Cluster B Personality Disorders Separated by Gender Expectations

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Abstract

Criticisms of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000), the most widely recognized system for classification of psychological disorders in the U.S., including gender discriminating disorders and diagnoses, have existed for all editions of the DSM. Arguably, gender construction has a profound influence on the standards and evaluation of normal and abnormal behaviors. Concern for the presence of gender bias of personality disorders has been raised within the DSM, in part, by the frequent diagnoses made according to gender stereotypes. The DSM-IV-TR characterizes personality disorders as marked distress and impairment caused by persistent and inflexible thoughts and behaviors that deviate from cultural norms (APA, 2000). Disorders are categorized into three clusters: (A) odd or eccentric, (B) dramatic, emotional, or erratic, and (C) fearful or anxious. With a specific focus on cluster b personality disorders (Antisocial, Borderline, Narcissistic, and Histrionic), I conducted a rhetorical analysis of the diagnostic criteria to evaluate evidence of consistency with, or deviation from, gender expected behaviors: four masculine and four feminine expectations, explicated by Wood (2007). Similar underlying characteristics of criterion between disorders were masked by differences of gendered behaviors, i.e. impulsivity, which has been defined differently across the gendered disorders. Disorders were then compared based on similarity of diagnostic characteristics, level of gender consistency, and the prevalence and frequency of gendered diagnoses. Adopting a multidimensional approach for the diagnosis of personality disorders would be more comprehensive and would accommodate for individual human differences and support the development of new treatments.

Cluster B Personality Disorders Separated by Gender Expectations

It comes as no surprise that social norms affect our everyday lives, but to what end? Gender expectations are the most fundamental elements of a person's life – our sense of self. Mental illness can cause a disturbance to the self identity and behavior (Barlow & Durand, 2005). In the US, psychological disorders are based on the standards of the Diagnostic and Statistical Manual (DSM). Gender, and sex, biases have been topic of interest from several editions and revisions of the DSM. According to the DSM-IV-TR (2000), the current edition of the DSM, a personality disorder is described 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" (American Psychiatric Association [APA], pp. 685; Barlow & Durand, 2005) These disorders are categorized into three clusters: (A) odd or eccentric, (B) dramatic, emotional, or erratic, and (C) fearful or anxious. Focusing on the cluster b, there are four disorders in this category: Antisocial Personality Disorder (ASPD), Borderline Personality Disorder (BPD), Histrionic Personality Disorder (HPD), and Narcissistic Personality Disorder (NPD). The DSM outlines the criteria requirements, both behavioral and historical, that need be present and observed in order to make a diagnosis of a psychological disorder. The behavior criteria concentrate on the social aspects of these disorders while the historical criteria address the development (see Appendix A, Appendix B, Appendix C, and Appendix D for diagnostic criteria of all cluster b personality disorders). All the cluster b personality disorders are similar in development; therefore historical criteria are not a focus of this investigation.

Since the addition of personality disorders in the DSM-III it has been under controversy, especially in regards to a sex/gender bias (Hartung & Widiger, 1998). To reevaluate the presence

of a gender bias within the diagnostic criteria, the language, or the verbiage, used to describe the symptoms of psychological disorders deserves a closer look. The underlying issues are similar but, due to stereotypes, are described in gendered manifestations (Adler, Rosenfeld, & Proctor, 2007;Jane, Oltmanns, South, & Turkheimer, 2007; Morey, Warner, & Boggs, 2002). The language of the criteria reflecting gender expectations has a result of more men being diagnosed with ASPD and NPD and women with BPD and HPD (Looper & Paris, 2000; Lynam & Widiger, 2007; Jane et al, 2007; Morey et al, 2002). There are several consistencies between all of the disorders, since they are all part of the same cluster of the disorders and share overlapping characteristics. These commonalities are worded differently for disorders that perpetuate stereotypic values of gender. Conversational style also affects the language of criteria by use of report-talk (masculine) and rapport-talk (feminine). Termed by Tannen (1990, as cited by Eckstein & Goldman, 2001) these conversation styles are gendered in nature; report is characterized as instrumental, direct and independence preservation, while rapport is primarily used for establishing connections with others (Eckstein & Goldman, 2001) and characterized as apologetic and negotiating (Wood, 2007; Adler et al, 2007); reflected in descriptions of symptoms as gendered behavior (Adler et al, 2007).

Several studies have concluded that personality disorders overall are not bias, but individual criterion could be biased (Morey et al, 2002). As a whole category, cluster b holds the highest potential of having gendered criterion; therefore higher potential of future actions, i.e. cross-treatments. In addition, previous research has maintained a biological influence (Feingold, 1994) where men and women react differently, partially based on the difference of experience for each gender, to similar situations (Morey et al, 2002). But men and women also have different issues to deal with and therefore respond differently (Adler et al, 2007). In summation,

some gender bias is due to differences that may actually exist between genders (Hartung & Widiger, 1998). Support for the use of a multi-dimensional approach to diagnosing personality disorders is needed (Krueger & Tackett, 2006; Morey et al, 2007), due to a gender bias that need not be present (Widiger & Samuel, 2005).

Method

To evaluate evidence of consistency with, or deviation from gender expected behaviors, leading to a possible gender bias I conducted a rhetorical analysis of the behavioral criteria of cluster b personality disorders. Consistency is the reinforcement of stereotypical gender expectations; gendered behaviors that fit into a prescribed range of appropriate behaviors. Inconsistency, or deviation, is behavior opposite of what is expected or consistent with an expectation of the opposite gender. The gender expectations used for analysis, explicated by Wood (2007), are four masculine expectations: (1) be self-reliant, (2) be successful, (3) be aggressive, and (4) don't be female (p. 171-174); the four feminine expectations utilized here are: (1) be superwoman, (2) appearance counts, (3) negative treatment by others, and (4) be sensitive and caring (p. 174-180). The criteria were evaluated individually by gender expectations to determine a gender identity for each disorder. Based on these evaluations and corroborating evidence from previous studies the disorders were compared across similarities and differences in expectations. *Note: All variables of this analysis are highly interwoven and overlap significantly; for simplicity and clarity all analyses are a 1:1 relationship.

Masculine Expectations

Be self-reliant. A "real man" depends on himself, takes care of himself and relies on no one, especially women (Wood, 2007).Driven by the masculine code, to fight, defend others, endure pain stoically, and (above all) win (Wood, 2007; Dindia & Canary, 2006) men are

expected to be self-reliant, to not be controlled or influenced by feelings or emotions (Wood, 2007). Some counselors believe that the social ideals that men try to live up to can increase psychological distress and have created an epidemic of male depression (Mahalik, Good, & Englar-Carlson, 2003). This is perpetuated by the fact that men are less likely to seek psychiatric treatment (Wood, 2007; Panayiotou & Papageorgiou, 2007).

Be successful. Men are expected to be successful at what they do; not just be good, but to surpass others. The status expectation of "better than all" is the foundation of competition (Mahalik et al, 2003). Competitive sports (among other activities) in adolescence are transformed in adulthood into status achieved in professional settings. Being expected to be a good provider, "breadwinner," for the family is a fundamental requirement of manhood that effects men regardless of race or class (Wood, 2007). Being regarded as "success objects," a man's status, as a value of success, becomes a measure of his worth as man, partner and friend (Wood, 2007).

Be aggressive. Aggressiveness that is encouraged in boys/men include standing up for oneself and being strong when confrontations arise; which can escalate and lead to violence, especially against women (Kivel, 1999; Messner, 1997a, 1997b as cited by Wood, 2007). Men are expected to stand up for themselves and not run from confrontation (Wood, 2007). Sports not only encourage success, i.e. competition, but also aggression. Males are often rewarded for toughness and beating the competition (Mahalik et al, 2003)Wood, 2007).

Don't be female. Reinforced early in development the main expectation instilled in boys, is not to be female. Men are to be tough, aggressive, not sensitive and not caring because displaying feminine characteristics is not acceptable (Wood, 2007); however, it is more acceptable now for women to be more masculine (Klonsky, Jane, Turkheimer, & Oltmanns, 2002).

Feminine Expectations

Be superwoman. Wood (2007) asserts, the hardest expectation to maintain is the pressure to be superwoman and "have it all;" an unrealistic expectation that will tax women both physically and psychologically (Panayiotou & Papageorgiou, 2007). The need to have it all, to do it all, and to be it all can be seen in the phenomenon that feminists have termed the "second shift" (Hochschild & Machung, 1989/2003). The first duty of women was to take care of the home until they also proved to be valuable in the work force. Men's duties and responsibilities didn't change, and continue to be well established, while women's duties doubled; they work outside the home to return home and work a "second shift," running the household.

Appearance counts. According to Wood (2007), it is no surprise that the influence of beauty standards (Hartung & Widiger, 1998), i.e. a focus on apparel, affect a lot of women and continue to be based on white standards. Women are regarded as "sex objects," especially in the media, as seen in discussion of female athletes in terms of their appearance instead of their skill (Wood, 2007; Messner, Duncan & Jensen, 1993).

Negative treatment by others. Aggression against woman is present in two forms, in between-group aggression, men v women, and in within-group aggression, women v women, due to the expectation of negative treatment by others that women face. According to the U.S. Department of Justice, women are nearly four times as likely to be victims of violence and aggression by men (Panayiotou & Papageorgiou, 2007). Women are also the focus of aggression by other women and it is just as damaging. Encouragement for women to build relationships and attacks on those relationships (most often manifested in a psychological form) can have devastating effects. Beginning early in the social development of girls, negative treatment of females can have a significant influence on peer groups and can be especially intense or extreme

(Chesler, 2001; Lamb, 2002; Simmon, 2002; Tarvis, 2002 as cited by Wood, 2007). Fearing disapproval or punishment women avoid overtly being mean to others, thus girls engage in social aggression (Simmons, 2002, 2004; Underwood, 2003 as cited by Wood, 2007; Skodol, 2003, 2005). This aggression is rarely physical, but as Wood (2007) states, the psychological distress can be far more damaging, for example through the spreading of rumors. The internalization of negative social views is apparent within the aggression among girls and women as a reaction to the high standards of appearance and attractiveness; reflected and reinforced by media influence.

Be sensitive and caring. In contrast, the most encouraged feminine ideal is to care about and empathize with others in order to maintain stable relationships. According to Wood (2007), in order to be sensitive there is a perceived need to be gentle with others' opinions and to be accommodating to others' feelings.

<div align="center">Analysis</div>

Evaluation of cluster b personality disorders

Antisocial Personality Disorder. According to the *Diagnostic and Statistical Manual of Mental disorders*, Antisocial Personality Disorder is characterized as a pervasive pattern of disregard for and violation of the rights of others (APA, 2000; see Appendix A). A person with ASPD is aggressive and violent in nature, but takes this behavior to excess. The majority of the criteria are related to aggression, specifically toward others. Some of ASPD criteria maintain physical aggressiveness with "reckless disregard for safety of self or others," "repeated physical fights" and "performing acts that are grounds for arrest" (see Appendix A). This is perpetuated by emotionally disruptive behavior of "being indifferent to or rationalizing having hurt" somebody, which leads to future violent behaviors (see Appendix A).

In regard to the expectation of being successful, ASPD is divided, being both consistent and inconsistent; "Deceitfulness: … for personal profit or pleasure" supports status and power behaviors (see Appendix A). The inability to be reliable for work responsibilities is not important to those with ASPD. They have no aspirations to get ahead within the work place, which is, contradictory to work related status; but continual failure to "honor financial obligations," to stay ahead monetarily (see Appendix A).

Relying on no one is a defining characteristic of ASPD. "Impulsivity or failure to plan ahead" makes it difficult to build a relationship, and consistent with masculine independence. This independence is maintained by "uses of aliases" and violation of work obligations to disconnect from others (as the label *Antisocial* Personality Disorder suggests, there is a resistance to socialization) (see Appendix A).

All but one criterion for ASPD is reinforced by extreme aggressive focus and disregard for anyone; examples are refusal to "conform to social norms," lying and cheating for personal gain without concern for safety when displaying aggressive behavior. ASPD has a characteristic of "lack of remorse" when violating the "safety of self and others" and the rationalization of one's actions (see Appendix A).

Narcissistic Personality Disorder. Narcissistic Personality Disorder is characterized by a pervasive pattern of grandiosity, need for admiration and lack of empathy (APA, 2000; see Appendix D). The "lack of empathy [for] the feelings and needs of others" (see Appendix D) by means of manipulation to achieve desired outcomes is opposite of the feminine expectation of being sensitive and caring of others. The expectation of being successful has a significant influence on the criteria of NPD, with the majority of the criteria relating to status. The thoughts and ideas associated with NPD are "preoccupied with fantasies of unlimited success, power,

brilliance,…" (see Appendix D). To maintain the high status requirement of masculinity, Narcissists will take "advantage for others to achieve [their] own ends" (see Appendix D) and feel that they are unique and can only relate to others as special as they are, leading to "exaggerat[ion of] achievements and talents" with the need to be "recognized as superior without commensurate achievements" (see Appendix D).

Borderline Personality Disorder. Borderline Personality Disorder is characterized by a pervasive pattern of instability of interpersonal relationships, self-image, and affect, with marked impulsivity (APA, 2000; see Appendix B). BPD impulsive criterion, partially rooted in the need to be liked by others, reveals itself in behaviors that are self-damaging in nature; examples include, promiscuity, substance abuse, and binge eating (see Appendix B). But, other presentations of self-damaging behaviors are of a personal focus, which is inconsistent with the expectation to care about others.

The negative treatment by others affects BPD the strongest; encouraging internalization of the negative treatment, which can lead to social aggression (the feminine equivalent to masculine physical aggression). According to Wood (2007), the expectation of being nice, that women are to care about others and maintain relationships, is affected by "frantic efforts to avoid real or imagined abandonment." This develops a "pattern of unstable and intense interpersonal relationships" affected by the dramatic shifts "between the extremes of idealization and devaluation." The ability to fit the expectations of friendships, BPD has an element of "identity disturbance" characterized as an "unstable self-image or sense of self" (see Appendix B).

The criteria most reflective of this trait are apparent in BPD behaviors. The need for acceptance is the most important quality for BPD; people with BPD think that if they can have the support and acceptance of others, everything else will just fall into place, making them happy

and able to earn the right for it all. Relational stability is considered to be the catalyst for success in the other aspects of their lives.

Histrionic Personality Disorder. Histrionic Personality Disorder is characterized as a pervasive pattern of excessive emotionality and attention seeking (APA, 2000; see Appendix C). HPD is the only disorder to have criteria that overtly discusses physical attractiveness. HPD has criteria of interpersonally "inappropriate sexually seductive or provocative behavior," and relies on "physical appearance to draw attention" (see Appendix C). Being judged by physical appearance encourages this preoccupation, but these behaviors lead to a higher risk of sexual assault.

The need to be accepted, HPD criteria of "easily influenced by others or circumstances," is presented in a speech style that is "excessively impressionistic and lacking in detail" (see Appendix C). HPD also is affected by the expectation that to have it all is rooted in acceptance by "consider[ing] relationships to be more intimate than they actually are," which mirrors the idea that having it all is achievable (see Appendix C).

Comparison of cluster b personality disorders

There are several criteria that overlap and describe similar concepts, i.e. impulsivity (Looper & Paris, 2000), and some that are opposite of the corresponding disorder, i.e. displays of affect. Most of the behaviors presented by personality disorders are consistent and extreme gender expectations, and only a few that are inconsistent (deviating from the gender expectation). There are several traits that connect disorders further; Antisocial Personality Disorder and Borderline Personality Disorder are characterized by more extreme behaviors than Histrionic Personality Disorder and Narcissistic Personality Disorder (Samuels et al, 2002). All behaviors of diagnostic criteria have been deemed as abnormal by numerous professional

agencies. However, many of these behaviors don't seem disordered until in combination with other behaviors causing disturbance and distress in one's life. It is a common perception to see ASPD and BPD as extreme behaviors, often involving aggression. NPD and HPD, on the other hand, are disordered in the sense that behaviors are exaggerated and considered more as annoying. Considering behavior extremity level, the groupings for comparison of this analysis are ASPD with BPD and NPD with HPD; the criteria analyzed are whether the criteria in these groups are consistent or inconsistent with gender expectations. A triplet of main themes present throughout these disorders are the basis of comparisons: affect, aggression and interpersonal relationships.

Antisocial v Borderline

Affect. In regards to emotionality it is not okay for men to express emotions but with woman it is encouraged. The "lack of remorse" and indifference of Antisocial Personality Disorder (APA, 2000, see Appendix A) is consistent with the masculine expectation of not being female. The encouragement of emotionality is consistent with being sensitive and caring and manifests as "affective instability due to marked reactivity of mood" in Borderline Personality Disorder (APA, 2000, see Appendix B). However, BPD also has another complication of affectivity as "chronic feelings of emptiness" (see Appendix B), and is an inconsistency in the fact that is consistent with the masculine expectation to not be controlled by feelings and emotions. These abnormal affective behaviors of these disorders are consistent with gender appropriate emotionality, as a function of the expectations of being sensitive and caring with relationship to not being female.

The language of the affective criteria implies a gender difference, as BPD's criterion is broad, while ASPD is more specific when presenting lack of affect; implying that men lack the

emotional range that women have. BPD lacks the emotions that women would typically show, and is thus considered abnormal. Anger is a prominent criterion that is addressed by both disorders. "Irritability and aggression" describes anger's influence of ASPD (see Appendix A), while the criterion for BPD is described by "inappropriate, intense anger or difficulty controlling anger" (see Appendix B). Irritability is defined as "readily excited to impatience or anger" or "very susceptible of anger" (Irritable, 2009), which highlights a similarity despite the difference in wording.

Aggression. ASPD and BPD are recognized by abnormal expressions of aggression as a result of the volatile and unstable affect that affect their behavior. Typically, men are encouraged to be physically, externally, aggressive; while women are internally and socially aggressive. Externalizing aggression is apparent in ASPD by showing "reckless disregard for safety for self or others" and repeated offenses of assault (see Appendix A). These outward behaviors are consistent with the masculine expectation to be aggressive. Women, on the other hand, are discouraged from outward expressions of aggression leading to a range of personally and socially directed behaviors. As an example of personal-directed attention, BPD is the only disorder to include "self-mutilating behavior" (see Appendix B). Socially-directed aggression is behaviors that negatively affect others, such as "suicidal behavior, gestures or threats" (see Appendix B) and can have manipulative aspects. Presenting these behaviors without the intention of suicide is a form of attention seeking (feminine characteristic); this is not to say that all behaviors of this nature are attention-based.

In regards to the language of criteria, both disorders have the phrase "physical fights" but differing preceding words: repeated for ASPD and recurrent for BPD (see Appendix A and Appendix B). Both terms are basically defined the same with the exception that "repeat" is a

more dominate term, or root word, to "recurrent," which could be interpreted as gendered. These criteria are focused on the same behavior but in relation to gender expectation ASPD is consistent with aggressiveness while BPD is inconsistent with sensitivity and caring. Aggression tends to manifest differently between genders as an effect of these expectations, but considering abnormal behaviors for either gendered disorder reveal commonalities; i.e. "repeated physical fights and assaults" in ASPD (see Appendix A) while BPD displays "frequent displays of temper, constant anger, recurrent physical fights" (see Appendix B).

Interpersonal Relationships & Impulsivity. Interpersonal behaviors and attitudes are encouraged differently for men, to be loners and independent, than for women, to build lasting relationships (Wood, 2007). The difference in the need for acceptance between genders is apparent in the criteria of ASPD and BDP regarding socialization with others. As the name suggests, Antisocial-diagnosed individuals are isolated and withdrawn from others; adding to that aggression and blatant disregard of others inhibits healthy socialization (see Appendix A). On the other hand, individuals diagnosed with BPD are the opposite in the need for acceptance. The need to be a part of it all leads to "frantic efforts to avoid real or imagined abandonment" and to "a pattern of unstable and intense relationships" is a feminine example of unhealthy socialization (see Appendix B). Women feel the pressure to have it all and when pushed and pulled in too many directions at once can ultimately create an "unstable self-image or sense of self" and "identity disturbance" (see Appendix B). The pressure for men, however, differs from those of women in the sense that independence and status are desired masculine characteristics, and are reflected in ASPD as "deceitfulness: repeatedly, use of aliases, or conning others for personal profit or pleasure" (see Appendix A). However, "consistent irresponsibility: repeated failure to sustain consistent work behaviors or honor financial obligation" can be interpreted in

different ways (see Appendix A). One way being that this behavior is inconsistent with the expectation of success by failing to "make it ahead." Another interpretation is that, in a small way, it is considered being successful, as financial debt that is not paid is profit.

Present within both disorders, impulsive behaviors are described differently in the criteria of each disorder. Impulsivity is a highly complex concept that is evaluated and interpreted on many levels (Flory et al, 2006). There are conflicting opinions and evidence of the presences of a gender association in regard to impulsivity. Regardless of the complication of evaluating impulsivity behavior the fact remains that the same criterion exists within both disorders (Looper & Paris, 2000). Therefore the evaluation of the impulsivity criteria is of the language component.

ASPD criteria are described in a direct, report-style of communication (masculine) as compared to BPD, which has more descriptive examples, like feminine rapport-style communication (feminine). ASPD is broad and lacking detail while BPD has limitations and specifies exactly how impulsivity is presented. The phrase "in at least 2 areas that are potentially self-damaging," would imply that women are more impulsive than men (see Appendix B), in general and indicates the need to distinguish between women's regular impulsivity and abnormal impulsivity. But for ASPD, simply being impulsive is interpreted as abnormal and implies that men are expected to plan and organize (see Appendix A). On the other hand, this criterion might be meant as an extreme without actually saying so (or encouraging attention toward it).

Narcissistic v Histrionic

Affect. Difference of emotionality and affect is highly recognized as a discriminator of gender and continues to be encouraged. Comparing Narcissistic Personality Disorder's "lack [of] empathy" and Histrionic Personality Disorder's "rapidly shifting and shallow expression of emotions," shows that both criteria are describing a disturbance in affect but are manifesting in a

gendered manner(APA, 2000, see Appendix D and Appendix C). Empathy is a feminine expectation (Wood, 2007), therefore to be accepted, as masculine, NPD emphasizes the need to not show emotion and as a power element, not to empathize, or see things from others' points of view. For women with HPD, the need to fit in is incredibly important, so the emotional instability and surfacing is a technique to fit in, and to please others (Wood, 2007). The emotional behavioral descriptions are worded in a gendered manner, as seen by the "theatrical and exaggerated" emotions of HPD compared to NPD being characterized by "rapid escalation" of mood (see Appendix C and Appendix D); suggesting that women exaggerate while men are just hot-tempered.

Aggression. Social behaviors, of aggression, of NPD and HPD are opposite of each other, and reflect gender norms. Narcissists use others to their advantage to achieve a sense of success. A person with HPD, on the other hand, is "easily influenced" (see Appendix C), playing into the dominate-male-and-subordinate-female expectations. As a result, the relationship of the masculine expectation of aggressiveness and feminine negative treatment by others is categorized as aggression, despite the lack of physicality. Fantasies of power and ideal love of NPD, combined with a "sense of entitlement" and "unreasonable expectations" (see Appendix D), has the potential to lead to manipulative and abusive behaviors in relationships. Paralleling that with HPD tendency of "considering relationships to be more intimate than they actually are" lead women with HPD to be taken advantage of and being placed in positions to be potential victims of abuse (Wood, 2007; Panayoitou & Papageorgiou, 2007); even negative attention is attention after all.

Interpersonal Relationships & Attention. Attention is a commonality of Narcissistic and Histrionic Personality Disorders but is acted out differently; therefore creating gender

discrimination between criteria. NPD embodies elements of manipulation and exploitation, in contrast to HPD's elements of emotionality and relationship building. The focus of attention is a distinguishing variable relating to expectations of success and appearance. The majority of NPD criteria relate to the masculine expectation to be successful as seen by "arrogant, haughty behavior and attitudes," and the exclusivity of associations with "other special or high-status people" (see Appendix D). Similarly, HPD criteria exemplify the feminine ideals of appearance and attractiveness by interacting with others in inappropriate seductive and provocative ways and often using "physical appearance to draw attention to self" (see Appendix C). Despite the different attention seeking behaviors of these disorders, the fact remains that the underlying concept of the criteria is attention.

The need for attention influences both disorders, but the language of the criteria is the most gendered aspect between disorders, reflecting the social norms of evaluating men by skill and achievement, but women by appearance (Adler, 2007; Messner, Duncan, & Jensen, 2003; Wood, 2007). The phrase "requests attention" implies active control and power of the situation, in NPD (masculine) (see Appendix D); conversely, HPD is more submissive (feminine) to circumstances, i.e. to be "uncomfortable in situations" when not "the center of attention" (see Appendix C).

Discussion

Gender expectations are not only embedded into the criteria points, but are based on them. The normalization of gender expectations influences the language of the criteria but not necessarily the diagnosis. Personality disorders are far from normal. Previous research has found a sex differential in the diagnoses of several disorders, among them the cluster b personality disorders (Howell & Watson, 2002; Jane et al, 2007; Lynam & Widiger, 2007, Morey, Warner,

& Boggs, 2002; Morey et al, 2007). A sex bias, however, does not equate to a gender bias, but they are related. Implications of gender bias that may explain the sex differential in the diagnoses of personality disorders are population sampling, assessment, application, diagnostic constructs, thresholds and the criteria themselves (Jane et al, 2007; Widiger, 1998; Widiger & Samuel, 2005; Widiger et al, 2005).

The development of these diagnostic criteria could very easily have been based on a bias population sample due to misapplications of criteria that are based on misunderstanding of gendered behaviors (Howell & Watson, 2002; Widiger, 1998). Diagnostic assessment and application are designed for gendered populations, increasing the likelihood of a gendered diagnosis. Creating diagnostic criteria for these disorders have a high possibility of having gendered population samples, several cases with similar symptoms, as prototypes for these disorders. For example, a large percentage of the population sample for ASPD exists in the correctional system (Boggs et al, 2005; Fatemi & Clayton, 2008). The highly subjective evaluations of these disorders lend to the need to examine constructs of the criterion. The constructs of these criteria have been linked to gender stereotypes, inferring gendered behaviors as pathological, and reflects the difference of perceptions and prevalence of personality disorders (Flanagan & Blashfield, 2003; Jane et al, 2007; Widiger, 1998).

Changing to evaluating disorders on a spectrum, instead of the yes/no format of the current diagnostic method, may be beneficial by better accommodating human differences (Galatzer-Levy & Galatzer-Levy, 2007). People are multi-dimensional in nature, and deal with issues differently (Adler et al, 2007; Feingold, 1994), not just as men and women but individually. Evaluating personality disorders dimensionally rather than categorically (Tyrer et al, 2007; Johnson et al, 2008; Skodol et al, 2003, 2005) increases accuracy in the identification of

an individual's personal threshold and dysfunction, compared to a prescribed set of normal-abnormal limits (Howell & Watson, 2002; Johnson et al, 2008; Skodol et al, 2005); affecting more biases than gender, i.e. class. Tyrer et al (2007) reports an increase in consistency of agreement of personality disorder diagnoses by examining personality on a continuum; placing normal variations at one end and personality disorders on the other,. An edition to this theory, where the norms are central within the continuum and extreme consistence with expectations (gender or otherwise) on one end and extreme inconsistence at the other, may need to be considered. Thus, creating a better understanding of a wider range on adaptive and maladaptive characteristics of the disordered behavior (Johnson et al, 2008; Sprock, Crosby, & Nielsen, 2001; Widiger, Simonsen, Krueger, Livesly, & Verheul, 2005); to which more appropriate and effective treatments, and cross-treatments, may be produced (Looper & Paris, 2000; Widiger & Samuel, 2005); at least in the case of similar disorders, as defined in the comparison section. Though some research has supported a higher accuracy of diagnosis of personality disorders with a dimensional assessment (Morey et al, 2007; Tyrer et al, 2007), the concern is that clinician's objectivity could be compromised. Conducting assessments multi-dimensionally in conjunction with the current systems would limit subjectivity and aid in the development of multi-dimensional diagnostic assessment (Morey et al, 2007; Samuels et al, 2002; Widiger 1998). The benefits of a multi-dimensional approach are not limited to DSM criteria but also benefits the International Classifications of Diseases-10, a closely related set of personality disorder diagnostic criterion, due to its universality of use (despite human differences) (Johnson, First, Cohen, & Kasen, 2008).

In addition to a multidimensional approach, examination the language of the criteria provides many commonalities that can be treated in a similar fashion. Rewriting the criteria,

without gender implications, may reveal such commonalities to support a collapse or combinations of all four disorders. Evaluating combined disorders (Antisocial-Borderline and Narcissistic-Histrionic) on a continuum may give valuable insight into the development of new and more effective treatments; whereas collapsing all into one disorder holds no significant benefits, beyond those of the combined disorders and existance within the same cluster. Collapsing disorders may reduce the sex/gender differential in the diagnosis, but not all aspects of mental health gender differential, i.e. men's aversion to psychiatric evaluation & treatment (Mahalik et al, 2003). Tyrer et al (2007) assert the maintenance of four dimensions of personality for historical continuity and accuracy. However, Bernstein, Iscan and Maser (2007) reports that 75% of experts feel that the current system needs change, but how is still highly discussed (Widiger et al, 2005).

There are several ways to view gender's influence on mental health diagnoses. One way is to recognize the level that gender influences these disorders. If the presentations are actually gendered behavior then it would make sense to diagnose and treat patients in a gender appropriate manner. Recognition of specific gendered expectations and their influence on behavior could also help provide more effective treatment plans (not to mention valuable information on the disorder themselves). However, gender specific disorders can have a counterproductive effect when diagnoses are of the opposite gender; for example, a man diagnosed with a "woman's" disorder has to, not only, resolve issues associated with a psychological diagnosis but also a gender discrepancy that can hinder therapeutic efforts.

Bem (1974; Bem & Lenney, 1976) asserts that the masculine-feminine dichotomy lacks the recognition of gender's complexity and added androgyny (exhibiting both gender characteristics) and undifferentiated (lacking gender characteristics). Adding the biological sex

with these gender styles create eight sex-gender relationships reveals complexity of gender. A limitation of this analysis is the assumption of a typical sex-gender relationship; based on Bem's (1974) finding that in general people identify as either sex-biological type, masculine-male and feminine-female, or androgynous (Adler et al, 2007; Bem & Lenney, 1976). Examining different sex-gender types may reveal further the influence of gender expectations embedded in criteria of diagnoses, i.e. women with ASPD may have increased masculine characteristics.

The limitation of using a one-to-one ratio for comparisons is that it denies the full complexity and commonalities (either as overlap or extreme opposition). When in combination with each other they may yield more evidence of gender bias; and incidentally lower the high use of "not otherwise specified" as a catch-all diagnosis for personality disorders (Samuel & Widiger 2006). The use of a one-to-one ratio was to isolate and identify aspects of gender, expectations, and personality disorders, in a clear and simplified deconstruction of information. Additionally, this analysis isolates four disorders, where other personality disorders have been seen to possess a gender bias but they seem to lack the strong similarities that exist between the cluster b personality disorders (Johnson et al, 2008; Morey et al, 2002; Skodol & Bender, 2003; Skodol et al, 2005; Widiger & Samuel, 2005).

The analyses of these disorders in the premise of a typical sex-gender relationship; further research of atypical sex-gender relationships and cluster b personality disorders is needed. Also, continuing the progression of integrating traditional assessments with a multi-dimensional approach, to improve assessment accuracy and overall understanding, could be beneficial for not only for personality disorders, but other psychological disorders as well. In addition, the benefits and drawbacks of gendered disorders should be explored, especially if in conjunction with a multidimensional approach. Within the same vein, collapsing the disorders

shows promise and is potentially beneficial, comparing the criteria on a one to one ratio. No cross evaluations were actively investigated; doing so could strengthen the support for the presence of gender bias inherent within the behavioral criteria. Finally, the continuation of gender research of mental illness for the battle of the sexes continues to be highly debated.

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Appendix A

Diagnostic criteria for 301.7 Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

    1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
    2. deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
    3. impulsivity or failure to plan ahead
    4. irritability and aggressiveness, as indicated by repeated physical fights or assaults
    5. reckless disregard for safety of self or others
    6. consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
    7. lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.

C. There is evidence of Conduct Disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (Personality Disorders pg. 706). Washington, DC: Author.

Appendix B

Diagnostic criteria for 301.83 Borderline Personality Disorder

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

1. frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.

2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3. identity disturbance: markedly and persistently unstable self-image or sense of self

4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.

5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

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

7. chronic feelings of emptiness

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

9. transient, stress-related paranoid ideation or severe dissociative symptoms

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental*

disorders: DSM-IV-TR (Personality Disorders pg.710). Washington, DC: Author.

Appendix C

Diagnostic criteria for 301.50 Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. is uncomfortable in situations in which he or she is not the center of attention
2. interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
3. displays rapidly shifting and shallow expression of emotions
4. consistently uses physical appearance to draw attention to self
5. has a style of speech that is excessively impressionistic and lacking in detail
6. shows self-dramatization, theatricality, and exaggerated expression of emotion
7. is suggestible, i.e., easily influenced by others or circumstances
8. considers relationships to be more intimate than they actually are

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (Personality Disorders pg. 714). Washington, DC: Author.

Appendix D

Diagnostic criteria for 301.81 Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3. 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)
4. requires excessive admiration
5. has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
6. is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
7. lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
8. is often envious of others or believes that others are envious of him or her
9. shows arrogant, haughty behaviors or attitudes

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (Personality Disorders pg. 717). Washington, DC: Author.

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