiveness" with respect to gender differences. Finally, Delphin (2002) proposes that, in attempting to minimize diagnostic bias, clinicians should engage in specific cognitive practices that allow for the conscious reflection of their own thought process and decision-making ability. Delphin (2002) suggests that questions clinicians might ask of themselves when making a diagnosis could include:

> "What are common general or clinical stereotypes associated with this person's ethnicity, gender, social class, etc.?"; "How are my perceptions of this client similar to, or different from these stereotypes?"; "Are there cultural influences impacting this person's clinical presentation?"; "What function are the symptoms in question serving for this individual?"; "Are these functions adaptive or maladaptive?" (p. 69).

The reason why Delphin (2002) proposes questions which "surround" bias as opposed to which directly question the existence of bias within the clinician is largely because her study

concluded that clinicians tend to underdiagnose personality disorders when actively attempting to achieve an unbiased diagnosis. Delphin (2002) also suggests that when possible, mental health professionals should implement "treatment teams" in which two or more professionals come to the same diagnostic conclusion before the diagnosis is given.

All in all, the concept of gender discrepancies and thus gender bias with regards to personality disorders is still a widely-debated topic within the realm of both academia and popular science. Within the field of personality disorder diagnosis, there is overwhelming evidence for the existence of diagnostic gender bias—both within the DSM criteria itself, diagnostic instruments and diagnostic decision-making—however, there is much potential for combating such bias. Overall, although the extent to which differential prevalence rates represent authentic gender differences is still an unanswered question, gender bias in the diagnosis of personality disorders does exist. One of the main causes of such bias is engrained within the DSM criteria itself—which can be explored through the lens of the social constructivist school of thought. Likewise, the many diagnostic tests and tools that clinicians utilize present a form of bias similar to that found in the DSM. And finally, clinicians may be hindered by gender bias in making accurate diagnostic decisions. Fortunately, however, researchers have suggested many potential improvements for combating gender bias within clinical psychology such improving the DSM criteria and associated diagnostic instruments as well as encouraging clinicians to engage in critical self-reflection when making a personality disorder diagnosis. And, as Brown (1995) makes mention of in his third concept of social constructivism—medical diagnoses are aspects of "science in action" (p. 36); thus, where there are problems, there are always solutions.

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