THE EFFECTS OF GENDER AND SEX-ROLE ATTITUDE ON THE DIAGNOSIS OF HYSTERICAL PERSONALITY OR HISTRIONIC PERSONALITY DISORDER USING DSM-II OR DSM-III

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CHAPTER I

INTRODUCTION

From as far back as 1400 B.C., the use of a psychiatric diagnostic classification system has enabled the diagnostician to characterize symptoms into groups. The intial system developed in India included seven major categories of psychological disorders. Through the centuries there have been alternative systems developed, including the forerunners of the present Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III). In 1952, the first edition of the DSM (DSM-I) was published and, not unlike the Indian system of seven classifications, contained eight major categories. The refinement could be seen in the nearly 100 specific diagnoses that were included in the eight divisions. In 1968, the DSM-II was released and likewise had approximately 100 diagnoses, but there were 10 major categories.

The most recent update of the DSM, the DSM-III, is more inclusive and detailed as evidenced by the 230 specific diagnoses subsumed under 17 major categories. A task force headed by Robert Spitzer, M.D., began work in the Fall of 1973 on this latest revision. Various investigators from across the country examined the drafts of the manual, and

their comments often resulted in modifications. Spitzer, Endicott, and Robins (1975) described the clinical criteria to be used for the diagnoses. In 1979, Spitzer, Forman, and Nee reported on the first set of field trials. Finally, Spitzer and Forman (1979) reviewed the second series of field trials for the manual and discussed, in more detail, the multi-axial features of the proposed DSM-III.

The DSM-III has been the target of much criticism, though no single feature has been the focus of these criticisms. McReynolds (1979) questioned the contention that the DSM-III hailed a new era in psychiatric diagnosis. He viewed it as a rewording of the previous manual and, thus, merely a semantic facelift. Karasu and Skodol (1980) were more specific in their reaction. It was their belief that, despite more than twice the number of specific diagnoses and major categories, the DSM-III failed to differentiate among cases in regard to conflicts, defenses, and coping mechanisms. Schacht and Nathan (1977) discussed multi-axial diagnostic simplicity in relation to the complexity of the process of classification and categorization. They further attacked the "medical model" format of DSM-III particularly as it affected psychologists. Finally, Frances (1980) reviewed the section of DSM-III on personality disorders, and discussed several of its more controversial diagnoses. From this brief review, one can see that the DSM-III is not without its critics and, more importantly, the criticisms appear to strike at the heart of the manual--the diagnostic

process. Appendix A of the present study provides a more complete review of the literature.

The basis for the present study can be found in the article by Schacht and Nathan (1977). In the discussion of the ramifications of "disease" oriented diagnoses, the authors point out that such a system ignores the social context of individual problems. They contended that the diagnostic process may actually affect what we see as normal. More specifically, the authors indicate that Briquet's syndrome (similar to DSM-II's hysterical neurosis) as defined by the diagnostic criteria in DSM-III is an easier category for the diagnostician to employ in respect to women than men; thus "proving" that women are more often diagnosed hysteric than men.

Such a conclusion infers a sex bias in psychological/psychiatric judgement. Several studies have been conducted that deal with that issue. Typically studies conducted on sex-bias in psychotherapy have dealt with the areas of assessment, treatment, and sex of judge or therapist. The results, not unlike the profession they reflect, are often contradictory.

Sex-bias in Psychotherapy

Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970), Billingsley (1977), and Kravetz (1976) explored the degree of sex-bias in the realm of clinical judgement. More specifically, they attempted to assess the clinician's

concept of optimum mental health, and found evidence of sex-role stereotype influence.

The most common dimension of assessment employed in investigations of sex-bias is the degree of maladjustment or psychopathology. In studies by Lewittes, Moselle, and Simmons (1973), Abramowitz, Abramowitz, Jackson, and Gomes (1973), LaTorre (1975), Zeldow (1976), Coie, Pennington, and Buckley (1974), and Schwartz and Abramowitz (1975), patient sex alone did not affect the evaluation of maladjustment.

Only three studies of diagnosis as a function of patient sex were found. Garland, Simon, and Sharpe (1973), Sue (1976), and Lewittes et al. (1973) looked at this more specific area and found contradictory results, thus, leaving the question unanswered. Studies on sex-bias by Brodey and Detre (1972), Sue (1976), and Schwartz and Abramowitz (1975) in the general area of treatment have centered on disposition variables such as differential assignment to individual versus group psychotherapy. Results were conflicting, and no sex-bias was found in the desirability for hospitalization.

Barocas and Vance (1974) investigated case loads at a university counseling center and found sufficient evidence to conclude a sex-bias. Abramowitz, Abramowitz, and Roback (1976) added the variable of duration of treatment as a function of sex. Their results indicate some basis for sex differential treatment procedures.

Billingsley (1977) investigated the effects of

therapist sex, patient sex, and type of psychopathology on the treatment goals of practicing psychotherapists. He found that client sex alone did not influence treatment goals.

Lastly, and importantly for the present study, are the results of the effect of sex of therapist/judge on various clinical judgements. Broverman et al. (1970) found no differences in female and male clinicicans' judgements of optimal mental health; they both endorsed a double standard. Billingsley's replication (1977) produced similar conclusions. Zeldow (1975, 1976) and LaTorre (1975) concluded that there was at least a tendency for assessor sex influencing clinicial judgements. Nowacki and Poe (1973) likewise found significant differences between male and female raters. In investigating sex-bias in diagnosis, one could also consider the more covert aspects of the process. Such study would include the assessor's attitude toward women. Although no specific research is available on diagnosis applied and the assessor's attitude toward women, inferences based on similar relationships could be made. A more detailed review of the literature in this area is found in Appendix A of the present study.

On a general level, research has shown evidence to indicate differential views of optimal mental health for males and females. More specifically, the sex of the patient appears to affect the diagnosis, and the sex of the therapist/judge was found to influence differing aspects

of clinical judgements. In addition, the latest revision of the DSM raises questions concerning the accuracy of the diagnostic process, more specifically the personality disorders section, the applicability and clarity of the diagnostic criteria, and the elimination of sex-bias in the diagnosis of histrionic personality disorder. Thus, there seems to be sufficient evidence to warrant research investigating the specific function of diagnosis and the effect of sex of patient, sex of therapist, level of training, and sex-role attitude on that process.

The diagnostic classification ambiguous enough to evidence sex-bias is that of hysterical personality (DSM-II). Some clinical researchers have reported that 92 percent of patients diagnosed as having hysterical personalities were women (Robins, 1966). Despite this rather remarkable figure, a review of the literature fails to show scientific research into the apparent sex-bias of this syndrome. Conversations with fellow clinicians most readily verify Robins' (1966) finding and represented the clinical "feel" of the hysterical personality. With the advent of DSM-III and its inclusive/exclusive criteria, it appears that a systematic approach to the study of this diagnosis is now available.

The Present Study

The present study was designed to investigate possible sex-bias of a specific diagnosis. For reasons discussed

previously, the diagnosis used was hysterical personality/ histrionic personality disorder. Literature suggests that the DSM-II classification of hysterical personality is employed more often for females than males. Considering the improvements of the DSM-III, this study examined the effect that the newer DSM edition has on diagnostic accuracy. Results of accurate diagnosis using DSM-II will be compared to the same results for persons using DSM-III.

Some indication has been found for sex-bias with respect to sex of patient in the diagnosis of hysterical personality. Although scientific study had yielded few results to support such a conclusion, demographic data and clinical "feel" warranted a controlled study of this variable. The present study investigated the influence that altering the sex of the client had on the diagnosis of hysterical personality/histrionic personality disorder.

Finally, an additional point brought out in the literature was the possible existence of sex-bias as a fucntion of the sex of the therapist/judge and the existence of an interaction between sex-role attitude and clinical assessment. The present study followed-up on this research but did so with the specific diagnosis mentioned above.

The study used both graduate and undergraduate students. Although the literature did not reflect research comparisons between trained and untrained assessors with respect to the application of clinical diagnosis, one might speculate on the results. This comparison enabled this

researcher to compare the diagnostic accuracy of professionals in training with the accuracy of the layman.

In summary, the present study was a straightforward analysis of the effects of sex of patient, sex of judge, trained versus untrained judges, and diagnostic description (DSM-II vs. DSM-III) on diagnostic accuracy, specifically, the diagnosis of hysterical personality/histrionic personality disorder. Additional data on the interactive effects of the variables was avialable, as well as the relationship of the variables to the judges' attitude toward women.

It was hypothesized that:

1. The sex of the hypothetical client would have a statistically significant effect on the choice of the hysterical personality/histrionic personality disorder diagnosis.

2. The edition of the DSM would have a statistically significant effect on the choice of the hysterical personality/histrionic personality disorder.

3. The sex of the judge would have no statistically significant effect on the choice of the hysterical personality/histrionic personality disorder.

4. The level of training of the judges would have a statistically significant effect on the choice of the most appropriate diagnosis.

5. There will be a statistically significant positive relationship between scores on the AWS (higher score indicating more liberal attitudes) and choice of the hysterical personality/histrionic personality diagnosis.

CHAPTER II

METHOD

Subjects

The present study utilized 40 (20 male and 20 female) graduate students and 40 (20 male and 20 female) undergraduate students. The graduate students were currently enrolled in Clinical Psychology at O.S.U. The undergraduate students were enrolled in psychology classes at O.S.U. and had completed no more than nine hours of undergraduate psychology prior to the present semester. The subjects were contacted individually. The graduate students who voluntarily agreed to participate received no extrinsic reward. The undergraduate students who participated were offered extra credit in their respective classes. All subjects signed a consent to participate form (Appendix B) and were informed they could withdraw at any time without penalty.

Materials

The materials used included: case histories (Appendix C), audio tape (Appendix D), graduate diagnostic questionnaires (Appendix E), undergraduate diagnostic questionnaires (Appendix F), handouts "A", Attitude Toward Women Scale (Spence & Helmreich, 1978, Appendix G) and a portable

Panasonic stereo.

Two case histories and two audio tapes were developed for the present study. As discussed previously, the diagnostic classifications of hysterical personality/histrionic personality disorder were to be investigated. The histories and tapes of simulated portions of an intake interview were carefully developed to appropriately reflect these diagnoses. Consideration was also given to the diagnostic criteria and descriptions of the four alternative diagnoses included in the diagnostic questionnaires (Appendices E and F). Material was included in the histories and tapes to display symptoms of the particular diagnosis, but not sufficiently descriptive to warrant that diagnosis.

In the text of the case history and the recording of the interview, the sex of the pseudo-client was varied. In addition to changing sexually identifying words, as in the case of the history, a male was recorded on one tape and a female was recorded on the other. Both used the same script but with sex-appropriate wording. The pseudo-therapist was the same on each tape and, likewise, followed identical sex-appropriate scripts.

The diagnostic questionaires for the graduate students (Appendix E) were sets of five questions, three of which pertained to the subject and his/her degree program. The fourth question varied with the edition of the DSM that the experimental condition called for and contained the possible diagnoses. For subjects using the DSM-III, the fourth

question contained the diagnoses: antisocial personality disorder, histrionic personality disorder, generalized anxiety disorder, compulsive personality disorder, and hypochondriasis. For the DSM-II group, the diagnoses were: antisocial personality, hysterical personality, anxiety neurosis, obsessive-compulsive personality, and hypochondriacal neurosis. The fifth question asked the subject to rate the depicted client's level of emotional disturbances. The diagnostic questionnaire for undergraduates (Appendix F) contained four questions. The first two related to the students and previous psychology courses and the third was identical to the fourth question of the graduate level diagnostic questionnaire. The fourth question was identical to the corresponding diagnostic choice question on the graduate questionnaire. Handouts "A" were copies of the diagnostic criteria (DSM-III) or the diagnostic description (DSM-II) of the five possible diagnoses. The copy of handout "A" each subject received was varied to ensure one-half of the male subjects used DSM-III materials and the other one-half used DSM-II. The same variation was true for the female subjects.

Appendix G displays the 25-item short form of the Spence & Helmreich (1973) Attitudes toward Women Scale (AWS). THE AWS consists of 25 declarative statements for which there are four response alternatives: agree strongly, agree mildly, disagree mildly, and disagree strongly. Each item was given a score ranging from 0 to 3, with 3

reflecting the most liberal, profeminist attitude using Spence and Helmreich's definition. The subject's score was obtained by summing the values for the individual items. Scores may range from 0 to 75, with higher scores reflecting more liberal attitudes and lower scores reflecting more conservative attitudes. A comparison of data collected from introductory psychology students at the University of Texas during two different semesters (Fall, 1971 and Spring, 1972) indicates that the AWS is a reliable instrument (Spence and Helmreich, 1973). Correlations between the full form AWS and the 25-item version were .97 for both male and female students.

Procedure

From a list of Clinical Psychology graduate students, 40 subjects were randomly assigned to four experimental conditions. The four conditions had ten subjects in each. The actual testing sessions were conducted in a classroom on the campus at O.S.U.

In each experimental session, the subjects were first seated and instructions to the subjects were read (Appendix H). Following the instructions, each subject was given a copy of the appropriate case history. When they finished reading the history, the subjects listened to the appropriate simulated portions of an intake interview. When the tape ended, each subject was given the appropriate handout "A" and the diagnostic questionnaire for the experimental

condition. Instructions for completing the diagnostic questionnaire were then read. The subject then completed the questionnaire. After completing the diagnostic questionnaire, the subjects were asked to write on a separate sheet of paper the words, either in the history or tape, that prompted their diagnostic choice. Adequate time was allowed for the completion of the tasks. Each session terminated with the collection of all materials and the debriefing of the subjects.

The undergraduate subjects were recruited from undergraduate psychology classes. The subjects were volunteers and participation received additional credit toward their course grade. The procedure outlined for graduate level subjects was also followed for the undergraduates. The undergraduates received separate instructions (Appendix I) and the appropriate undergraduate diagnostic questionnaire (Appendix F).

Statistical Analysis

The design of the present study allowed the author to employ a four-way analysis of variance to investigate the effects of the following factors:

trained vs. untrained judges

male judges vs. female judges

male client vs. female client

DSM-II vs. DSM-III

In addition, additional information was available from the interaction of the factors.

Correlational analysis provided data showing the relationship of the four variables with other factors that may affect diagnostic choice.

CHAPTER III

RESULTS

Results will be presented in two sections. The first will present the results of the fixed effects ANOVA, sex of assessor (2) X sex of depicted client (2) X diagnostic manual edition (2) X level of training (2). The second section will display the results of the correlational analysis.

Analysis of Variance

The data was numerically represented for use in computer analysis. The data given a value of one (1) were: male subject, graduate level, female depicted client materials, and hysterical personaltiy/histrionic personality disorder diagnosis. Data given a zero (0) value were: female subject, undergraduate level, male depicted client materials, and other diagnostic choices. DSM II was given a value of two (2), and DSM III given a value of three (3). Scores on the AWS ranged from 0 to 75, and the measure of the degree of emotional disturbance ranged from one to six with one indicating no emotional disturbance and six indicating extreme disturbance.

Table I shows the results of the ANOVA. The present study supported the hypothesis that the sex of the depicted

TABLE I

4-WAY ANOVA SUMMARY

Source	DF	Anova SS	F Value	p Value
TAP	1	1.0125	4.76*	0.03*
MAN	1	0.1125	0.53	0.47
SEX	1	0.1125	0.53	0.47
LVL	1	0.3125	1.47	0.22
LVL X TAP	1	0.0125	0.06	0.81
LVL X SEX	1	0.1125	0.53	0.47
LVL X MAN	1	0.0125	0.06	0.81
LVL X TAP X SEX	1	0.1125	0.53	0.47
LVL X SEX X MAN	1	0.0125	0.06	0.81
TAP X SEX	1	0.0125	0.06	0.81
TAP X MAN	1	0.1125	0.53	0.47
TAP X SEX X MAN	1	0.1125	0.53	0.47
SEX X MAN	1	0.0125	0.06	0.81
LVL X TAP X SEX X MAN	2	0.725	1.71	0.19

Note: TAP = Sex of depicted client.

MAN = Diagnostic manual.

SEX = Sex of subject.

LVL = Level of training.

client would have a statistically significant effect on the assessors' diagnostic choices, $E(1,79) = 4.76$, $p < 0.0327$. Appendix J, Table A, shows the mean for those subjects receiving materials depicting the male client and the mean for those receiving materials depicting the female client. The subjects receiving the materials depicting the female client were more inclined to apply the diagnosis of hysterical personality/histrionic personality disorder to the hypothetical client.

To gain some insight on the basis for this effect, the differing means for the graduate and undergraduate students were examined. Appendix J, Table B, displays these means. If other variables are introduced, sex of the assessor and the diagnostic manual used, the composition of the means becomes clearer. Tables C and D (Appendix J) illustrate this data. As has been reported, the proposal that the sex of the hypothetical client would have a statistically significant effect on the subjects' choices was supported. However, the results fail to support the other hypotheses. Tables B, C, and D (Appendix J) are useful in noting the tendencies of the data as one moves across levels, manuals, sex of hypothetical client, and sex of the assessor.

The data in Appendix J failed to support the notion that the subjects using the DSM-II would be significantly less effective in their diagnostic choices than those using the DSM-III. The means, $\bar{X}(40) = 0.675$ and $\bar{X}(40) = 0.750$ for the DSM-II and DSM-III, respectively, were surprisingly

similar. In combination with the level of training (Table B, Appendix J), it appears the graduate students, regardless of which manual was used, chose the diagnosis most reflective of the hypothetical client more often than the undergraduates. The difference, however, does not approach significance.

When one looks at the means in Table B (Appendix J), it can be seen that, regardless of the manual used, the male subjects tended to choose the hysterical personality/ histrionic personality disorder diagnosis more often than the female subjects. Table A (Appendix J) displays the comparative means for male, $\underline{\overline{X}}(40) = 0.75$, and female, $\underline{\overline{X}}(40) = 0.675$, subjects. Although there was no significant difference found, the direction of the difference may be indicative of a sex-bias in diagnosis, based on the sex of the assessor.

Table A (Appendix J) displays the mean diagnostic scores for the subjects broken down by level of training. The graduate students applied the most reflective diagnosis more often than the undergraduates. Table B (Appendix J) shows the results when the subjects were divided by sex and level of training. The male undergraduates' mean was 0.65 and their female counterparts' the same. This finding compares to $\underline{\overline{X}}(20) = 0.85$ for the male graduate students and $\underline{\overline{X}}(20) = 0.70$ for the female graduate students. In effect, the graduate male subjects tend to choose the hysterical personality/histrionic personality disorder diagnosis more

often than any other group of subjects. An extension of Table B (Appendix J) is Table C (Appendix J) in which the factor of sex of client was added. The means ranged from $\bar{X}(20) = 0.50$ for the female undergraduates to $\bar{X}(20) = 1.0$ for the male graduate students.

It appears, from the data in Table B (Appendix J), that when the female subjects are compared to their male counterparts, the sex of the depicted client did not alter the direction of the results. The male subjects receiving the materials for male clients had a mean diagnostic score of $\bar{X}(40) = 0.65$ and the female subjects a mean of $\bar{X}(40) = 0.55$. The trend was true for the female materials also, as the male subjects obtained a mean diagnostic score of $\underline{X}(40) = 0.85$, and again the female mean was lower, $\underline{X}(40) = 0.80$.

Correlational Analysis

Appendix K displays the correlation coefficients for the variables in the present study. By referring to Table II, one can see the statistically significant correlations. The subjects' scores on the Attitude toward Women Scale (AWS) was negatively correlated with the sex of the subject. This finding indicates that the more liberal was the AWS score, the more likely the subject was a female, $\underline{r}(80) = -0.29$, $\underline{p} < 0.004$.

One of the most revealing correlations was between the AWS score and level of training. The correlation coefficient $\underline{r}(80) = 0.67$, $\underline{p} < 0.00005$ is an indicator of the

TABLE II

STATISTICALLY SIGNIFICANT CORRELATIONS
(N = 80)

Variables	N	*r*	*p* Level
SEX X AWS	80	-0.29	0.00421
LVL X AWS	80	0.67	0.00005
TAP X DX	80	0.25	0.01312

Note: SEX - Sex of Subject (Male = 1, Female = 0).

LVL - Level of Training (Undergraduate = 0, Graduate = 1).

TAP - Sex of depicted client (Male = 0, Female = 1).

DX = Diagnostic choice (Hysterical personality/ histrionic personality disorder = 1, Other = 0).

AWS = Attitude toward Women Scale score.

disparity in terms of the AWS between the undergraduate and graduate subjects. The graduate students tend to be more liberal in their attitudes toward women. The correlation between the diagnostic choice and the sex of the depicted client also reached significance, $r(80) = 0.25$, $p < 0.01$. This result gives indications of the influence the depicted client's sex exerted on the diagnostic choice; the female client material was statistically significantly associated with the most appropriate diagnosis. This finding relates well to the results of the previously discussed ANOVA. A complete listing of the combined ($N = 80$) correlation coefficients is found in Appendix K, Table E.

To further inspect these correlations, the subjects were isolated by level of training and correlations were again computed. The only correlation coefficient that reached statistical significance for the undergraduate subjects was for the AWS score and the sex of the subject, $r(40) = -0.39$, $p < 0.007$. The results implies that the more liberal AWS score was most frequently associated with female undergraduates. Table F (Appendix K) contains a complete listing of the undergraduate coefficients.

When the same procedure was conducted with the graduate data, several significant findings were discovered, Table III. Table G (Appendix K) contains the complete listing. The relationship between the appropriate diagnostic choice and the sex of the depicted client was found to be significant, $r(40) = 0.30$, $p < 0.03$. This was not surprising in

TABLE III

STATISTICALLY SIGNIFICANT CORRELATIONS FOR THE GRADUATE STUDENTS (N = 40)

Variables	N	*r*	*p* Level
TAP X DX	40	0.30	0.030
SEX X ADF	40	0.27	0.044
ADF X MAN	40	-0.27	0.04
SEX X AWS	40	-0.47	0.002

Note: SEX - Sex of Subject (Male = 1, Female = 0).

LVL - Level of Training (Undergraduate = 0, Graduate = 1).

TAP - Sex of depicted client (Male = 0, Female = 1).

DX = Diagnostic choice (Hysterical personality/ histrionic personality disorder = 1, Other = 0).

AWS = Attitude toward Women Scale score.

light of the results of the ANOVA. The choice of the most reflective diagnosis was most often related to the subjects that were presented the materials depicting the female client.

A significant correlation was found to exist between the sex of the assessor and the level of adaptive functioning, $\underline{r}(40) = 0.27$, $\underline{p} < 0.04$. This implies that the males tended to view the depicted client's level of emotional disturbance as more severe. Closely related to this finding is the correlation between the assessors' ratings of the level of disturbance and the diagnostic manual the assessor used, $\underline{r}(40) = -0.27$, $\underline{p}$ 0.04. Those subjects that used the DSM-II were more inclined to rate the depicted client as more severely impaired.

Lastly, the assessors' score on the AWS was significantly correlated with the sex of the subject, $r(40) = -0.47$, $p < 0.002$. This correlation is similar to the correlations for the same variables in the undergraduate ($N = 40$) and total subjects ($N = 80$) groups, and implies that a more liberal score on the AWS was most commonly associated with female subjects.

Summary

The results of the present study supported the hypothesis that the sex of the depicted client would have a statistically significant effect on the assessors' diagnostic choices, $\underline{F}(1.79) = 4.76$, $\underline{p} < 0.0327$. The assessors' presented materials depicting the female client were more

inclined to apply the most appropriate diagnosis. In addition, significant correlation coefficients were discovered between female assessors and a liberal score on the AWS. Significant corelations were also found between the level of training and liberal AWS scores, and the depicted female client materials and the choice of the most appropriate diagnosis. In addition, there was a statistically significant relationship between the graduate student's ratings of the degree of emotional disturbance and the sex of the depicted client and the diagnostic manual used.

CHAPTER IV

DISCUSSION

Results of the data analysis supported the initial hypothesis relating to the effect the sex of the depicted client on diagnostic choice. The analysis indicated that if the sex of the depicted client was female, it exerted a significant effect on the choice of diagnosis. If the materials reviewed by the judge identified a female client, the hysterical personality/histrionic personality disorder diagnosis was applied more often than the same diagnosis with a male depiction. The significance of the main effect of client sex on diagnostic choice indirectly answers the question of a possible sex-bias in the diagnosis of hysterical personality/histrionic personality disorder. Rather than mislabeling females as hysterical personality/histrionic personality disorder, the nature of the study allowed for the application of the diagnosis to a male client. It could be concluded that judges were more inclined to consider an alternative diagnosis for a male client presenting identical symptomology as the female client. The sex-bias results in fewer males, exhibiting the same symptomology as females, being diagnosed as hysterical personality/ histrionic personality disorder.

Due to the paucity of diagnostic research in relation to sex-bias, this study holds a tangential connection to the broader topic of sex-bias in psychotherapy and treatment services. The data analysis indicating a main effect for the sex of the client supports previous research by Fleiss et al. (1975). However, the present research is counter to the findings of Abramowitz et al. (1973), Zeldow (1976), Schwartz and Abramowitz (1975), Sue (1976), and Billingsly (1977). It should be noted that several works listed did not deal directly with diagnosis, but rather the areas of psychotherapy and treatment services. Abramowitz et al. (1973), Zeldow (1976), and Schwartz and Abramowitz (1975) considered the clinical inferences made by the subject. These decisions were analyzed as they varied with the sex of the client. The results indicated no evidence of a sex-bias in the inferences the clinicians made. Sue (1976) and Billingsly (1977), likewise, found no evidence of sex-bias in decisions relating to treatment planning. The present study was not as broad an investigation as conducted by Fleiss et al. but corroborated the findings of sex-bias by finding the same bias present in the application of a specific diagnosis.

With the advances in the DSM-III, the failure of the DSM edition to show a significant effect on diagnostic choice was surprising. Less ambiguity in diagnostic description and reliance on the use of diagnostic criteria would appear to have some influence, although in this study

it was not a significant one. The comparison of the cell means (Table A, Appendix J) indicates the DSM-III was somewhat more effective in aiding the judges. The failure to achieve significance is not attributable to the inexperience of the undergraduates with diagnostic manuals because the undergraduates' cell means for DSM-II and DSM-III are comparable to the respective graduate means and both groups indicate more appropriate diagnoses were applied when using the DSM-III (Table B, Appendix J).

The findings of the present study reflect the thinking of researchers like Karasu and Skodol (1980) and Frances (1980). These authors were of the opinion that despite the revisions in the DSM-III, there was a certain quality in the diagnostic process that the newest edition did not address. Perhaps the dimensionality of personality disorders (Frances, 1980) or the lack of adequate differentiating measures in the diagnostic criteria of the DSM-III (Korasu and Skodol, 1980) account for the lack of support for the hypotheses. It is beyond the scope of this study to supply an answer.

The literature suggests the possibility that sex of the therapist (judge) affects portions of the diagnostic process. Broverman et al. (1970) found female and male clinicians both endorsed a double standard of mental health for clients. Zeldow (1975), found that sex of the therapist yielded no significant effect on clinical judgements. LaTorre's (1975) findings suggest some variation in

generally supporting the notion that males were less severe in their judgements of maladjustment than their female counterparts. Likewise, Zeldow (1975) found a subtle, non-significant but consistent, tendency for female judge to perceive a greater need on the patient's part for some sort of psychiatric intervention than males judges. The present study's hypothesis that the sex of the judge would produce a significant effect on diagnostic choice was not supported. It appears that neither male or female judges were more effective in applying the most appropriate diagnosis. The rejection of this hypothesis yields some credence to the findings of Broverman et al. (1970) and Zeldow (1975). Yet, the tendency for some effect due to sex of the assessor cannot unequivocably be ruled out.

In looking at the data in Table B (Appendix J), one could speculate about training and its effect on clinician sex-bias given that the cell mean for graduate males was .85 and for undergraduate males was .65 and the female subject means were .70 and .65, respectively, for graduate and undergraduate. To carry the speculation one step further, Table C reports comparisons between graduate students and undergraduate students divided by the sex of the subject and the sex of the depicted client. Means of .50 and .60 were reported for female undergraduate and graduate judges (subjects), respectively, for the subject groups receiving male client materials. When the female subjects were presented materials depicting the female client, the cell means rose to .80 for each.

The answer as to the true effect of graduate training on assessor bias may lie in the more dramatic changes in the means of the male subjects as the sex of the client is varied. The cell mean for undergraduate male subjects receiving the male client materials was .60 and their graduate counterparts was .70. However, the mean for the undergraduate male subjects reviewing the female client materials was .70 while the cell mean for the graduate level judges receiving identical materials rose to 1.00. All male graduate students receiving the female materials diagnosed the client as hysterical personality/histrionic personality disorder. It is the change in male graduate student diagnostic choices from relative equality with undergraduates, when presented male materials, to the overwhelming unanimity when female materials are presented that leads to speculation that the sex-bias changes occur with male graduate clinicians.

The fourth hypothesis in the present study was designed to answer the question of the value for diagnostic training. The lack of significance for a main effect on diagnostic choice resulting from the variation of level of judge (subject) training indicates undergraduate students performed statistically as well as the more highly trained graduate students. The differences in cell means (Table D, Appendix J) reveal greater disparity among the graduate students, whereas, the means for undergraduate students, regardless of the DSM edition or sex of the depicted client, were

relatively stable. Female graduate students receiving the male materials varied widely in their ability to apply the most reflective diagnosis depending upon which edition of the DSM they used. Using the DSM-II, the mean was .80 with a mean of .40 for those using the DSM-III. Again, when the female graduate subjects reviewed the female client materials, their diagnostic choices appeared to vary strongly as a function of the edition of the DSM used. The mean for those using the DSM-II was .60 with a mean of 1.0 (unanimity) for those using the DSM-III. The wider variation in the means for the graduate students may reflect a subtle interaction that the present study failed to detect.

The final hypothesis related to the correlational relationship between the score on the AWS and the application of the most appropriate diagnostic label. If, in fact, the hypothesis was true, a significant correlation would have been found. The relationship was positive but did not reach significance at the .05 level or better. Thus, in the present study, a liberal or non-traditional attitude toward women was not necessarily related to the subjects' application of the hysterical personality/histrionic personality disorder diagnosis.

Factors Relating to the Hypotheses

There were several correlation coefficients that did reach a level of statistical significance of .05 or better. With the graduate and undergraduate subjects combined into

one group, the analysis revealed three such correlations. It appears that graduate students were more likely to obtain a more liberal score on the AWS. Although the graduate students were generally older than the undergraduates, one might speculate that the nature of this finding relates more to training than to age. Is one of the "benefits" of graduate training an awakening of a sense of equality between the sexes? If this is assumed, how does that belief relate to the results of the ANOVA that pointed out that client sex has a significant effect on diagnostic choice? This is a question posed for future research.

The score on the AWS was negatively and significantly correlated with the sex of the judge (subject). The female subjects tended to score more liberally on the AWS than did the male subjects. The non-traditional view of women as purported by the female subjects, may have influenced the diagnostic decisions they made, however, the actual source of the effect is not within the scope of the present study.

When correlations were computed for the undergraduates as a separate group, the only significant result was the relationship between the liberalness of the subjects' attitude toward women and the sex of the subject. The females tended to score higher on the AWS. The undergraduate correlation is similar to the same result for the graduate students. The female graduate students also tended to score more liberally on the AWS than did their male counterparts. Thus, when considered as a whole (N = 80) as well as in

parts (N = 40) the consistent correlational finding was for the females to express an attitude toward the role of women as non-traditional. No startling revelation is available from such a result. The disturbing point is that the graduate student correlation is actually higher. Clinicians might wish to think the attitude expressed by men at the graduate level toward women would tend to lower that coefficient. Such an occurrence would indicate a more egalitarian perspective and lower the risk of sex-bias attitude by the therapist. That did not appear to be the case in this study.

The rating of the depicted client's level of emotional disturbance was statistically significantly correlated at the graduate level with both sex of the judge (subject) and edition of the DSM used. It seems that the male graduate students more often gave ratings of greater emotional disturbance. Of the 20 male graduate students, 90 percent rated the depicted client as moderately or severely emotionally disturbed, whereas only 65 percent of the female graduate students rated the client similarly. The high correlation and difference in percentage adds credence to speculation as to the basis for the significant ANOVA result and subsequent subtle cell mean differences. The males also responded more "harshly" to disturbance ratings for the female client as opposed to the male client. One hundred percent of male graduates viewed the depicted female client as moderately to severely disturbed and only 80% viewed the

male client as similarly disturbed. The male subjects' ratings of the level of disturbance found in the present study are counter to the research of LaTorre (1975), Lewittes, Mosell, and Simons (1973), and Coie, Pennington, and Buckly (1974) who found females to be the harsher of the raters of psychopathology or emotional disturbance. The basis for the differing perspectives on the level of disturbance cannot be established through the analysis of data in the present study.

In addition to the significant correlation between the rating of the level of emotional disturbance and the sex of the judge, the rating was also negatively and significantly correlated with the edition of the DSM used. The subjects using the DSM-II were more likely to rate the level of disturbance as more severe than their counterparts using the DSM-III. Eighty-five percent of the subjects using DSM-II rated the depicted client's level of emotional disturbance as moderate or severe as compared to only 70 percent of those using the DSM-III. In part, such a result may be due to the degree to which one is allowed to form his/her own-diagnostic criteria when using DSM-II. The DSM-II contains more subjective and briefer descriptions of the diagnostic categories. In contrast, the DSM-III specifically delineates the diagnosis and offers additional informtion to the reader. The variation allowed in the use of the DSM-II may accentuate the ratings of the level of disturbance.

Summary

In conclusion, it appears that the sex of the client exerts a strong enough influence to significantly affect the clinician's judgement when applying the diagnosis of hysterical personality/histrionic personality disorder. The sex-bias evidences itself in this diagnostic category as seen in the greater number of depicted females than males being given the hysterical personality/histrionic personality disorder diagnosis. There were no significant main effects nor interactions due to the edition of the DSM used, the level of training of the judge (subject), or the sex of the judge (subject). In addition, there was no statistically significant correlation between a conservative score on the AWS and the choices of the most appropriate diagnosis. Thus, one's attitude toward women was not related to the diagnosis chosen. Several additional correlations were discovered that gave information on the subtle differences in the data and directions of those differences.

The study established several objectives. First, it suggests that there is evidence of a sex-bias in the application of the diagnosis of hysterical personality/histrionic personality disorder, and it casts doubts on any sex-bias due to DSM edition, level of training, or sex of the judge. Secondly, this study has shown the feasibility of producing audio tapes and case materials that are capable of aiding in the training of clinicians. These materials were useful in depicting clients realistically enough that the subjects

(students) expressed their enthusiasm with the challenge of choosing the most appropriate diagnosis.

As a result of the present study, there are several possiblities for future research in the area of sex-bias in psychotherapy. In the present project, the subject was to choose the most appropraite diagnosis from several options. The depicted client materials were designed to reflect the diagnostic category being studied. In this way, it was investigated whether there was a client sex-bias in the application of the appropriate hysterical personality/ histrionic personality disorder diagnosis. Alternative research might question sex-bias in other disorders. Hysterical personality/histrionic personality disorder could be given as an alternative, thus, evaluating the judge's willingness to inappropriately apply these diagnoses and the effect of the sex of the client on that process.

Based on the findings of the present paper, there are some doubts as to the positive effect of the DSM-III revisions upon the diagnostic process. By comparing the DSM-III with other diagnostic manuals, research could investigate the source of any benefit in the use of the newest manual for treatment planning, prognosis, etc.

The subtle findings of the present study, the non-significant effects and cell mean differences, indicate the need for additional research in the area of sex-bias in psychotherapy. The results of the present study indicate some deviation from previous findings. The subtleties

reflect the need for more extensive and intensive study into the effects of graduate training upon the clinician and the clinician's attitude toward women. By increasing the number of subjects, the investigator could increase the power of the statistical tests and be more likely to detect the significance of the many interactions resulting from such a design. It is perhaps the interaction effects that hold the answers to many of the remaining questions concerning sex-bias in diagnosis and psychotherapy.

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APPENDICES

APPENDIX A

SELECTED LITERATURE REVIEW

SELECTED REVIEW OF THE LITERATURE

The Development of the DSM-III

The Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III) is the culmination of nearly eight years work by clinicians across the country. The latest edition of the DSM contains 17 major categories of mental disorders which contain some 230 specific diagnoses. The manual employs a multiaxial system for evaluation. Axis I and II include all mental disorders (two classes of mental disorders, Personality Disorders and Specific Developmental Disorders are assigned to Axis II). Axis III is for physical disorders and conditions. Axis IV, Severity of Psychosocial Stressors, and Axis V, Highest Level of Adaptive Functioning in the Past Year, are for use in special clinical and research settings and are designed to aid in treatment planning and predicting outcome. Robert Spitzer, M.D., and several colleagues were primarily responsible for the guidance and direction that the American Psychiatry Association had in the development of the manual.

Spitzer et al. described the major advances of DSM-III and the most important differences between DSM-III and DSM-II in a 1979 article. The use of over 80 clinicians in the field trails, the production of a definition of mental disorder, the increased diagnostic reliabilty, and most importantly, the use of a multiaxial system and diagnostic criteria in psychiatric evaluation were seen as the significant

improvements in DSM-III over its predecessors. In addition, one of the major departures from DSM-II was the omission of the category Neuroses. Citing the failure of the profession to define neuroses and the conflicting sentiment as to the etiology of such a category, the authors of DSM-III omitted Neurotic Disorder as a separate category or diagnosis, and included such symptom groups in the Affective, Anxiety, Somatoform, Dissociative, and Psychosexual Disorders.

The formal explanation of inclusion and exclusion criteria, one of the most radical advances in DSM-III, and the subsequent unrealibility of these criteria was presented in a 1975 article by Spitzer et al. Subsequent drafts of the manual altered the criteria to increase the reliability. There was a wide range expressed by the coefficient of agreement, but as a whole it achieved satisfactory inter-rater realiability.

In an article by Spitzer et al. (1979), the authors described phase one of the field trials. This phase dealt with the primary statistical analysis conducted with DSM-III inter-rater diagnostic reliability. The authors described the selection of volunteer clinicians to participate in the trials and listed 274 actual participants. Two hundred eighty-one adults (18 years and older) were evaluated, and represented white, black, and hispanic backgrounds. Using drafts of DSM-III, each clinician, along with a colleague, evaluated at least one client. Blind to their colleagues' diagnosis, each clinician evaluated the client and using the

multiaxial system, arrived at a diagnosis.

In the second phase, the clinicians' ratings of Axes IV and V were examined. The results yielded Kappa coefficients of at least fair reliabliity for Axis IV (.62 and .58 for separate and joint interviews, respectively). Axis V showed much higher levels of agreement (.80 and .69 for separate and joint interviews, respectively). Despite the apparent acceptable reliability of Axis IV, there remained some concern about its wide-spread acceptance.

Major Criticism of DSM-III

In April of 1977, the first draft of DSM-III became available. The following review of criticisms of this and subsequent drafts represent the articles most pertinent to the present study.

McReynolds (1979) attacked the DSM-III on the broadest front. He contended that the latest revisions reflected merely semantic changes in the description of socio-behavioral problems that had been known for years. He continued by criticizing the use of the "medical model" in the development of the manual and concluded with the viewpoint that, by accepting the definition of mental disorder found in DSM-III, other social scientists would be forced to accept the previously mentioned "medical model". The author proposed that alternative methods be developed that would allow input from other social scientists.

Karasu and Skodol (1980) discussed the diagnostic

diagnostic validity of the new manual and proposed an additional sixth axis. The basis for their proposal was an application of DSM-III diagnostic criteria to three case studies. The three cases received identical diagnoses on the first three axes, and similar ratings on Axes IV and V. However, the three cases differed widely as to their psychodynamic evaluation. These differences occurred in their conflicts, object relations, defenses, and coping mechanisms. The authors' sixth axis would, they proposed, eliminate this problem by standardizing the psychodynamic evaluation with a set of criteria, much like the inclusion/ exclusion criteria in the DSM-III.

Much in the manner of McReynolds (1979), Schacht and Nathan (1977) approached their appraisal of the DSM-III from the perspective of its implication to other social scientists; particularly psychologists. Their criticisms included: the drive for increased reliability yielded categories that failed to reflect the complexity of the diagnostic process; the use of the "medical model" in the DSM-III would have an adverse effect on the psychologist's diagnostic formulations and conceptualizaton; and that the DSM-III would serve to ultimately enhance the scope of psychiatry while diminishing the domain of other professionals.

Much more specific was Frances' (1980) review of the Personality Disorders section of the DSM-III. Despite his contribution to the development of this section, he views it as the least reliable. His view of personality disorders as

no more than variants of normally occurring personality traits and the inherent difficulty in state-trait distinctions were cited as reasons for the low reliability. On this basis, he felt that a categorical diagnosis may actually be inapplicable, whereas a dimensional one would more accurately reflect the true person. He concludes the article with a call for intensive research on the personality disorders section in an effort to answer the questions he raised.

Sex-Bias in Psychotherapy

Broverman et al. (1970) suggested that people identifying the traits of mature, healthy, individuals varied those characteristics as a function of the sex of the described person. In addition, they hypothesized that clinicians considering behavioral attributes regarded as healthy for an adult (viewed from the "ideal" viewpoint thus sex unspecified) would find those attributes more often in men than women. The subjects were clinically trained professionals (N = 79). T-tests were conducted on the results of the Stereotype Questionnaire (Rosenkrantz, 1968). Masculinity, femininity, and adult health scores of male clinicians were not significantly different from the female clinicians' views. The results also indicated that the attributes of the healthy man and those of the healthy woman differ and that those differences parallel the sex-role stereotypes prevalent in society in general. Furthermore,

they found that regardless of the sex of the clinician, their concept of a healthy adult did not differ from the characteristics of the healthy man, whereas the healthy female traits were significantly different.

Kravetz (1976) used 150 women at the University of Wisconsin-Madison to examine sex-role concepts. Fifty women described a healthy adult man, 50 described a healthy adult woman, and 50 described themselves. All were using a sex-role questionnaire to provide data for two-way analyses of variance. The author found that, regardless of whether or not the women identified themselves as members of the women's liberation movement, the sample of 150 did not adopt sex-role stereotypes. Although this study excluded males, it did stand somewhat in contrast to the results of Broverman et al. (1970).

The most common dimension of assessment employed in investigation of sex-bias is the degree of maladjustment or psychopathology. Lewittes, Moselle, and Simons (1973) investigated whether sex-role stereotyping extended to the interpretation of Rorschach protocols and the subsequent clinical judgements. Twenty-two male and 22 female clinicians volunteered to rate the Rorschach protocol of a 26 year-old female patient. At random, one-half of the raters were told the material was from a male patient while the remaining half were told the identifying data and protocol pertained to a female. By employing a Chi-square test with Yates correction, the authors concluded that both the

identical sex of the respondant and the sex of the rater affect clinical judgements of mental health status. The results were opposite those of Broverman et al. (1970) in that female raters tended to be less severe in rating females and more severe in rating males.

Abramowitz, Abramowitz, Jackson, and Gomes (1973) demonstrated the role played by political beliefs in the drawing of clinical inferences. Using 71 professionals in mental health or education, the authors employed a 2x2x2 factorial design and a three-way expected cell frequencies analysis of variance. Each subject received one of four versions of a brief case history. The versions were politically left-oriented male, left-oriented female, right-oriented male, and right-oriented female. The results indicated that politically conservative exmainers attributed greater psychological maladjustment to a politically left-oriented female client than to her male counterpart. However, there was no main effect for patient sex alone.

LaTorre (1975) studied attitudes, as a function of gender, toward those described as mentally ill. A 2x2x2 factorial design was employed with the variables gender of patient, gender of the rater, and age of the patients. One hundred and eight undergraduates served as subjects. The age and gender of each patient was manipulated in two case histories (one obsessive-compulsive disorder and one schizophrenic disorder). The data failed to support the notion that female patients are considered to be less severely ill,

given a similarity of symptoms.

The purpose of a study by Zeldow (1976) was to investigate the effects of both sex of judge and sex of patient on decisions that clinicians make during simulated intake sessions. One set of judges were representative of the public at large, while the other set had more training or experience in evaluating psychiatric patients. With the first group, absolutely no evidence of bias in judgement as a function of sex of patient or judge was found. The same results were found for the second set of judges, however, female judges recommended psychiatric intervention more than their male counterparts.

A study by Coie, Pennington, and Buckley (1974) was designed to test the hypothesis that laymen arrive at mental illness judgements through a consideration of the situational stress facing a client as well as the sex of that client. Using 288 male and 288 female undergraduate students in a 2x2x3x4 repeated measures MANOVA, the authors found situational stress factors had a significantly different effect on the attribution of disorder to males and females. Given equivalent stress situations, male's deviant behavior is judged much less pathological than females exhibiting the same behavior under identical conditions. Moreover, mental health services were seen as less appropriate for males than females. However, females were not perceived as more mentally ill than males.

In a study by Schwartz and Abramowitz (1975) patient

sex and race attributions were systematically varied in an analogue situation in which clinical impressions and treatment recommendations were analyzed. Using a 2x2x2 factorial design with an analysis of variance, the authors analyzed the voluntary responses of 102 professionals. The subjects were asked to make two clinical inferences about a hypothetical patient and to rate the suitability of four treatment alternatives along eight-point Likert scales. Each rater received one randomly selected (from four variations) case history. The major finding of the study was the absence of statistically significant results for a bias against patients identified as black or female. Rather than indicating systematic devaluation of women by mental health professionals, previous research disclosed that sex-related biases are mediated by clinicians' sociopolitical convictions (Abramowitz et al., 1973).

Assessment with respect to diagnoses as a function of patient sex was reported by Fleiss, Garland, Simon and Sharpe (1975) to show a negative bias toward women. In London they found the differential diagnosis of schizophrenia from manic-depressive illness varies as a function of the sex of the patient. The female patients were more often diagnosed as schizophrenic and the males a manic-depressive.

Sue (1976) investigated the relationship between the client's demographic characteristics (age, sex, education, income, marital status, and ethnicity) and services received (diagnosis, type of treatment program, type of personnel

rendering services, type of therapy, and the number of sessions). The author concluded that sex of the patient bore no relationship to the services received.

Another finding of the Lewittes et al. (1973) study indicated that the diagnoses of female clinicians were more lenient when the patient was designated as female as opposed to male. The sex of the patient by itself did not significantly influence diagnosis.

Treatment

The article by Brodey and Detre (1972) reported their investigation of decision making regarding treatment recommendations as made by clinicians at a student mental health clinic. They wanted to identify what factors determine clinical decision and to correlate the referral pattern with personal biases. Following an interview with each of the 180 prospective clients, the nine clinicians completed a checklist of factors that influenced their decision. The subjects were more likely to refer females than males for individual rather than group therapy. The authors did not report data for the interaction of the sex of clinician and recommendations, despite the 8/1 ratio of males to female subjects. In the previously reviewed study by Sue (1976) the author also found that the sex of the patient bore no relationship to individual versus group therapy placements with a much larger sample (> 2,000 clients) in a consortium of community mental health centers.

Billingsley (1977) replicated the Broverman et al. (1970) study, but used a 2x2x2 factorial design with two between-subject factors and one repeated measures factor. The subjects were 64 practicing therapists (32 males, 32 females). The author sought data to assess the extent to which a pseudo client's sex and pathology influenced the treatment planning of male and female therapists. The results showed that client sex was not related to therapist treatment goal choices at least not for the two types of pseudo clients (explosive and restricted) used in the study. The author also found that male and female therapists differ as to their treatment goals. Male therapists chose more feminine treatment goals for their patients, and female therapists chose more masculine treatment goals for their clients.

Seventy-five male and 80 female students were seen by 11 male and four female counselors in a study conducted by Barocas and Vance (1974). The counselors' retrospective attractiveness ratings were related to interviewer performance, initial clinical status, final clinical status and prognosis. They concluded that an equal number of female and male clients were assigned to male counselors, whereas the female counselors showed a disproportionate number of female clients.

The aim of the Abramowitz et al. (1976) research was to determine the prevalence of sex-role related counter-transference among psychotherapists with psychological or

psychiatric training. In order to do this, demographic and treatment data were collected from a psychologically oriented mental health facility and a psychiatrically oriented one. Chi-square analyses, corrected for discontinuity, reinforced previous findings of a tendency for male psychotherapists to see female patients for a greater length of time than male patients.

Sex of Judge or Therapist

In the previously reviewed Broverman et al. (1970) study, female clinicians behaved no differently than their male counterparts, i.e., they, too, endorsed a double standard of mental health. Nowacki and Poe (1973), using 138 female and 117 male undergraduate students, obtained ratings of a mentally healthy male and a female using the Broverman et al. (1970) sex-role stereotype scale. On both scales, there was a statistically significant difference between the mean scores for the mentally healthy male and female. The male scores were typically higher than the female scores. Likewise, the difference between the mean ratings made by males and females reached statistical significant ($p < 0.05$). This finding is in direct contrast with the Broverman et al. (1970) study.

Zeldow (1975) conducted two studies investigating the effects of sex differences on clinical judgements. The first study utilized 50 male and 50 female college students as judges of statements attributed to seriously disturbed

patients of both sexes. The results of an ANOVA on the 2x2 factorial design showed that the self-disclosing statements attributed to the patient were not influenced by the sex of the patient or judge. In the second study, the author used 40 male and 40 female volunteers all with some exposure to psychopathology (Zeldow, 1976). Eight case histories, each typical of a diagnostic category, were read by the subjects and they, in turn, made clinical judgements on: (1) degree of psychiatric disability, (2) how intense was the need for professional intervention, (3) the likelihood for recovery. Again a 2x2 factorial design was used and the data analyzed by means of an ANOVA. The author concluded that the sex of the patient did not influence any of the three ratings either alone or in interaction with the sex of judge. However, the sex of the judge consistently affected the judgements of the need for psychiatric intervention. The female judges perceived a greater need on the patient's part for some sort of psychiatric intervention than males did.

A 2x2x2 factorial design by LaTorre (1975) examined attitudes toward those stigmatized as mentally ill as a function of that individual's gender. The 108 undergraduates (36 males and 72 females) each read two case histories; one of an obsessive-compulsive patient and one of a paranoid schizophrenic. The age and sex of each patient was manipulated in each case. The three-way ANOVA yielded results that generally supported the notion that males were more "accepting", i.e., less severe in their judgements of maladjustment than their female counterparts.

APPENDIX B

RESEARCH SUBJECT CONSENT FORM

RESEARCH SUBJECT CONSENT FORM

The following conditions apply to this study:

1. Participation in this study is of a voluntary nature.
2. Subjects may withdraw from the study at any point.
3. Subject anonymity will be protected throughout the study.
4. No extrinsic rewards will be given for participation.
5. The study complies with the spirit of Principle 9 of the APA 'Ethical Standards of Psychologists (1977 Revision)', the APA 'Ethical Principles in the Conduct of Research with Human Participants', and the Department's Human Research Ethical Guidelines.
6. Subjects will be debriefed following their participation.

I have read and understand the above statements, and I consent to participate in this study.

Signed:_____

APPENDIX C

CASE HISTORIES

CASE HISTORY (MALE)

M. is a 25 year old Caucasian male. He is currently divorced after two years of marriage. He has no children from this marriage. He has an undergraduate degree in business management and is currently a realtor for a large real estate firm in Dallas, Texas. He has dated frequently since the divorce and is currently in a monogamous relationship. This relationship has existed for two months.

He came to therapy at the recommendation of his doctor. M. complains of a lack of concentration at his job and periods of uncontrolled crying. He is the youngest of three children born to a middle class family. There were no developmental difficulties nor physical traumas; although he complains of numerous allergies and is often bothered by headaches. He was a B student in high school and participated in activities and clubs both in school and extracurricularly. He was the president of his class and had many friends. After grduation, he became quite upset and for two weeks was given Valium by the family doctor.

In college, he experienced periods where he did not feel like going to class and would return home where he would remain until he "felt better". He dated a lot, but had no long-term relationships in college. He met his future wife in the summer of his junior year and was married after graduation.

Initially, his marriage was quite happy, but soon deteriorated. There were two separations; each lasting two

to three weeks. Conflict areas centered around children, job, and finances. The divorce proceedings were quickly completed, and they have not seen each other for the past ten months.

CASE HISTORY (FEMALE)

M. is a 25 year old Caucasian female. She is currently divorced after two years of marriage. She has no children from this marriage. She has an undergraduate degree in business management and is currently a realtor for a large real estate firm in Dallas, Texas. She has dated frequently since the divorce and is currently in a monogamous relationship. This relationship has existed for two months.

She came to therapy at the recommendation of her doctor. M. complains of a lack of concentration at her job and periods of uncontrolled crying. She is the youngest of three children born to a middle class family. There were no developmental difficulties nor physical traumas; although she complains of numerous allergies and is often bothered by headaches. She was a B student in high school and participated in activities and clubs both in school and extracurricularly. She was the president of her class and had many friends. After graduation, she became quite upset and for two weeks was given Valium by the family doctor.

In college, she experienced periods where she did not feel like going to class and would return home where she would remain until she "felt better". She dated a lot, but had no long-term relationships in college. She met her future husband the summer of her junior year and was married after graduation.

Initially, her marriage was quite happy, but soon deteriorated. There were two separations; each lasting two

to three weeks. Conflict areas centered around children, job, and finances. The divorce proceedings were quickly completed, and they have not seen each other for the past ten months.

APPENDIX D

SIMULATED INTAKE INTERVIEW TRANSCRIPT

SIMULATED INTAKE INTERVIEW TRANSCRIPT

(The tape begins some ten minutes after the session has begun.)

M: Well, some people at work, particularly my boss, had been telling me that my work was not up to par recently. My boss said that it appeared as if I wasn't even there. I wasn't doing anything at all according to him. He suggested that I go to a doctor; so I went to my family physician. He's the one that I've gone to all my life, and he said that there was nothing wrong. I told him that I was having headaches and that my allergies were really bothering me. I admitted that I had been kind of nervous. My nerves bother me some. To be honest, there have been times lately when it appears that for no particular reason I start crying. So I guess I am kind of upset, but I didn't know that it was affecting work. I'm doing just fine at work; I think. So anyway, he said to come over here. I really can't think why. I think that some of them at work ought to be here; but--well anyway, that's kind of why I'm here. He said to come over here and see if there's something wrong.

T: Do you feel that anything in particular is affecting your work?

M: No---nothing in particular, I guess. I've got a pretty responsible job. I've got to get listings, handle closings, etc. My boss said it just seemed as if I wasn't quite attuned to what I was doing. I don't know. The last two closings I had in the summer--I thought I did just fine. I guess that I made a couple of errors on the contracts. That's no big deal. He just said that I seemed kind of nervous and on edge.

T: You mentioned that you've been going to the same doctor all your life.

M: Yes.

T: For what reasons?

M: Oh, there was one time that I remember--(nervous chuckle)--it was after our high school graduation. We just had a great time. We stayed out all night, and I think that I just had a reaction to that. For about a couple of weeks after that, I felt kind of like I was nervous and uh--boy, I just didn't know what was going on. I didn't sleep very well. It wasn't any big deal. My doctor gave me some Valium, but I didn't even take it all. I felt a lot better after that--I didn't go back, not for that anyway.

T: What have you gone back for?

Well, a lot of times when it gets really hectic, I get extremely bad headaches. You know, the kind that almost knock you out. Then, my sinuses start acting up. Dr. Anderson says that it's just tension, but I think I have a lot of allergies.

(PAUSE IN TAPE--"The session is rejoined sometime later.")

T: O.K., you've got some things that are problems for you; at least that others have commented to you about. Why don't you now tell me what a typical day is like for you?

M: Kind of hectic right now--I'm trying to deal more in commercial properties than I have before. Well--I don't see how this has much to do with anything--well, I guess it might. I'm kind of dating this girl/guy. I was married before and have been divorced for almost a year now. I dated a lot of people for a while, and--her/his name is Ann/Al--and I started dating only her/him about two-and-a-half months ago. It just kind of evolved into that. Before that I didn't date anyone for very long. We started seeing each other, and you know how it is. It just kind of evolved into a one-to-one thing. Anyway I work in the Smith Bldg., and she/he works right around the corner and down the street in Market Square. We usually meet at a little delicatessen for lunch, and the other day--well, that's not true--about two weeks ago, she told me that this new person had come to work for the insurance company. She said that a bunch of people were going to take this person out to lunch and give him/her a kind of an introduction to the company. Well, that would've been fine with me; but--I don't know--it wasn't just somebody, it was a guy/girl and it wasn't a bunch of them it was just her/him. It still didn't bother me much really. Well, then the next day, she/he had to go introduce this person to some of the accounts of the realtor that he/she replaced. We didn't get to eat together again. So, I began to wonder about that. I asked her/him what this new person was like. She/He said, "Oh, he's/she's a nice enough person--kind of nervous about the new job and all."; but I could tell by the gleam in her/his eye that there was more to it than that.

T: So you asked Ann/Al about these luncheons?

M: Yes!

T: It seems to bother you that she/he went out to lunch with this person.

M: Well! We told each other that we were not going to date anybody else you know! I kind of felt that she/he--I wouldn't really call it cheating, but--I really enjoy our lunches together! We sit and talk, you know, share things about what we've done that day. It's just fun, and it makes me feel great. It just seems to take a lot of pressure off of me. You know, everybody needs support from someone. It's tough out there, and a lot of times you need a pat on the back. Boy, after something like that, you just feel like you can conquer anything. In fact, if somebody cares about you that's the main thing that they should give you. You know, really support you and help you through problems.

T: So, you get a lot out of your lunches with Ann/Al.

M: Yes!

T: When you talked to Ann/Al about this, what was her/his response?.

M: Hmm, I was kind of afraid to bring it up to her/him at first. After it happened the second time; though, I was fed up! She/He almost laughed, and she/he said that I was making a mountain out of a molehill. I don't feel like I am! I feel that there is something going on. She/He said that I was trying to control her/him, and that I was being selfish. I just don't feel that's true at all. So we had kind of a big fight, and we did a lot of yelling at each other. I guess that I did get pretty upset about that.

T: Did you manage to work things out during this?

M: Oh, I guess so. I don't really remember now.

T: When you and Ann/Al have problems like this; are you usually able to work them out?

M: Oh, that's a problem in itself. I blow off steam and then I feel great. The problems are no longer an issue then, but she'll/he'll just nag and nag at it. You know, that kind of reminds me--Joyce/John used to bug the heck out of me with that same kind of thing?

T: Joyce/John?

M: My ex-wife/husband. She/He used to just work things to death before she/he felt like things were solved. You can't just get it out of your system and go on. You have to work and work it to death.

T: Perhaps we ought to talk about your marriage. Tell me something about that.

M: Oh, O.K. Let's see. I met Joyce/John in the summer of my junior year in college. We got married after graduation. She/He was a business major. I met her/him because we took some courses together in the marketing department. She/He was a very attractive girl/guy. We dated all that year and then got married. Our marriage was fantastic at first, but it sure went to hell later. Mostly because of arguments. I remember that I wanted a new car after we got married. So I went out and I bought one. Boy, it was a great car. Joyce/John just blew up when I got home with it. She/He said that we couldn't afford a new car then, but we had the money. We were both working; oh it made things kind of tight I guess. She/He said that I was inconsiderate of her/him, but I wanted a new car then. I need one in my profession. You can't have just any car; you need a really sharp one. Joyce/John said I was just selfish; boy, I don't know how I go onto all of this. Anyway, I guess it's kind of the same thing that Ann/Al says to me; and I just don't understand what they're talking about. They just beat stuff to death, and I feel like you can just let that sort of stuff go.

T: Besides finances, were there any other problems in your marriage?

M: Yes, I put a lot of importance in my job, and I think that Joyce/John couldn't understand that. She/He kept saying that I didn't pay any attention to her/him, and that I was always at work. She/He said that I seemed like I enjoyed my job more than I enjoyed her/him, and I guess there were some other problems.

T: Other problems?

M: Oh, I guess the biggest one was that she/he kept saying that she'd/he'd like to have a family and we'd discussed that before we got married. We were going to wait until we were at the point where we'd have time to raise a family. I just didn't feel like that was the time. Hey, kids are nice, but we still had car payments and were talking about buying a house.

T: You felt that having a child would be too large a financial burden?

M: I didn't think that we could afford it. It's a big sacrifice to have children. Do you know what it costs to raise a child now? I just didn't feel like it was the thing to do right then. There were still a lot of other things that I wanted to do.

T: I see.

M: Those were the kind of things--you know that hounding and nagging--the same old things. You know, these same problems kept coming up and coming up. Then it finally just got to be too much.

T: Which of the two of you initiated the divorce?

M: Oh, I finally went ahead and filed. I just couldn't handle it anymore. You know, if you're just going to beat the things to death--I felt like I wasn't going to stay in that relationship. It would've just totally wrecked me! There were too many demands, and I just decided that I wasn't going to take it.

T: I realize that sometimes it's difficult to talk about these things, but there may be information here that would help us work together on your situation. Could you tell me some more about the divorce? Was it amiable or difficult?

M: Oh, I thought it was just fine. It wasn't the happiest thing that ever occurred; but one day I just got my stuff and left.

T: Uh huh, so it was fairly quick?

M: Oh yes, I just--we had argued one day and I just went down to my lawyer and said draw it up! Then I went home, packed my stuff and left!

T: Were the divorce proceedings themselves fairly amiable?

M: It was for me! I just totally had my lawyer deal with the whole thing.

T: O.K., we've covered your marriage and divorce. What was life like after that?

M: It was a ball! I just had a fantastic time--a lot of fun! I dated a different person nearly every time. You meet a lot of different people in this city anyway. In my profession, a lot of the people that I deal with are female/male; and it was just a lot of fun. I did a lot of partying!

T: You've been dating the same person, Ann/Al, for sometime now though.

M: Yes, about 2 or 3 months now.

T: O.K., I think that we're back to the present and the reasons for your coming in today. You're having some problems at work now. Your supervisor has mentioned this to you anyway. How long have these problems been going on? Is this fairly recent?

M: No, I think that I've been kind of a tense person for a long time. It's very hard for me to relax. I don't remember---I do remember something now! When I was in college, a lot of times I would find myself kind of daydreaming. It was really difficult to concentrate. That's something that I've felt for a long time. It's extremely hard for me to just relax. I get so bored and then kind of anxious or something. I really enjoy doing a lot of different things all the time.

(TAPE PAUSE--The tape begins again sometime later in the session.)

T: What was happening at your work or with Ann/Al just prior to your supervisor mentioning your problems at work?

M: Nothing! Well, not a lot; it's just that thing about Ann/Al going to lunch with that guy/girl. That bothers me--our lunches together really mean a lot to me! I'd like to see the look on her/his face if I would get killed in a car wreck, or if I jumped off a bridge! That would change her/his tune! She'd/He'd see how much she/he would miss me!

T: That would show her/him how important your relationship is to both of you.

M: Yes! I don't think that she/he knows that.

APPENDIX E

GRADUATE DIAGNOSTIC QUESTIONNAIRES

GRADUATE DIAGNOSTIC QUESTIONNAIRE

1. Male_____ Female_____

2. Through which program are you seeking your degree?

   ABSED_____ MHS_____ CLIN.PSYCH._____

3. How many years have you been in your program?_____

4. Diagnostic Classification (Check One Only):

   301.70 Antisocial personality disorder_____
   301.50 Histrionic personality disorder_____
   301.40 Compulsive personality disorder_____
   300.02 Generalized anxiety disorder_____
   300.70 Hypochondriasis_____

5. How disturbed do you feel this person is?

   1. None_____ 2. Minimally_____ 3. Mildly_____

   4. Moderately_____ 5. Severely_____ 6. Extremely

GRADUATE DIAGNOSTIC QUESTIONNAIRE

1. Male_____ Female_____

2. Through which program are you seeking your degree?

   ABSED_____ MHS_____ CLIN.PSYCH._____

3. How many years have you been in your program?_____

4. Diagnostic Classification (Check One Only):

   301.7 Antisocial personality_____
   301.5 Hysterical personality_____
   301.4 Obsessive-compulsive personality_____
   300.0 Anxiety neurosis_____
   300.7 Hypochondriacal neurosis_____

5. How disturbed do you feel this person is?

   1. None_____ 2. Minimally_____ 3. Mildly_____

   4. Moderately_____ 5. Severely_____ 6. Extremely

APPENDIX F

UNDERGRADUATE DIAGNOSTIC QUESTIONNAIRE

UNDERGRADUATE DIAGNOSTIC QUESTIONNAIRE

1. Male_____ Female_____

2. Please list undergraduate psychology courses that you have completed:

3. Diagnostic Classification: (Please check one only)

   301.7 Antisocial Personality_____
   301.5 Hysterical Personality_____
   301.4 Obsessive-Compulsive personality_____
   300.0 Anxiety Neurosis_____
   300.7 Hypochondriacal neurosis_____

4. How disturbed do you feel this person is?

   1. None_____ 2. Minimally_____ 3. Mildly_____

   4. Moderately_____ 5. Severely_____ 6. Extremely

UNDERGRADUATE DIAGNOSTIC QUESTIONNAIRE

1. Male_____ Female_____

2. Please list undergraduate psychology courses that you have completed:

3. Diagnostic Classification: (Please check one only)

   301.70 Antisocial Personality_____
   301.50 Histrionic Personality disorder_____
   301.00 Compulsive Personality disorder_____
   300.02 Generalized Anxiety disorder_____
   300.70 Hypochondriasis_____

4. How disturbed do you feel this person is?

   1. None_____ 2. Minimally_____ 3. Mildly_____

   4. Moderately_____ 5. Severely_____ 6. Extremely

APPENDIX G

ATTITUDE TOWARD WOMEN SCALE

The statements listed below describe attitudes toward the role of women in society which different people have. There are no right or wrong answers only opinions. You are asked to express your feelings about each statement by indicating whether you (1) Agree Strongly, (2) Agree Mildly, (3) Disagree Mildly, or (4) Disagree Strongly. Please indicate your opinion by marking 1, 2, 3, 4, whichever corresponds to the alternative which best describes your personal attitude on the blank line preceding each statement. Also, please indicate your response on the answer sheet. Please be sure to answer every item.

1. Agree Strongly
2. Agree Mildly
3. Disagree Mildly
4. Disagree Strongly

_____ 1. Swearing and obscenity are more repulsive in the speech of a woman than a man.

_____ 2. Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.

_____ 3. Both husband and wife should be allowed the same grounds for divorce.

_____ 4. Telling dirty jokes should be mostly a masculine prerogative.

_____ 5. Intoxication among women is worse than intoxication among men.

_____ 6. Under modern economic conditions with women being active outside the home, men should share in household tasks such as washing dishes and doing the laundry.

_____ 7. It is insulting to women to have the "obey" clause remain in the marriage service.

_____ 8. There should be a strict merit system in job appointment and promotion without regard to sex.

_____ 9. A woman should be as free as a man to propose marriage.

_____10. Women should worry less about their rights and more about becoming good wives and mothers.

_____11. Women should assume their rightful place in business and all the professions along with men.

_____12. Women earning as much as their dates should bear equally the expense when they go out together.

_____13. A woman should not expect to go to exactly the same places or to have quite the same freedom of action as a man.

_____14. Sons in a family should be given more encouragement to go to college than daughters.

_____15. It is ridiculous for a woman to run a locomotive and for a man to darn socks.

_____16. In general, the father should have greater authority than the mother in the bringing up of children.

_____17. Women should be encouraged not to become sexually intimate with anyone before marriage, even their fiances.

_____18. The husband should not be favored by law over the wife in the disposal of family property or income.

_____19. Women should be concerned with their duties of childrearing and house tending, rather than with desires for professional and business careers.

_____20. The intellectual leadership of a community should be largely in the hands of men.

_____21. Economic and social freedom are worth far more to women than acceptance of the ideal of femininity which has been set by men.

_____22. On the average, women should be regarded as less capable of contribution to economic production than are men.

_____23. There are many jobs in which men should be given preference over women in being hired or promoted.

_____24. Women should be given equal opportunity with men for apprenticeship in the various trades.

_____25. The modern girl is entitled to the same freedom from regulation and control that is given to the modern boy.

APPENDIX H

INSTRUCTIONS TO GRADUATE SUBJECTS

INSTRUCTIONS TO GRADUATE SUBJECTS

First of all, I would like to thank you for participating. I am investigating the diagnostic process. In this session, you will be given a written case history to read, and will hear portions of a simulated intake interview. Following this, you will be given a Diagnostic Questionnaire to complete. Care has been taken to ensure that the case history and simulated intake interview will provide you with adequate information to complete the questionnaire. Are there any questions?

INSTRUCTIONS FOR THE DIAGNOSTIC QUESTIONNAIRE

The first three questions, on the form before you, pertain to you and your degree program. The last two questions relate to the client that is depicted in the case history and interview. It is vital for this research project that there be no consultation among you while you are completing this questionnaire.

The first three questions are self-explanatory. On the fourth question, please check the diagnostic classification you feel is most appropriate for the depicted client. Materials, describing the five diagnoses from which you must choose, may be found in Handout A. This handout should aid you in making your choice. The fifth question relates to your rating of the client's emotional stability. Please check one category. Adequate time will be given for you to complete the task.

APPENDIX I

INSTRUCTIONS TO UNDERGRADUATE SUBJECTS

INSTRUCTIONS TO UNDERGRADUATE SUBJECTS

First of all, I would like to thank you for participating. I am investigating the diagnostic process. In this session, you will be given a written case history to read, and will hear portions of a simulated intake interview. Following this, you will be given a Diagnostic Questionnaire to complete. Care has been taken to ensure that the case history and simulated intake interview will provide you with adequate information to complete the questionnaire. Are there any questions?

INSTRUCTIONS FOR THE DIAGNOSTIC QUESTIONNAIRE

The first two questions, on the form before you, pertain to you and your psychology background. The third and fourth questions relate to the client that is depicted in the case history and interview. It is vital for this research project that there be no consultation among you while you are completing this questionnaire.

The first three questions are self-explanatory. On the third question, please check the diagnosis you feel is most appropriate for the depicted client. Materials, describing the five diagnoses from which you must choose, may be found in Handout A. Please use this handout when making your choice. The fourth question relates to your rating of the client's emotional stability. Please check one category. Adequate time will be given for you to complete the task.

APPENDIX J

GROUP DIAGNOSTIC CHOICE MEANS

TABLE A

GROUP DIAGNOSTIC CHOICE MEANS FOR SINGLE VARIABLES

Variable	N	Mean
LVL		
Undergraduate	40	0.650
Graduate	40	0.775
TAP		
Male	40	0.600
Female	40	0.825
SEX		
Female	40	0.675
Male	40	0.750
MAN		
DSM-II	40	0.675
DSM-III	40	0.750

Note: TAP = Sex of depicted client.

MAN = Diagnostic manual.

SEX = Sex of subject.

LVL = Level of training.

TABLE B

GROUP DIAGNOSTIC CHOICE MEANS FOR PAIRS OF VARIABLES

Variable	N	Mean
	Graduate Level Subjects	
TAP:		
Male	20	0.65
Female	20	0.90
SEX		
Male	20	0.85
Female	20	0.70
MAN		
DSM-II	20	0.75
DSM-III	20	0.80
	Undergraduate Level Subjects	
TAP		
Male	20	0.55
Female	20	0.75
SEX		
Male	20	0.65
Female	20	0.65
MAN		
DSM-II	20	0.60
DSM-III	20	0.70
	Depicted Client (Male)	
SEX		
Male	20	0.65
Female	20	0.55
MAN		
DSM-II	20	0.60
DSM-III	20	0.60
	Depicted Client (Female)	
SEX		
Male	20	0.85
Female	20	0.80
MAN		
DSM-II	20	0.75
DSM-III	20	0.90

TABLE B (Continued)

Variable	N	Mean
	Sex of Subject (Male)	
MAN		
DSM-II	20	0.70
DSM-III	20	0.80
	Sex of Subject (Female)	
MAN		
DSM-II	20	0.65
DSM-III	20	0.70

TABLE C

GROUP DIAGNOSTIC CHOICE MEANS FOR THREE VARIABLE GROUPS

Variable	N	Mean
Undergraduate Subjects		
Depicted Client (Male)		
SEX		
Male	10	0.60
Female	10	0.50
Depicted Client (Female)		
SEX		
Male	10	0.70
Female	10	0.80
Sex of Subject (Female)		
MAN		
DSM-II	10	0.60
DSM-III	10	0.70
Sex of Subject (Male)		
MAN		
DSM-II	10	0.60
DSM-III	10	0.70
Graduate Subjects		
Depicted Client (Male)		
SEX		
Male	10	0.70
Female	10	0.60
Depicted Client (Female)		
SEX		
Male	10	1.00
Female	10	.80
Sex of Subject (Female)		
MAN		0.70
DSM-II	10	0.70
DSM-III	10	
Sex of Subject (Male)		
MAN		0.80
DSM-II	10	0.90
DSM-III	10	

TABLE C (Continued)

Variable	N	Mean
	Sex of Depicted Client (Male)	
Sex of Subject (Female)		
MAN		
DSM-II	10	0.60
DSM-III	10	0.50
Sex of Subject (Male)		
MAN		
DSM-II	10	0.60
DSM-III	10	0.70
	Sex of Depicted Client (Female)	
Sex of Subject (Female)		
MAN		
DSM-II	10	0.70
DSM-III	10	0.90
Sex of Subject (Male)		
MAN		
DSM-II	10	0.80
DSM-III	10	0.90

TABLE D

GROUP DIAGNOSTIC CHOICE MEANS FOR FOUR VARIABLE GROUPS

Variable	N	Mean
Undergraduate Subjects		
Depicted Client (Male)		
Sex of Subject (Female)		
MAN		
DSM-II	5	0.40
DSM-III	5	0.60
Sex of Subject (Male)		
MAN		
DSM-II	5	0.60
DSM-III	5	0.60
Depicted Client (Female)		
Sex of Subject (Female)		
MAN		
DSM-II	5	0.80
DSM-III	5	0.80
Sex of Subject (Male)		
MAN		
DSM-II	5	0.60
DSM-III	5	0.80
Graduate Subjects		
Depicted Client (Male)		
Sex of Subject (Female)		
MAN		
DSM-II	5	0.80
DSM-III	5	0.40
Sex of Subject (Male)		
MAN		
DSM-II	5	0.60
DSM-III	5	0.80
Depicted Client (Female)		
Sex of Subject (Female)		
MAN		
DSM-II	5	0.60
DSM-III	5	1.00
Sex of Subject (Male)		
MAN		
DSM-II	5	1.00
DSM-III	5	1.00

APPENDIX K

CORRELATION MATRICES FOR RELEVANT VARIABLES

TABLE E

CORRELATION MATRIX FOR RELEVANT VARIABLES
(COMBINED LEVELS)

	SUB	SEX	DX	ADF	MAN	PSYCHRS	LVL	AWS
TAP	0.00	0.00	0.25***	0.13	0.00	0.20	0.00	-0.06
SUB		0.06	0.07	0.13	0.00	-0.14	0.00	-0.14
SEX			0.08	0.17	0.00	-0.14	0.00	-0.29*
DX				0.12	0.08	-0.14	0.14	0.18
ADF					-0.10	0.09	0.10	-0.02
MAN						0.20	0.00	0.07
PSYCHRS							0.00	0.20
LVL								0.67**

* $p < 0.004$

** $p < 0.005$

*** $p < 0.01$

TABLE F

CORRELATION MATRIX FOR RELEVANT VARIABLES (UNDERGRADUATE SUBJECTS)

	SUB	SEX	DX	ADF	MAN	PSYCHRS	LVL	AWS
TAP	0.00	0.00	0.21	0.09	0.00	0.20	0.00	-0.17
SUB		0.05	0.07	0.11	0.00	-0.14	0.00	-0.13
SEX			0.00	0.09	0.00	-0.14	0.00	-0.39*
DX				0.20	0.10	-0.14	0.00	0.17
ADF					0.03	0.10	0.00	-0.10
MAN						0.20	0.00	0.17
PSYCHRS							0.00	0.17
LVL								0.00

* $p < 0.007$

TABLE G

CORRELATION MATRIX FOR RELEVANT VARIABLES (GRADUATE SUBJECTS)

	SUB	SEX	DX	ADF	MAN	LVL	AWS
TAP	0.00	0.00	0.30*	0.20	0.00	0.00	0.05
SUB		0.07	0.07	0.17	0.00	0.00	-0.28
SEX			0.18	0.27**	0.00	0.00	-0.47****
DX				0.08	0.06	0.00	0.03
ADF					-0.27***	0.00	-0.18
MAN						0.00	-0.04
LVL							0.00

* $p < 0.03$

** $p < 0.04$

*** $p < 0.04$

**** $p < 0.002$

VITA

William C. Gentry

Candidate for the Degree of

Doctor of Philosophy

Thesis: THE EFFECTS OF GENDER AND SEX-ROLE ATTITUDE ON THE DIAGNOSIS OF HYSTERICAL PERSONALITY OR HISTRIONIC PERSONALITY DISORDER USING DSM-II OR DSM-III

Major Field: Psychology

Biographical:

Personal Data: Born in Chickasha, Oklahoma, December 28, 1947, the son of Mr. Belford and Mrs. Mildred Gentry. Child, Erin Brooke Gentry.

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