Order Number 9520536

An investigation of diagnostic sex bias for narcissistic personality disorder, in comparison to histrionic and antisocial personality disorders

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The University of North Carolina at Greensboro, 1994

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AN INVESTIGATION OF DIAGNOSTIC SEX BIAS FOR NARCISSISTIC PERSONALITY DISORDER, IN COMPARISON TO HISTRIONIC AND ANTISOCIAL PERSONALITY DISORDERS

by

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A Dissertation Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro
1994

Approved by

Rosemery Nelson-Grey, Ph.D.

KOLKER, JEANETTE I., Ph.D. An Investigation of Diagnostic Sex Bias for Narcissistic Personality Disorder, In Comparison to Histrionic and Antisocial Personality Disorders. (1994).
Directed by Dr. Rosemery Nelson-Grey. 230 pp.

The present study investigated diagnostic sex bias. Specifically, the validity of the gender base rate hypothesis (i.e, relying on the gender base rate information provided in the DSM-III-R for differential diagnoses), which has previously been offered as an explanation for diagnostic sex bias, was tested against an alternative hypothesis, that clinicians base their diagnoses on gender sex role expectations. It was predicted that clinicians would display a diagnostic sex bias for Narcissistic personality disorder, which the gender base rate hypothesis could not explain, but the sex role expectations hypothesis could. This study also investigated how strictly clinicians adhere to DSM-III-R criteria when making diagnostic decisions. Three hundred and seventy-two doctoral level clinicians comprised the sample. Each clinician read one of eighteen versions of a case scenario, made a diagnosis, and completed several post-experimental questionnaires. A subset of the clinicians also completed a DSM-III-R criterion checklist.

As predicted, chi-square analyses indicated a diagnostic sex bias for Narcissistic personality disorder. Narcissistic personality disorder was overdiagnosed for

male clients and underdiagnosed for female clients. This finding is consistent with predictions based on the sex role expectations hypothesis, but inconsistent with the hypothesis that clinicians use gender base rate information provided in the DSM-III-R, since the DSM-III-R does not provide base rate information for this diagnostic category.

The DSM-III-R criterion checklist did not have any discernable effect on clinicians' diagnostic decisions. This is consistent with previous research that has found little agreement between DSM-III-R diagnostic rules and clinicians' actual diagnoses. However, there was some evidence that when clinicians actually consulted the DSM-III-R, they were more likely to make the correct diagnosis.

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro

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November 18, 1994
Date of Final Oral Examination

ACKNOWLEDGEMENTS

I would like to acknowledge the support and expertise, my chair, Rosemery Nelson-Grey, has given me throughout this project and my entire graduate training. I would also like to thank my committee members for their guidance and support. David Herr, my statistical consultant for this project, also a committe member, deserves special acknowledgement for his quintessential role in helping me complete this project. Lastly, I would like to thank my family for the unfailing support they have give me throughout my graduate training, without which I could have never completed this project. This dissertation is dedicated to the memory of my father.

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CHAPTER I

INTRODUCTION

Research on personality disorders has increased dramatically (Blashfield & McElroy, 1987; Gorton & Akhar, 1990) since the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; 1980) by the American Psychiatric Association. Part of the reason for this resurgence in the study of personality disorders has been due to the multi-axial format introduced in DSM-III, which placed personality disorders on a discrete axis of classification. A second reason for this resurgence was the introduction of more specific operational diagnostic criteria for each personality disorder. These more specific operational diagnostic criteria were introduced in response to criticisms of the low reliability of personality disorder diagnoses afforded by earlier editions of the DSM (Spitzer, Williams, & Skodol, 1980).

However, the introduction of more specific criteria in the DSM-III (and DSM-III-R) did not substantially improve problems associated with the classification of personality disorders. The diagnosis of personality disorders

continues to be relatively unreliable, especially when compared to the diagnostic reliability levels of Axis I disorders (Livesley, 1987; Siever & Klar, 1986; Widiger & Francis, 1985). Several reasons for this relatively low reliability include the fuzziness of boundaries between normal and abnormal personality functioning (Drake & Valliant, 1985; Widiger, Frances, Spitzer, & Williams, 1988; Widiger, Trull, & Hurt, 1987), the overlap among criteria for different personality disorder diagnoses (Pfohl, Coryell, Zimmerman, & Stangl, 1986; Widiger & Frances, 1985), the influence of state and situational factors (Reich, 1987), clients' inability to report symptoms due to the ego-sytonicity of the symptoms (McLemore & Brokaw, 1987), and sex bias (Morey & Ochoa, 1989).

Several of these possible reasons, namely, the fuzziness of boundaries between normal and abnormal personality functioning, the overlap among criteria for different personality disorder diagnoses, and sex bias, seem to be intrinsically intertwined. For example, studies on categorization in social and cognitive psychology have found that the more readily apparent the defining features of a category are, the more likely it is that people will be categorized into groups on the basis of those features (Fiske & Cox, 1979; McArthur, 1981). Thus, if the personality disorder diagnostic categories themselves, and

presumably the criteria that define these categories, are somewhat fuzzy (i.e., not readily apparent), it would seem likely that clinicians would use information, such as sex, age, etc., that is more readily apparent in attempting to place persons in diagnostic categories. Furthermore, if the boundaries between some diagnostic categories overlap, it would also seem likely that clinicians would use information, such as sex, age, etc., to help them make differential diagnoses among personality disorder categories, if those factors had been shown to be more closely associated with a particular diagnostic category than another. Clearly, this introduces the possibility of sex bias in personality disorder diagnoses if clinicians are using the sex of a client as a defining or differentiating criterion on which to base a diagnosis, when it is not scientifically sound to do so.

If clinicians are using the sex of a client as a defining or differentiating criterion when making clinical judgments, such as diagnosing personality disorders, the primary question is whether or not their use of this information is valid. On the one hand, if one particular diagnostic category is more frequently diagnosed for one sex than the other, clinicians may be valid in using this base rate information, all other factors being equal, when making a diagnosis. On the other hand, if clinicians

diagnose one sex with a particular disorder more frequently than the other, not because they are using base rate information, but because it fits with their sex role expectations, their use of the client's sex may not be valid. It may instead reflect the existence of a diagnostic sex bias.

Psychotherapy in general, and clinical judgments in particular, have long been considered susceptible to the cultural forces and biases within which it operates (e.g., Breggin, 1975; Chesler, 1972; Szasz, 1960, 1970). Clinicians are, after all, members of the same society as non-clinicians and would seem to be vulnerable to the same forces and biases when making their clinical judgments. Thus, it seems plausible that a diagnostic sex bias could exist.

Several of the personality disorder diagnostic categories have been said to represent the role/role stereotypes of both sexes. For example, Kaplan (1983) has asserted that Dependent and Histrionic Personality Disorders, "Represent caricatures of the traditional female role...reflect partially a labeling of women who overconform to sex role stereotypes as pathological" (p. 787). Williams and Spitzer (1983) have posited that, "Many would consider the features of Antisocial and Schizoid Personality Disorders to be caricatures of masculinity" (p. 796).

These assertions imply that several of the personality disorder categories, currently codified in the DSM-III-R, may be biased in the sense that they may be more likely to be diagnosed for males v. females because they are more representative of males v. females or vice-versa. Whether it is valid to classify possible "caricatures" of sex-typed behavior as a mental illness is a subject of wide theoretical debate, that is difficult to test empirically. However, whether clinicians are primarily basing their diagnostic decisions on base rate information, all other factors being equal, or whether they are instead basing their decisions on their sex role expectations, is testable empirically, and is the subject of this study.

The Role of Base Rate Information versus Sex Role Expectations in Clinical Judgment. Studies in social and cognitive psychology have indicated that expectancies bias the selection of information to be processed so the expectancy-confirming information is usually selectively attended to (Langer & Abelson, 1974; Rodin & Langer, 1980; Synder & Cantor, 1979). Therefore, if clinicians use sex of the client as one of the defining features for a particular diagnostic category, it would seem likely that this would elicit expectancies about what types of behaviors the client would display based on their sex. Several investigations (e.g., Spence, Helmreich, & Holahan,

1979; Williams & Bennett, 1975) have found that males and females are typically expected to differ in the behaviors they display. This could account for differences in base rates between the sexes for particular diagnostic categories. As noted above, several of the personality disorder diagnostic categories have been said to "represent the role/role-stereotypes of both sexes" (p.332) (e.g., antisocial PD for males, histrionic and dependent PD for females). Therefore, males and females may be more likely to differentially receive the diagnosis that is more characteristic of their particular sex, other factors being approximately equal (Landrine, 1989).

Thus, differential base rates by sex for particular diagnostic categories may be due clinicians' sex role expectations. Clinicians' expectations, in general, however, would seem to be influenced by a wide variety of factors, such as the clinicians' sex, age, theoretical orientation, etc. Therefore, the clinicians' sex role expectations are just one of many factors that may affect their clinical judgments.

However, whether differential diagnostic rates by sex for particular personality diagnostic categories are due to clinicians' use of base rate information, clinicians' sex role expectations in general, or other factors influencing their clinical judgments, is open to empirical test. If it can be ruled out that these differential diagnostic rates

are not due to clinicians' use of base rate information, than this explanation can be discarded and other explanations can be explored. This study directly addressed this issue, as is subsequently discussed.

In addition, as the goal of increased reliability of personality disorder diagnoses rests on the assumption that clinicians adhere to the criteria specified in the DSM-III-R, it would seem imperative to investigate whether practicing clinicians actually adhere to DSM-III-R criteria when making diagnoses. If they do not, as has been suggested by several studies (Adler, Drake, & Teague, 1990; Loring & Powell, 1988; Morey & Ochoa, 1989), the possibility of bias influencing personality disorder diagnoses would appear even more probable; clinicians would presumably be making their diagnoses largely based on other information, such as sex of the patient, which would result in potentially incorrect diagnoses due to the processes discussed in the preceding paragraph. Thus, clinicians would presumably be making their diagnoses based on their own conceptualizations of the various personality disorders based on their training and experience rather than on the criteria specified by DSM-III-R . As clinicians are raised in the same culture as non-clinicians, it would appear reasonable to assume that they are as susceptible to the gender/sex stereotypes that are present in our culture and

that these stereotypes would influence their clinical judgment.

Sex Bias in Clinical Judgement

The debate over the influence of gender/sex stereotypes on the diagnosis, treatment, and outcome of mentally ill individuals is not new. The most often cited and influential study on sex differences in clinical judgement is that of Broverman, Broverman, Clarkson, Rosencratz, and Vogel (1970). In that study, 79 psychologists, psychiatrists, and social workers were asked to describe either a mature, healthy socially competent male, female, or sex-unspecified adult. One major finding of that study was that stereotypic sex-role differences paralleled clinical judgements of optimal mental health for each sex. For example, the healthy woman was described by clinicians as more submissive, less independent, less aggressive, more emotional, less objective, and less adventurous than her male counterparts. The second major finding was that clinicians were less likely to attribute traits characteristic of the healthy adult (sex unspecified) to a healthy woman than to a healthy man.

However, a number of conceptual and methodological limitations with the Broverman et al. (1970) study have been noted (Gove, 1980; Phillips & Gilroy, 1985; Smith, 1980; Widiger & Settle, 1987). For example, Widiger and

Settle (1987) demonstrated that the findings of the Broverman et al. (1970) study were "the result of an imbalanced ratio of male-valued to female-valued items in the dependent measure that forced the subjects to display a sex bias" (p. 463). In fact in a more recent study (Kaplan, Winget, & Free, 1990) where 133 psychiatrists were asked to characterize optimal mental health for hypothetical female and male patients on the Bem Sex Role Inventory, subjects' ratings for men and women were similar with two exceptions: more of the female psychiatrists rated masculine traits as optimal for female patients, and more male psychiatrists chose traits characteristic of Bem's undifferentiated category (low levels of both masculine and feminine traits) as optimal for both male and female patients. Nonetheless, the Broverman et al. (1970) study continues to be cited as the principal support for sex bias in clinical judgements (Hare-Mustin, 1983; Kaplan, 1983; Lemkau, 1983; LoPiccolo, Heiman, Hogan, & Roberts, 1985; Russell, 1986).

In Zeldow's (1978) review of sex-based differences in psychiatric/psychological assessment and treatment, he concluded that the results of the studies he reviewed were sufficiently diverse and ambiguous as to be interpretable both as strong and weak evidence for sexism in the mental health field. He also posited that of the published studies available at the time of his review, many were

"sorely in need of replication" (p. 93). Furthermore, he asserted that "further research must attempt ... to avoid a shotgun approach to research by selecting variables for study with an eye to their theoretical and previously demonstrated relevance" (p. 93).

Of the studies published since Zeldow's (1978) review, a substantial number have followed his advice by concentrating on the possibility of sex bias in the diagnosis of certain personality disorders. Personality disorders are of particular "theoretical and previously demonstrated relevance" because of the strong correlation between certain personality disorder diagnoses and stereotypic male/female behaviors (Sprock, Blashfield, & Smith, 1990). For example, Sprock, Blashfield, and Smith (1990) found that the criteria for sadistic personality disorder was seen as the most stereotypical of men, followed by the criteria for antisocial and schizoid personality disorder. In contrast, the criteria for dependent personality disorder was seen as most stereotypical of women, followed by histrionic, and avoidant personality disorder. This differential gender weighting of several personality disorders would appear to increase the probability for gender bias to occur. Furthermore, personality disorders are also particularly relevant for the issue of sex bias because clinicians more

frequently give women diagnoses of histrionic, dependent, and borderline personality disorders and give men diagnoses of paranoid, antisocial, and compulsive personality disorders (Kaplan, 1983). While it is certainly possible that the differential diagnostic rates for these disorders reflects reality, it is also possible that these differential rates may be occurring due to some type of sex bias in diagnosis. Thus, there is clearly a potential for sex bias in the diagnosis of certain personality disorders.

Widiger and Spitzer (1991) have raised the issue that sex bias in personality disorders has several potential forms, including etiologic, sampling, diagnostic, assessment, and criterion bias. They proposed that although there is clearly the potential for sex bias in the DSM-III-R, the findings of the studies investigating this possible bias are difficult to interpret because they have largely failed to recognize the distinctions among these various sources of bias. They define sex bias as "a systematic deviation that is associated with the sex of the subject" (p. 3). An etiologic sex bias would be present if a differential sex prevalence for a disorder results from social-cultural factors (e.g., differences in social opportunities, child rearing) and represents a sex bias "because the sex differentiation in this case involves an arbitrary, unnecessary, and/or socially created distinction between the sexes (Widiger & Spitzer, 1991, p.3). A

sampling sex bias exists when a differential sex prevalence for a disorder is due to the particular setting from which the subjects are sampled (e.g., VA hospital). A diagnostic sex bias exists when there is a differential prevalence of either "false positive diagnoses (i.e., the misdiagnosis of the presence of a disorder occurs more often in one sex than for the other) and/or false negative diagnoses (i.e., the misdiagnosis of the absence of a disorder occurs more often for one sex than for the other)" (p. 3). Diagnostic sex bias can exist in two forms: (a) criterion sex bias (bias in the criteria that codify the disorder); and/or (b) assessment sex bias (bias in the instruments used to assess the disorder). It would appear important to keep these distinctions in mind when reviewing the studies on sex bias in personality disorders.

Review of Studies Examining Sex Bias in Personality Disorders

A number of studies appear to support the contentions of sex bias in the diagnosis of some of the personality disorders codified in DSM-III-R (Adler, Drake, & Teague, 1990; Ford & Widiger, 1989; Hamilton et al., 1986, Morey & Ochoa, 1989; Warner, 1978), although several studies have failed to support this hypothesis (Fuller & Blashfield, 1989; Henry & Cohen, 1983; Loring & Powell, 1988). The most frequently employed paradigm in these studies has been

to provide clinicians with case histories that vary with respect to sex. Although this paradigm has been criticized for being too transparent and weakly correlated with actual clinical practice (Hare-Mustin, 1983; Stricker, 1977), it is also said to provide the most direct test of diagnostic prejudice (Abramowitz & Dokecki, 1977; Smith, 1980).

The most often cited study of sex bias in the diagnosis of personality disorders was by Warner (1978). Warner presented case histories with mixed features of DSM-II histrionic (HPD) and antisocial (APD) personality disorders to 175 mental health professionals in the Denver area. When the patient was male, he was diagnosed with HPD by 49% of 86 clinicians and with APD by 41%. When the patient was female, she was diagnosed with HPD by 76% of 87 clinicians and with APD by 22%. Warner concluded that there is "a tendency for therapists to perceive men as antisocial personalities and women as hysterical personalities even when these patients have identical clinical features" (p. 842). Although it is unclear why Warner concluded that therapists have a tendency to perceive men as antisocial personalities when they were actually more frequently diagnosed with HPD, more substantial problems with his study have been noted. Warner's study and conclusions (1978) have been criticized on several grounds. First, it is unknown whether the case

history that Warner (1978) presented was indeed balanced in terms of HPD and APD criteria. For example, if the case history contained more APD than HPD criteria, the results might suggest an underdiagnosis of APD in both males and females rather than an overdiagnosis of HPD in females. Second, Warner's (1978) results are ambiguous because the true diagnosis if sex was not a factor is unknown. Third, diagnosing APD when the patient was male and HPD when the patient was female may have been an appropriate response to differential base rates for these disorders in the absence of sufficient information to make a definitive diagnosis and not necessarily an indication of sex bias (Ford & Widiger, 1989; Widiger & Spitzer, 1991). However, it should be noted again, that clinicians actually diagnosed males with HPD slightly more often than APD.

Differential base rates should be a less defendable explanation when the diagnosis is less ambiguous. Fuller and Blashfield (1989), for example, presented 88 clinicians (nationally sampled) with 15 case histories, five of which involved masochistic patients. Three of the masochistic case histories were prototypic, and two were not. Prototypes are highly typical cases associated with a diagnostic category. Fuller and Blashfield found no effect of sex on the diagnosis of masochistic personality disorder for the prototypic cases of masochistic personality disorder, which does not support the hypothesis of a

diagnostic sex bias for this disorder. Furthermore, the failure to find a sex bias effect for the ambiguous cases does not support the base rate hypothesis, since the masochistic diagnosis is thought to be more commonly associated with females (Shainess, 1985; Symonds, 1985). However, the rate of masochistic diagnosis in the ambiguous cases was so low that sex comparisons might be inappropriate. As suggested by Widiger and Spitzer (1991), these cases "might have been so atypical that they were unable to stimulate sex-role assumptions and biases" (p. 8).

Hamilton, Rothbart, and Dawes (1986) obtained antisocial and histrionic applicability ratings on cases that varied in the relative number of antisocial and histrionic criteria as well as the sex of the patient. Five levels of ambiguity were provided, ranging from all histrionic to all antisocial. Ratings were not obtained on a sex unspecified case. Histrionic ratings were higher for women than for men at all levels of ambiguity. Hamilton et al. (1986) indicated that this sex effect did not interact with level of ambiguity, but no statistical comparisons were reported. A visual inspection of their data, however, suggests that the differences between the sexes was highest for the most ambiguous case, consistent with the base rate explanation for sex differences. However, a major

methodological problem in this study was that each subject provided ratings for both sexes and for all levels of ambiguity, making it quite likely that the purpose of the study was apparent to the subject.

Henry and Cohen (1983) provided a case history of borderline personality disorder (BPD) obtained from the DSM-III Case Book (Spitzer, Skodol, Gibbon, & Williams, 1981) that varied with respect to sex, to 65 attending and resident psychiatrists from two metropolitan hospitals. Since the case history was obtained from the DSM-III Case Book, it should have contained enough information to make a definitive diagnosis, and sex should not have affected the diagnosis. Subjects diagnosed BPD in 50% of the 28 male case histories and in 54% of the 37 female cases. Thus, no evidence of a diagnostic sex bias was found. The BPD was given less than 55% of the time, suggesting that the results of the study could not be explained by subjects' familiarity with the DSM-III Case Book or to the obvious nature of the diagnoses. However, it is possible that subjects' knowledge of the purpose of the study and the independence of their ratings might have been compromised by confining the sample to the staff of two local hospitals. This study also suggests that clinicians do not strictly adhere to DSM-III criteria since BPD was diagnosed only 50% of the time, even though the case study was taken directly from the DSM-III casebook.

Adler, Drake, and Teague (1990) asked 46 clinicians to rate personality traits and disorders on one of two versions of a single clinical profile constructed to meet the four DSM-III Axis II diagnoses of histrionic, narcissistic, borderline, and dependent, with the two versions differing only in the sex of the patient. Clinicians tended to use only a single diagnostic category, although they had been directed to consider each category separately. The diagnosis of BPD was unrelated to sex of case: approximately half of the males and half of the females were rated as borderline. However, both narcissistic and histrionic diagnoses were strongly related to gender. Men were more likely to be rated as narcissistic because the narcissistic personality disorder diagnosis was largely overlooked when the patient was identified as female. In contrast, women were more likely to be rated as histrionic because the HPD diagnosis was almost totally ignored when the patient was identified as male. Both narcissistic and histrionic diagnoses were inversely related to the borderline diagnosis; that is, clinicians who diagnosed BPD were unlikely to diagnose either narcissistic personality or histrionic personality disorder. Other diagnoses, including dependent, were rarely assigned. The findings of this study have several possible implications. First of all, they do not provide

compelling support for the base rate hypothesis. Although gender did influence the diagnosis of HPD, in keeping with the base rate explanation, no gender influence was found for the diagnosis of BPD (for which base rates favor females) and a strong gender influence was found for the diagnosis of narcissistic personality disorder, for which no prevalence data are known. Second, clinicians do not appear to strictly adhere to DSM-III-R directives, as the hypothetical client met criteria for four DSM diagnoses but was typically given only one. Thus, it would appear that the clinicians in this study made a global judgment and then subsumed further information in terms of that category. Third, the results of this study suggest that clinicians tend to use BPD as a "catch-all" category of diagnosis when presented with a hypothetical severely personality disordered client. Fourth, although the results of this study do provide support for sex bias in the diagnosis of personality disorders, the support is somewhat muddled and unclear. The results of this study seem to suggest that clinicians prefer to give a diagnosis of HPD to females and NPD to males when presented with a client who meets criteria for several personality disorders. However, it is not possible to discern if this differential sex bias would be present when clinicians were presented with a client who did not meet criteria for several personality disorder diagnoses.

Loring and Powell (1988) presented separate case histories to 290 nationally sampled psychiatrists that varied according to sex and race. A sex unspecified case was also included. Dependent personality disorder was given to 62% of the sex unspecified cases, 52% of the white males, 39% of the white females, and 33% of the black females. They found little to no bias against females, although this study was not optimally constructed to investigate sex bias, since DPD was the correct diagnosis. However, there was a substantial effect of race, with black patients given an overdiagnosis of paranoid personality disorder.

Morey and Ochoa (1989) nationally sampled 291 psychologists and psychiatrists, asking them to provide the personality disorder diagnosis for one (or more) of their patients and to rate this patient on each of the DSM-III-R personality disorder criteria (presented in random order). They found marginal tendencies to overdiagnose BPD in females and APD in males, and no effect of sex for the diagnosis of HPD. They also found that clinical diagnoses and diagnoses based on the DSM-III-R system frequently disagreed. For example, in 72% of the cases, diagnostic inconsistencies (i.e., the diagnosis given was not the same as the diagnosis DSM-III-R criteria would give, based on the criteria the client met) were observed, strongly

suggesting that clinicians do not adhere to DSM-III-R criteria.

Ford and Widiger (1989) provided case histories to 266 psychologists sampled from Southeastern states which varied by sex (male, female, sex unspecified) and personality disorder criteria (met the DSM-III criteria for HPD but not APD, contained a balanced number of criteria for HPD and APD but did not meet criteria for either disorder, met the DSM-III criteria for APD but not HPD). Borderline personality disorder was the personality disorder diagnosis most often made across all three case histories when the gender was neuter, which is not surprising given its popularity and relatively nonspecific, overlapping criteria (Gunderson, 1984; Widiger & Frances, 1985). However, for the histrionic case history, subjects were significantly more likely to diagnose HPD in female patients (76%) than in male patients (44%). In contrast, for the antisocial case history, subjects were significantly more likely to diagnose APD in male patients (42%) than in female patients (15%). Furthermore, antisocial female patients were significantly more likely to be diagnosed with HPD than with APD (46% vs. 15%, respectively). Ford and Widiger (1989) also had a separate group of 88 clinicians rate the extent to which each of a list of 10 individual behaviors extracted from the case histories was an example of a respective DSM-III histrionic or antisocial criterion for a

male, female, or neuter (sex unspecified) patient. Eighty percent of the sentences were rated as indicating the presence of the respective criteria for APD or HPD by a majority of the subjects. Furthermore, in general, subjects did not differentiate between males and females with respect to the presence of each individual diagnostic criterion.

Ford and Widiger (1989) interpreted their results as not supporting the base rate explanation of sex differences in the diagnosis of certain personality disorders. They argued that base rates would be most relevant when the case history information is ambiguous, but their study found that the least ambiguous case histories that met DSM-III criteria were those most affected by the sex of the patient. Furthermore, they proposed that since bias was not evident in the assessment of the individual APD and HPD criteria that the individual items may not be sex-biased, but that bias may be generated by stereotypic expectations with respect to the diagnostic label (i.e., histrionic or antisocial). Thus, they argued that the best way to diminish sex bias would be an increased emphasis in training programs and clinical settings on the systematic use and adherence to the criteria and diagnostic rules of DSM-III-R and not in the development of explicit, specific, and sex-neutral criteria.

Cognitive/Social Explanations for Ford and Widiger (1989)

The findings of Ford and Widiger (1989) support the presence of assessment sex bias for histrionic and antisocial personality disorders. However, Ford and Widiger's (1989) results might also be interpreted in terms the social and cognitive psychology literature on categorization and information processing, some of which was previously discussed. One consistent finding of this literature base that is applicable to the findings of Ford and Widiger is the tendency to perceive and process information in terms of readily accessible categories, called critical sets (Ross, Lepper, & Hubbard, 1975; Srull & Wyer, 1979). Clinicians, like others, make attributions based on salient pieces of information, whether or not this information is related to diagnostic criteria (Taylor & Fiske, 1978). It is highly probable that gender constitutes a particularly salient piece of information, one that activates a critical set, and one that clinicians use to understand behavior (i.e., sex role categorization leads to a series of cognitive steps that permit the reduction of a large amount of information into a more manageable typology) (Bem, 1974; Cantor & Mischel, 1979). Moreover, research has shown (e.g., Bell, Wicklund, Manko, & Larkin, 1976; Hayden & Mischel, 1976) that once critical sets are activated, they become tenacious, with perceivers biased to maintain consistency. For example, once

perceivers have formed a trait impression, they are more likely to attribute subsequent behaviors that are consistent with their initial impression to the stimulus person's "real self" whereas inconsistent subsequent behaviors are attributed to superficial and transient factors.

Furthermore, research suggests that individuals tend to seek a single, sufficient, and salient explanation of behavior, frequently the first satisfactory one that comes along (e.g., Jones & Davis, 1965; Kanouse, 1972; Tversky & Kahneman, 1974). For example, researchers have found that instead of employing base rate or consensus information logically, most people are more influenced by a single, colorful piece of case history evidence (Kahneman & Tversky, 1973; Nisbett, Borgida, Crandall, & Reed, 1976). One explanation for this tendency that has been offered is that case history information is easier to imagine than statistical information (Taylor & Fiske, 1978).

Furthermore, it has been frequently proposed (e.g., Nisbett & Valins, 1972; Taylor & Fiske, 1978) that a cognition, once made salient, functions as hypothesis. A search for data is then made that is undoubtedly biased in favor of the original hypothesis. In addition, research on perceived covariation (e.g., Smedslund, 1963; Ward, 1965) indicates that in estimating degree of correlation ++

instances are the primary sources of data considered, with +-, -+, and -- instances going relatively ignored.

The findings of this area of cognitive/social research are particularly relevant for the interpretation of the findings of the Ford and Widiger (1989) study. For example, it would seem plausible in light of the research discussed above, that sex of the patient in the Ford and Widiger (1989) case histories would activate a critical set related to sex/gender stereotypes. Once this critical set has been activated, it would seem likely that the clinician would seek to find information that confirms their hypothesis and give little weight to information that is inconsistent with their hypothesis. For example, in the Ford and Widiger (1989) study, case histories that presented a female patient would activate a critical set concerning female stereotypes, and the information in the case history (i.e., histrionic criteria) consistent with the stereotype would be attended to and information inconsistent with that stereotype (i.e., anti-social criteria) would be dismissed. This was indeed the case in the Ford and Widiger (1989) study, where they found that for the histrionic case history, subjects were significantly more likely to diagnose HPD in female patients than in male patients. Furthermore, for the case histories that actually contained more criteria for the disorder not consistent with the stereotype (e.g., APD for

females), this tendency might be enhanced because the criteria consistent with the stereotype would be even more salient due their lower frequency in comparison to the criteria for the other disorder. This possibility was also supported by Ford and Widiger's (1989) findings; for the antisocial case history, female patients were significantly more likely to be diagnosed with HPD than with APD. This tendency might also explain the failure to find a sex bias in the balanced case histories in the Ford and Widiger (1989) study. Although gender stereotypes might have been activated by the sex of the patient, the criteria consistent with that stereotypic disorder might not have been salient enough because there was an equal number of criteria for the non-stereotypic disorder.

Furthermore, although Ford and Widiger (1989) state that their findings do not support the base rate hypothesis because no sex bias was found for the balanced case history, it is not known whether the case was truly balanced in terms of how the criteria they chose to include were representative of the disorder. A number of studies (e.g., Livesley, 1989; Morey & Ochoa, 1989) have shown that clinicians give more weight to certain personality disorder criteria than they do to others. Therefore, it is possible that the case histories used in the Ford and Widiger (1989) study were not balanced in the sense that they may have

included criteria for each disorder (i.e., HPD and APD) that had different weights.

A more stringent test of whether the base rate hypothesis is a sufficient explanation for differential sex prevalence rates for selected personality disorders, would seem to be one that compares clinicians ratings for each sex for a case history that meets criteria for a disorder without a known differential sex prevalence rate (e.g., Narcissistic PD) and also contains features of a disorder (but does not meet criteria for that disorder) that is stereotypic of a particular sex (e.g., Histrionic PD). If it were found that clinicians' diagnoses differed according to the sex of the client, the base rate hypothesis would clearly not be supported because base rates should not have entered into the clinician's assessment of Narcissistic PD.

STATEMENT OF PURPOSE

The present study investigated whether clinicians would give differential diagnoses to hypothetical clients who presented with identical symptoms but varied by sex. Clinicians were asked to give a diagnosis based on the information presented in the case history. Each clinician was presented with only one case history. The case histories varied by sex, with each case involving either a male, a female, or a gender neutral (sex unspecified) client. The case histories also varied according by which

diagnosis was appropriate according to DSM-III-R criteria and rules. Four histories were constructed: (a) met DSM-III-R criteria for Narcissistic Personality Disorder (NPD) and contained some features of Histrionic Personality Disorder (HPD) but not enough to make that diagnosis; (b) met DSM-III-R criteria for NPD and contained some features of Antisocial Personality Disorder (APD) but not enough to make that diagnosis; (c) met DSM-III-R criteria for HPD and contained some features of NPD but not enough to make that diagnosis; and (d) met DSM-III-R criteria for APD and contained some features of NPD but not enough to make that diagnosis.

The three personality disorders (i.e., Histrionic PD, Antisocial PD, and Narcissistic PD) which were the focus in the case histories were chosen for specific reasons. Histrionic PD was chosen because the DSM-III-R reports a differential base rate for this disorder, favoring females, and because it has been said to be stereotypic of females. Antisocial PD was chosen because the DSM-III-R reports a differential base rate for this disorder, favoring males, and because it has been said to be stereotypic of males. Narcissistic PD was chosen primarily because the DSM-III-R does not report a differential base rate for this disorder and it has not been previously thought to be stereotypic of either sex. Furthermore, NPD was chosen because it is in the same cluster as APD and HPD, which means that it shares

some similarity with these disorders in that people with diagnoses in this cluster often appear dramatic, emotional, or erratic. It was felt that choosing a disorder from the same cluster as APD and HPD would make the case histories more realistic since many people who meet criteria for one disorder within a cluster often also present with features of other disorders within that cluster.

This study also investigated whether clinicians would give differential diagnoses to hypothetical clients who presented with identical symptoms but varied by sex if they were forced to take DSM-III-R criteria and rules into account before making their diagnosis. For the first version of the case history (i.e., meets DSM-III-R criteria for NPD with HPD features), half of the clinicians in each condition were given a list of DSM-III-R criteria for each diagnosis to be considered (i.e., DSM diagnostic checklist) and asked to check whether or not their hypothetical client met those criteria before making a diagnosis. For the other three versions of the case history, only in the condition where clinicians were predicted to make an incorrect diagnosis due to the sex of the hypothetical client were half of clinicians also asked to complete a DSM diagnostic checklist. Thus, this study investigated whether an assessment sex bias exists in the diagnosis of selected personality disorders. According to Widiger and

Spitzer (1991), an assessment sex bias is one resulting from the instruments (in this study, clinical judgments) that provide the diagnosis.

The hypotheses of this study were based on the theoretical position that the base rate explanation for differential sex prevalence rates for certain personality disorder diagnoses is not a sufficient explanation for these differential rates. Instead, it was proposed that a better explanation for these differential rates is one derived from the social/cognitive literature on the role of critical sets, expectancies, and saliency in making categorical judgments about people. Specifically, it was proposed that the sex of a patient operates as a critical set that elicits certain expectancies about what types of behavior that patient is more or less likely to display. Furthermore, the extent to which the sex of a patient functions in this manner also partially depends on the saliency of other information that is consistent and/or inconsistent with the expectancies elicited by the patient's sex. Thus, it was proposed that clinicians are not simply using differential base rate information when making certain personality disorder diagnoses but instead are making their diagnoses based on the cognitive processes, discussed above, elicited by the information presented to them. Furthermore, it seemed likely that the differential base rates themselves result from the

cognitive processes discussed above.

The specific hypotheses tested in this study were:

(1) Clinicians will be more likely to correctly diagnose HPD for females and incorrectly diagnose NPD for males, for the case history meeting diagnostic criteria for HPD with some NPD features, when simply asked to make a diagnosis. Specifically, it was proposed that the base rate explanation for sex bias in the diagnosis of personality disorders is not an adequate explanation for the differential sex prevalence rates, based on the mixed support this hypothesis has received (e.g., Adler, Drake, & Teague, 1990; Ford & Widiger, 1989). Instead it was hypothesized that the sex of the patient will activate a critical set related to the gender stereotype for that sex. The most stringent test for this hypothesis will be if clinicians give differential diagnoses based on sex for the case history that meets diagnostic criteria for HPD and contains some NPD features. On the one hand, since no prevalence rates are known for NPD, the base rate hypothesis could not explain a finding of differential diagnosis based on sex of the patient, and the activation of critical set related to gender stereotypes would serve as a better explanation for the diagnosis of NPD for male clients. On the other hand, if NPD is not more frequently diagnosed for males compared to females, the gender base

rate hypothesis could not be dismissed as a plausible explanation for differential gender base rates.

(2) Clinicians will be more likely to correctly diagnose APD for males, and incorrectly diagnose NPD for females for the case history meeting criteria for APD with NPD features, when simply asked to make a diagnosis. Similar to the reasoning discussed above, it is proposed that the sex of the patient will activate a critical set related to the gender stereotype for that sex. It is hypothesized that APD criteria will be largely overlooked when the patient is female because that criteria is inconsistent with the critical set associated with female stereotypes. This will make the NPD criteria more salient, and clinicians will thus be more likely to give females the NPD diagnosis. For males, the APD diagnosis is both the correct diagnosis and consistent with male stereotypes, so clinicians will be more likely to give male clients the APD diagnosis.

(3) Clinicians will be more likely to incorrectly diagnose HPD for females, and correctly diagnose NPD for males, for the case history meeting diagnostic criteria for NPD with some HPD features, when simply asked to make a diagnosis. This hypothesis is based on the findings of several previous studies (e.g., Adler, Drake, & Teague, 1990; Ford & Widiger, 1989) that have suggested that sex of the patients activates a critical set related to the gender

stereotypes for that sex and that patients will be given a diagnosis that most closely corresponds to those stereotypes. Since the NPD diagnosis has not been previously strongly associated with either gender, it probably will not provide the striking contrast that the pairing of HPD and APD criteria typically elicits for diagnostic decisions. Therefore, it is predicted that although clinicians will still display a preference for diagnosing HPD more frequently for female clients than male clients, they will probably also diagnose NPD for female clients at a rate comparable to their diagnosis of HPD. NPD will be more frequently diagnosed for males, compared to females, because it is the correct diagnosis and is not inconsistent with male stereotypes.

(4) Similarly, clinicians will be more likely to incorrectly diagnosis APD for males and correctly diagnose NPD for females for the case history meeting criteria for NPD with APD features, when simply asked to make a diagnosis. This hypothesis is based on the reasoning discussed for Hypothesis 3, that sex of the patient will activate a critical set related to the gender stereotypes for that sex and that patients will be given a diagnosis that most closely corresponds to those stereotypes.

(5) Clinicians will give the correct diagnosis, according to DSM-III-R criteria and rules, for all three

gender neutral versions of the case history. Thus, it was proposed that gender stereotypes will not be activated when the sex of the client is unspecified, in keeping with Ford and Widiger's (1989) findings.

(6) Clinicians will give the correct diagnosis, according to DSM-III-R criteria and rules, when they are instructed to use DSM-III-R criterion checklists before making a diagnosis. This hypothesis is based on the finding that sex biases in personality disorder diagnoses do not typically appear when a structured interview is used to make the diagnosis (Reich, 1987; Zimmerman & Coryell, 1989). Thus, it is hypothesized that the DSM-III-R criterion checklists will function similarly to a structured interview in that they will make clinicians consider the specific DSM-III-R criteria for each possible diagnosis before making a final diagnosis.

CHAPTER II

METHODS

PARTICIPANTS

Subjects were psychologists randomly selected from the National Register of Health Service Providers in Psychology (Council for the National Register, 1992). A total mailing of 1800 questionnaires obtained 372 useable responses (20%). The return rate was 24% when it was adjusted for questionnaires returned but not completed. This return rate is lower than the average reported response rate of 30%, but still within the range of the overall response rate reported by previous survey studies, which ranges from 10% to 100% (e.g., Ford & Widiger, 1989; Lipkowitz & Idupuganti, 1985). Response rates vary for a variety of reasons such as length of the questionnaire, incentives provided for responding to the questionnaire and characteristics of the sample. For example, a study by Wilkinson (1980) on racial attitudes of psychiatrists yielded only a 10% response rate. However, a 1988 study by Loring and Powell on gender, race, and the DSM-III yielded a 59.4% response rate. They asserted that their relatively high response rate was the result of (a) the letter of

support provided by the APA; (b) the controversial nature of the DSM-III; and (c) the questionnaire itself, which was not especially long or labor-intensive.

In an attempt to increase the response rate, subjects were told that if they fully completed and returned the questionnaire by July 15, 1993, their name would be entered in a lottery offering $50 to the first prize winner, $40 to the second prize winner, and $20 to the third prize winner. Winners of the lottery were selected by writing the subject numbers of all eligible participants on slips of paper and blindly drawing for the prize winners. The first prize winner was a subject living in Phoenix, Arizona. The second prize winner was a subject living in Bethesda, Maryland. The third prize winner was a subject living in Miami, Florida.

Participant Characteristics. Fifty-seven percent (N = 212) of the participants were male and 43% (N = 160) were female. This is roughly equivalent to the total mailing where 50% of each version of the case history were sent to males and 50% were sent to females. The sex ratio of the participants in this study is slightly different from the sex ratio of participants in similar studies, such as Ford and Widiger's (1989), where 76% of the participants were male. However, it is not known whether previous studies attempted to obtain a balanced number of male and

female participants, as this study did, by sending out an equal number of mailings to male and female participants. Although the sex ratio of participants may have influenced the results obtained in this study, it seems unlikely. Prior research in this area has found no substantial or reliable differences in the results obtained from male and female participants (Ford & Widiger, 1989; Hamilton et al., 1986; Warner, 1978). A breakdown of the sex of the participants by the version of the case history they resulted to is provided in Appendix A. Mean age of participants was 50.7 years (SD = 9.4). This is similar to Ford and Widiger's (1989) participant characteristics, where a mean age of 46.6 years (SD = 10.8) was reported. Twenty-seven percent of participants listed themselves as psychodynamic, 26% as cognitive-behavioral, 3% as social learning, 4% as systems oriented, 3% as existential-humanistic, 4% as interpersonally oriented, 1% as Rogerian, 1% as Gestalt, 29% as eclectic, and 2% listed other orientations as primary. This is fairly similar to the orientations listed by participants in Ford and Widiger's (1989) study where 29% listed themselves as psychodynamic or insight-oriented, 19% as behavioral or cognitive behavioral, 13% as systems- or family-oriented, and 38% as eclectic. The participants in Ford and Widiger's (1989) study may not have listed such orientations as existential-humanistic, Gestalt, etc., becauase they may not have been

specifically listed as options, as they were in this study. Eighty-four percent of participants were in private practice, 20% in a hospital setting, 17% in a college/university as a professor, 3% in a college/university counseling center, and 8% in other categories. Participants were asked to indicate all settings in which they currently practiced. In comparison, 57% of participants in Ford and Widiger's (1989) were in private practice, 21% in inpatient settings, 12% in outpatient clinics, 6% in academic settings, and 4% in other categories. Although there are noticeable differences among the settings reported for Ford and Widiger's (1989) study participants and the participants in this study, it seems likely that these differences are due to how participants were asked to report this information.

In this study, participants were asked to report all settings in which they practice, whereas it seems likely that in the Ford and Widiger study they were asked to only list the primary setting in which they practice. This would account, for example, for the higher percentage of participants in this study reporting private practice as a setting since many clinicians work primarily in a setting other than private practice, but also see several clients in private practice. Forty-three percent of respondents reported working with children under 12 years of age, 65%

with adolescents aged 13 to 17 years of age, 98% with adults aged 18 to 64 years, and 55% with adults aged 65 years or older. Participants were asked to indicate all ages of clients with which they worked. Other studies have not reported this information when published, so no direct comparisons on this participant characteristic could be made. The mean year when respondents received their Ph.D. or Psy.D. was 1973 (SD=9 years). Assuming most respondents began practicing soon after receiving their degree, this is similar to the results of Ford and Widiger's (1989) study which reported participants having an average of 15.6 years of clinical experience (SD = 8.4) since obtaining their degree. Approximately 10% of the respondents were Psy.D.'s, with the remaining 90% having Ph.D.'s. A direct comparison of this participant characteristic with the Ford and Widiger (1989) study could not be made since they only reported utilizing psychologists as participants, without specifying what specific degree their participants possessed. However, since they obtained their participant pool from the same source as this study (i.e., the National Register of Health Services Providers in Psychology), it seems likely that their participants were roughly equivalent to the participants in this study on this participant characteristic. The mean number of hours reported by participants per week spent in various types of clinical practice was: individual therapy, 16 (SD=10);

group therapy, 2 (SD=3); couples therapy, 2 (SD=3); diagnosis, 5 (SD=8); consultation, 3 (SD=5); family therapy, 1 (SD=2); supervision, 2 (SD=3); teaching, 3 (SD=7); and other activities (e.g., writing, research) 6 (SD=19). A direct comparison on these participant characteristics could not be made, since similar studies have not reported these data. Overall, however, the characteristics of the sample were comparable to those of similar surveys (e.g., Ford & Widiger, 1989; Morrow-Bradley & Elliott, 1986). Furthermore, it should be noted that statistical analyses on the possible effects of participant characteristics on the dependent measures in this study were not conducted due to the low sample size that resulted when these charcteristics were broken down by the eighteen experimental cells.

EXPERIMENTAL MATERIALS

Case Histories. Four case histories were constructed. However, it should be noted to the reader that there were actually eighteen different versions of the case history sent out when one takes into account the variation of the sex of the client for each of the four versions of the case history. The first case history met DSM-III-R criteria for Narcissistic PD and contained some features of Histrionic PD but did not meet criteria for that disorder (See

Appendices B, C, D). The second case history met DSM-III-R criteria for Narcissistic PD and contained some features of Antisocial PD but did not meet criteria for that disorder (See Appendices E, F, G). The third case history met DSM-III-R criteria for Histrionic PD and contained some features of Narcissistic PD but did not meet criteria for that disorder (See Appendices H, I, J). The fourth case history met DSM-III-R criteria for Antisocial PD and contained some features of Narcissistic PD but did not meet criteria for that disorder (See Appendices K, L, M).

Pilot work was conducted to ensure that the statements in the case histories meant to represent specific DSM-III-R criteria actually represented those criteria. Fifteen advanced level (i.e., third or higher year in the program) clinical psychology graduate students from the University of North Carolina at Greensboro rated on a 7-point scale (ranging from not at all to fully represents) the extent to which each statement represented the specific criterion it was constructed to represent. These students also rated on a 7-point scale, (ranging from not at all to completely characteristic) the extent to which each statement was characteristic of males and females. Only those statements that received ratings of 5 or above on both their representativeness of DSM-III-R criteria and applicability to both males and females were included in the case histories (See Appendix N for mean ratings of statements

included in case histories).

Furthermore, due to the fact that the number of DSM-III-R criteria needed to make a diagnosis for each of the personality disorders of interest in this study varies, the total number of statements pertaining to personality disorder criteria also varied among the case histories. Taking this into account, the case histories were constructed so that approximately 70% of the statements for the correct diagnosis were present and 30% of the secondary diagnosis were present. For the Narcissistic Personality Disorder with Histrionic features case history, seven statements applied to NPD criteria and three statements applied to HPD criteria. In order to meet criteria for NPD according to the DSM-III-R, five of a possible nine criteria are needed. In order to meet criteria for HPD according to the DSM-III-R, four of a possible eight criteria are needed.

For the Narcissistic Personality Disorder with Antisocial features case history, six statements applied to NPD criteria and four statements applied to APD criteria. This case history was constructed in this way in order to make APD a realistic secondary diagnosis because seven of a possible eighteen criteria are needed to make the diagnosis of APD (aside from the criteria of current age being 18, which was true for all clients presented in the case

histories).

For the Histrionic Personality Disorder with NPD features case history, seven statements applied to HPD criteria and three statements applied to NPD criteria. For the Antisocial Personality Disorder with NPD features case history, nine statements applied to APD criteria and four statements applied to NPD criteria.

DSM-III-R Criterion Checklist. The checklist gave the brief description of each disorder (i.e., dysthymic, generalized anxiety, adjustment, bi-polar, narcissistic, histrionic, borderline, antisocial, and passive-aggressive), provided in the DSM-III-R, including the number of criteria that must be met in order to give that diagnosis (see Appendix O for DSM-III-R criterion checklist). Individual criteria for each disorder were listed, with subjects rating on a 7-point scale the extent to which the client met that criteria. Subjects were told that ratings of 5 through 7 indicate that the person fully met that particular criteria.

DSM-III-R Diagnosis Checklists. As the major dependent variable in this study, subjects were asked to rate on a 7-point scale the extent to which the client appeared to have each of four Axis I disorders (dysthymic, generalized anxiety, adjustment, and bi-polar disorder) and five Axis II disorders (narcissistic, histrionic, borderline, antisocial, and passive-aggressive personality

disorder) (See Appendix P for a sample diagnosis checklist). A variety of diagnoses were included in order to minimize awareness of the purpose of the study. Subjects were allowed to provide multiple diagnoses for the same case history, consistent with clinical practice. Subjects were instructed that ratings of 5 through 7 indicated that they believe the disorder to be present.

PROCEDURE

All subjects were mailed a packet containing one of eighteen possible versions of the experimental materials. A cover letter explaining the project and soliciting the participation of potential respondents (See Appendix Q) and a consent form (See Appendix R) proceeded the experimental materials. A portion of the subjects also had DSM-III-R criterion checklists included in their packet. Three post-experimental questionnaires were also included in subjects' packets (See Appendices S, T, U). Subjects were told that if they fully completed and returned the packet by July 15, 1993, their name would be entered in a lottery where they could win either $50, $40, or $20 dollars. Subjects were instructed to complete the entire survey uninterrupted and in the order in which it was stapled together. Subjects were also told that they would receive a debriefing statement once all participants had returned their responses (See Appendix V).

CHAPTER III

RESULTS

The results are divided into four sections: (a) categorical analyses; (b) dimensional analyses; (c) post-experimental questionnaire analyses; and (d) post-hoc analyses. The categorical analyses examined whether subjects' ratings on the DSM-III-R diagnosis checklist yielded any differences among the personality disorder diagnoses when considered as a category endorsed or rejected for male, female, and gender neutral clients. The dimensional analyses examined whether subjects' 1 to 7 ratings on the DSM-III-R diagnosis checklist yielded any differences in the certainty of their personality disorder diagnoses for male, female, and gender neutral clients. For both the categorical and dimensional analyses, comparisons of subjects' ratings on the DSM-III-R diagnosis checklist were also made between subjects who completed a DSM-III-R criterion checklist prior to making a diagnosis and those who did not. The post-experimental questionnaire analyses include the mean ratings and standard deviations for the questions on the three post-experimental questionnaires. The post-hoc analyses present demographic

and some other information from the post-experimental questionnaires for subjects who gave correct, "close" (definition of close is discussed in the post-hoc analysis section), and wrong diagnoses.

Due to quantity of results from the analyses conducted, only those results that were statistically significant or otherwise meaningful are presented in this section. Thus, if a comparison is not discussed, the reader should conclude that the comparison was not statistically significant or otherwise meaningful. For example, for the Narcissistic case history with Antisocial features, females received significantly higher certainty ratings for the Histrionic PD diagnosis than males. This result is reported in the relevant section of the results. However, for this same case history, there were not any statistically significant differences in the certainty ratings for the Histrionic PD diagnosis between gender neutrals and males or females. Thus, this comparison was not reported and the reader can conclude from its absence that this comparison was not statistically significant. The overall experimental design is provided in Appendix W.

CATEGORICAL ANALYSES

Subjects were instructed when filling out their DSM-III-R diagnosis checklists that ratings of 5 and above

in any diagnostic category indicated that they believed the client in the case history they just read fully met the criteria for that diagnostic category. Thus, subjects who gave ratings of 5 or above in any diagnostic category were placed in the "yes" category for assigning that diagnosis. In other words, their 5 and above ratings were seen as an endorsement of that particular diagnosis for the client. Subjects who gave ratings of 4 or below in any diagnostic category were placed in the "no" category for that diagnosis. In other words, their ratings of 4 or below in any diagnostic category were seen as a rejection of that particular diagnosis for the client. Subjects rated the hypothetical client on nine separate diagnostic categories. Thus, a subject could hypothetically endorse all nine diagnoses, reject all nine diagnoses, or reject some diagnoses and endorse others. Four of the diagnostic categories (i.e., dysthymic disorder, generalized anxiety disorder, adjustment disorder, and bipolar disorder) were included only to distract subjects from the purpose of the study. Subjects' ratings of these diagnostic categories were not analyzed because they were not of interest in this study. Only subjects' ratings for the five personality disorder diagnoses (i.e., Narcissistic PD, Histrionic PD, Borderline PD, Antisocial PD, and Passive-Aggressive PD) included in the study were analyzed.

OVERALL SEX DIFFERENCES

The first categorical analysis examined whether there were any overall sex differences among the personality disorder diagnoses assigned. In other words, this analysis investigated whether subjects endorsed or rejected a particular diagnostic category at statistically different rates for males versus females versus gender neutral clients, regardless of the version of the case history subjects read. Chi-square tests of independence indicated that subjects were significantly less likely to diagnose Narcissistic Personality Disorder (NPD) in female clients and significantly more likely to diagnose male clients with Narcissistic PD, Likelihood Ratio Chi-Square (2, N = 372) = 6.236, p = .044. Subjects also were significantly less likely to diagnosis Borderline Personality Disorder in male clients and significantly more likely to diagnose gender neutral clients with Borderline Personality Disorder, Likelihood Ratio Chi-Square (2, N = 372) = 8.552, p = .014 (Appendix X; Table 1 and all subsequent tables may be found in Appendix X).

SEX DIFFERENCES FOR EACH CASE HISTORY

The second set of categorical analyses examined whether there were any sex differences among the personality disorder diagnoses when each version of the case history was considered separately. This set of

analyses tested the specific hypotheses, presented earlier, for differential diagnostic rates for specific personality disorders among the gender types presented (i.e., male, female, gender neutral) based on the version of the case history presented. For example, it was predicted that subjects who read the Narcissistic case history with Histrionic personality features would misdiagnose Histrionic PD for females clients and give the correct diagnosis of Narcissistic PD only to male and gender neutral clients. In contrast, it was predicted that subjects who read the Histrionic case history with Narcissistic features would misdiagnose Narcissistic PD for male clients and give the correct diagnosis of Histrionic PD only to female and gender neutral clients. In order to investigate these potential differences, chi-square tests of independence were conducted separately for each of the four versions of the case history.

These tests were only conducted for subjects who did not complete a DSM-III-R diagnostic checklist prior to making a diagnosis. An exception is the chi-square test of independence conducted for the Narcissistic case history with Histrionic features for subjects who did complete a DSM diagnostic checklist prior to making a diagnosis. The test was conducted because for this version of the case history, all three gender categories (i.e., male, female, gender neutral) were sent out, along with the DSM

diagnostic checklist. For the other three versions of the case history, only one gender category was sent out, along with the DSM-III-R diagnostic checklist. For these three versions of the case history (and for the first version), Fisher's Exact Test (2-tailed) was used to make direct comparisons between subjects who completed the DSM-III-R criterion checklist prior to making a diagnosis compared to those who did not, to examine whether or not the DSM-III-R criterion checklist influenced personality disorder diagnoses for the relevant gender category.

Narcissistic PD with Histrionic Features. For the Narcissistic case history with Histrionic features, an examination of the differences in expected frequencies indicated subjects were significantly more likely to fail to diagnose Narcissistic Personality Disorder (NPD) for female clients as compared to male and gender neutral clients, Likelihood Ratio Chi-Square (2, N = 61) = 11.94, p = .003 (see Table 2). Furthermore, subjects were significantly more likely to misdiagnose Borderline Personality Disorder (BPD) for female clients and significantly less likely to give this diagnosis to male clients, Likelihood Ratio Chi-Square (2, N = 61) = 6.53, p = .038.

For subjects who completed a DSM-III-R criterion checklist prior to making a diagnosis, an examination of

expected frequencies indicated subjects were more likely to misdiagnose Borderline Personality Disorder (BPD) for gender neutral and female clients and less likely to give this diagnosis to male clients, Likelihood Ratio Chi-Square (2, N = 61) = 6.23, p = .044.

A direct comparison between subjects who completed a DSM-III-R criterion checklist versus those who did not indicated that subjects who did not complete the checklist were significantly more likely to fail to diagnose Narcissistic Personality Disorder (NPD), for female clients, Fisher's Exact Test, (N = 41), p = .000 and to misdiagnose Borderline Personality Disorder (BPD), for female clients, Fisher's Exact Test, (N = 41), p = .043.

Narcissistic PD with Antisocial Features. For the Narcissistic case history with Antisocial features, an examination of differences in expected frequencies indicated that subjects were significantly more likely to fail to diagnose Narcissistic Personality Disorder (NPD) for female clients compared to male and gender neutral clients, Likelihood Ratio Chi-Square (2, N = 62) = 16.194, p = .000 (see Table 3). Furthermore, subjects were significantly less likely to diagnose Antisocial Personality Disorder (APD) for female clients compared to male and gender neutral clients, Likelihood Ratio Chi-Square (2, N = 62) = 7.15, p = .028. No differences were found between diagnoses given for male clients between

subjects who did not complete a DSM-III-R criterion checklist and those who did (See Table 3).

Histrionic PD with Narcissistic features. For the Histrionic case history with Narcissistic features, no differences were found for any of the comparisons made with chi-square analyses or Fisher's Exact Test (See Table 4).

Antisocial PD with Narcissistic features. For the Antisocial case history with Narcissistic features, for subjects who did not complete a DSM-III-R criterion checklist, an examination of expected frequencies indicated that subjects were significantly more likely to misdiagnose Histrionic Personality Disorder (HPD) for female and gender neutral clients compared to male clients, Likelihood Ratio Chi-Square (2, N = 63) = 9.33, p = .009 (see Table 5).

A comparison between subjects who completed a DSM-III-R criterion checklist versus those who did not indicated that only those subjects who completed a DSM-III-R criterion checklist prior to making a diagnosis were significantly more likely to misdiagnose Borderline Personality Disorder for female clients Fisher's Exact Test (N = 41), p = .043.

DIMENSIONAL ANALYSES

Subjects were asked to rate the extent to which they believed the person described in the case history should receive one or more of the possible diagnoses provided for

them on a one to seven scale. These ratings were treated as certainty ratings. That is, the higher the rating, the more certain the subject was that the hypothetical client met the criteria for any provided diagnostic category.

CERTAINTY RATINGS BY SEX FOR THE FIVE PERSONALITY DISORDERS

The first set of dimensional analyses examined whether there were sex differences in the certainty ratings for any of the personality disorder diagnoses. This set of analyses provided a more fine-tuned examination of possible sex differences in personality disorder diagnoses. Specifically, this type of analyses examined whether subjects displayed a trend toward perceiving a particular PD diagnostic category as more characteristic of one gender category than the others. Planned comparisions between each of the gender categories were conducted separately for each of the possible personality disorder categories. In order to conduct these planned comparisions, a one-way ANOVA with all eighteen cells included was conducted. This was done in order to increase the degrees of freedom and was based on the assumption that the variability across all eighteen experimental cells was roughly equivalent to the variability present when each cell was considered separately. However, due to the fact that only the planned comparisons are of interest, F values are not reported in the text but may be found in the tables which correspond to the specific sections of the text.

Narcissistic PD. No significant differences in certainty ratings by sex were found for Narcissistic PD.

Histrionic PD. Planned comparisons indicated that males were given significantly lower certainty ratings for a Histrionic Personality Disorder diagnosis, $p = .0516$, than females, and gender neutrals, $p = .0065$, the latter two not differing from each other. Means are: Males ($X = 3.366$), Females ($X = 3.779$), Neutrals ($X = 3.980$). (See Table 6 for ANOVA table and Table 7 for means).

Borderline PD. Planned comparisons revealed that males were given significantly lower certainty ratings for a Borderline Personality Disorder (BPD) diagnosis than females, $p = .0110$, or gender neutrals, $p = .0002$, the latter two not differing from each other. Means are: Males ($X = 2.908$), Females ($X = 3.433$), and Neutrals ($X = 3.728$)

Antisocial PD. Planned comparisons approached significance, with males receiving higher certainty ratings than females, $p = .0606$. The means are: Males ($X = 3.04$), Females ($X = 2.65$), and Neutrals ($X = 3.02$).

Passive-Aggressive PD. No significant differences in certainty ratings by sex were found for Passive-Aggressive PD.

CERTAINTY RATINGS FOR EACH CASE

The second set of dimensional analyses examined whether there were any sex differences in the certainty

ratings of any of the personality disorder diagnoses, when each version of the case history was considered separately. This set of analyses investigated whether the specific hypotheses, presented earlier, for differential diagnostic rates among the gender types presented (i.e., male, female, gender neutral) based on the version of the case history presented, would be supported by similar trends in the certainty ratings. Only planned comparisons are reported in the text. F values may be found in the tables corresponding to specific areas of the text.

Narcissistic PD with Histrionic Features Case Without DSM-III-R Criterion Checklist. For the Narcissistic case history with Histrionic features without the DSM-III-R criterion checklist, planned comparisons indicated that males received a significantly higher certainty rating for the Narcissistic diagnosis than females, $p = .0035$. Planned comparisons also indicated that males received significantly lower certainty ratings for the Borderline diagnosis than females, $p = .0225$ and gender neutrals, $p = .0312$. No significant differences were found for the other PD diagnostic categories (See Tables 8 & 9).

Narcissistic PD with Histrionic Features Case with DSM-III-R Criterion Checklist. For the Narcissistic PD with Histrionic features case with the DSM-III-R checklist, two of the planned comparisons were significant. Males received significantly lower certainty ratings than

neutrals for Borderline PD, p = .0287 and Passive-Aggressive PD, p = .0492 (See Tables 10 & 11).

Narcissistic PD with Antisocial Features Case Without DSM-III-R Checklist. For the Narcissistic PD with Antisocial features case without the DSM-III-R checklist, planned comparisons indicated that females received significantly higher certainty ratings for the Histrionic diagnosis than males, p = .0046. Planned comparisons also indicated that gender neutrals received significantly higher certainty ratings for the Antisocial diagnosis than females, p = .0081. Furthermore, males received significantly lower certainty ratings for the Borderline diagnosis compared to gender neutrals, p = .0225 (See Tables 12 & 13).

Histrionic PD with Narcissistic Features Case Without DSM-III-R Criterion Checklist. For the Histrionic PD with Narcissistic features case without the DSM-III-R criterion checklist, planned comparisons indicated that males received significantly lower certainty ratings for the Histrionic diagnosis than gender neutrals, p = .0082 and females, p = .0511. Planned comparisons also indicated that males received significantly lower certainty ratings for the Borderline diagnosis than gender neutrals, p = .0328 (See Tables 14 & 15).

Antisocial PD with Narcissistic Features Case Without

DSM-III-R Criterion Checklist. For the Antisocial PD with Narcissistic features case without the DSM-III-R criterion checklist, planned comparisons indicated that females received significantly higher certainty ratings for the Narcissistic diagnosis than gender neutrals, $p = .0021$ No other comparisons were significant (See Tables 16 & 17).

EFFECT OF DSM-III-R CRITERION CHECKLIST ON CERTAINTY RATINGS FOR EACH PD DIAGNOSTIC CATEGORY

A second set of planned comparisons was conducted by sex, for each of the PD diagnostic categories, for the three versions of the case history where subjects completed a DSM-III-R criterion checklist and only the gender category of interest was sent out. (The comparison for the case history with a DSM-III-R criterion checklist where all three gender categories were sent out is presented in the previous section). This set of comparisons consisted of estimates of differences in certainty ratings by sex, between subjects who completed a DSM-III-R criterion checklist versus those who did not, for each of the three versions of the case history where only one gender category was sent out with the DSM-III-R criterion checklist. This set of analyses was conducted in order to examine whether completing the checklist prior to making a diagnosis would have any differential effect on the certainty ratings for the personality disorder diagnoses.

Narcissistic PD with Antisocial Features Case. For

the Narcissistic PD with Antisocial features case, a difference was found for the Borderline Personality Disorder diagnosis, p = .006 (See Table 18). Subjects who completed the DSM-III-R criterion checklist prior to making a diagnosis gave higher certainty ratings for Borderline Personality Disorder for males compared to subjects who did not complete the DSM-III-R criterion checklist prior to making a diagnosis. A significant difference was also found for the Histrionic Personality Disorder diagnosis, p = .05. Subjects who completed the DSM-III-R criterion checklist prior to making a diagnosis gave higher certainty ratings for Histrionic Personality Disorder for males compared to subjects who did not complete the DSM-III-R criterion checklist prior to making a diagnosis.

Histrionic PD with Narcissistic Features Case. For the Histrionic PD with Narcissistic features case, no differences were found in diagnostic certainty ratings between subjects who did and did not complete the DSM-III-R criterion checklist (See Table 19).

Antisocial PD with Narcissistic Features Case. For the Antisocial PD with Narcissistic features case, differences approached significance for the Narcissistic Personality Disorder diagnosis, p = .06 (See Table 20). Subjects who completed the DSM-III-R criterion checklist prior to making a diagnosis gave lower certainty ratings

for Narcissistic Personality Disorder for females compared to subjects who did not complete the DSM-III-R criterion checklist prior to making a diagnosis (See Table 20). No other differences were found.

DIFFERENCES IN CERTAINTY RATINGS ACROSS PD DIAGNOSTIC CATEGORIES BY SEX

In order to investigate whether subjects' certainty ratings varied across the five personality disorder categories when each sex type (i.e., male, female, gender neutral) was considered separately, a series of analyses of variance were performed. In order to increase statistical power, five one-way ANOVAs were conducted comparing certainty ratings for each PD diagnostic category across all possible combinations of sex x case history x inclusion/exclusion of DSM-III-R criterion checklist. This resulted in eighteen possible combinations. Five planned comparisons (one for each version of the case history without the DSM-III-R checklist and for the version of the case history where subjects completed the DSM-III-R criterion checklist and all three gender categories were sent out), were then conducted by sex, for each of the PD diagnostic categories. Next, separate contrasts were made within each PD diagnostic category for each possible sex comparison, (i.e., male v. female, male v. neutral, female v. neutral) for each version of the case history without the DSM-III-R checklist and for the version of the

case history where subjects completed the DSM-III-R criterion checklist and all three gender categories were sent out.

A second set of planned comparisons was conducted by sex, for each of the PD diagnostic categories, for the three versions of the case history where subjects completed a DSM-III-R criterion checklist and only the gender category of interest was sent out. This set of comparisons consisted of estimates of differences in certainty ratings by sex, between subjects who completed a DSM-III-R criterion checklist and those who did not, for each of the three versions of the case history where only one gender category was sent out with the DSM-III-R criterion checklist.

This set of analyses was conducted in order to determine whether subjects' viewed some diagnostic categories as essentially the same or as distinctly different, depending on the sex of the client and the version of the case history presented. For example, would subjects' certainty ratings for diagnostic categories more strongly associated with females be essentially the same for females but significantly different for males? A repeated measures analysis was originally considered but rejected due to the finding of significant correlations among some of the diagnostic categories. These

correlations violated the assumption of homogeneity required for repeated measures analyses.

Narcissistic PD with Histrionic Features Case Without DSM-III-R Criterion Checklist. For the Narcissistic PD with Histrionic features case without the DSM-III-R criterion checklist, when a male client was presented, subjects' ratings for Narcissistic PD were significantly different from all the other PD diagnostic categories at $p = .0001$. Ratings for Histrionic PD were also significantly different from all the other PD diagnostic categories (HPD-NPD, $p = .0001$; HPD-BPD, $p = .0046$; HPD-APD, $p = .0002$; HPD-PAPD, $p = .0024$). The ratings for Borderline PD, Antisocial PD, and Passive-aggressive PD, however, were not significantly different from one another (BPD-APD, $p = .3869$; BPD-PAPD, $p = .8070$; APD-PAPD, $p = .2400$).

When a female client was presented, subjects also rated Narcissistic PD as significantly different from all the other PD diagnostic categories (NPD-HPD, $p = .0323$; NPD-BPD, $p = .0039$; NPD-APD, $p = .0001$; NPD-PAPD, $p = .0001$). The ratings for Histrionic PD were significantly different from the ratings for Antisocial PD (HPD-APD, $p = .0001$) and Passive-Aggressive PD (HPD-PAPD, $p = .0001$) but were not significantly different from the ratings for Borderline PD (HPD-BPD, $p = .2284$). Furthermore, the ratings for Borderline PD were different from the ratings for Antisocial PD (BPD-APD, $p = .0001$) and Passive-

aggressive PD (BPD-PAPD, p = .0001) but the ratings for Antisocial PD and Passive-aggressive PD did not differ from one another (APD-PAPD, p = .1919).

When the client's sex was neutral, subjects ratings for Narcissistic PD also were significantly different from the ratings for all of the other PD diagnostic categories (NPD-HPD, p = .0062; NPD-BPD, p = .0001; NPD-APD, p = .0001, NPD-PAPD, p = .0001). The ratings for Histrionic PD also differed significantly from the ratings for the other PD diagnostic categories (HPD-BPD, p = .0330; HPD-APD, p = .0001; HPD-PAPD, p = .0001). In addition, the ratings for Borderline PD differed from the ratings for the rest of the PD diagnostic categories (BPD-APD, p = .0002; BPD-PAPD, p = .0031). The ratings for Antisocial PD and Passive-aggressive PD, however, were not significantly different (APD-PAPD, p = .4444).

Narcissistic PD with Histrionic Features Case with DSM-III-R Criterion Checklist. For the Narcissistic PD with Histrionic features case with the DSM-III-R criterion checklist, when a male client was presented, subjects' ratings for Narcissistic PD were significantly different from the ratings for the other PD diagnostic categories at p = .0001. The ratings for Histrionic PD also differed significantly from the ratings for the other PD diagnostic categories at p = .0001. The ratings for Borderline PD

however, were not significantly different from the ratings for Antisocial PD (BPD-APD, p = .2661) and Passive-aggressive PD (BPD-PAPD, p = .1433). Furthermore, the ratings for Antisocial PD and Passive-aggressive PD did not differ significantly from one another (APD-PAPD, p = .6951). When a female client was presented subjects' ratings for Narcissistic PD also were significantly different from the ratings for the other PD diagnostic categories (NPD-HPD, p = .0003; NPD-BPD, p = .0001; NPD-APD, p = .0001; NPD-PAPD, p = .0001). Similarly, the ratings for Histrionic PD differed from the ratings for the other PD diagnostic categories (HPD-BPD, p = .0005; HPD-APD, p = .0001; HPD-PAPD, p = .0001). Ratings for Borderline PD also differed the ratings for the other PD diagnostic categories (BPD-APD, p = .0001; BPD-PAPD, p = .0091). The ratings for Antisocial PD and Passive-aggresive PD, however, were not significantly different from one another (APD-PAPD, p = .2028).

When the client's sex was neutral, subjects' ratings for Narcissistic PD also were significantly different from their ratings for the other PD diagnostic categories (NPD-HPD, p = .0009; NPD-BPD, p = .0001; NPD-APD, p = .0001; NPD-PAPD, p = .0001). Similarly, ratings for Histrionic PD differed significantly from ratings for the other PD diagnostic categories (HPD-BPD, p = .0046; HPD-APD, p = .0001; HPD-PAPD, p = .0001). The ratings for Borderline PD

also were significantly different from the ratings for the other PD diagnostic categories (BPD-APD, p = .0047; BPD-PAPD, p = .0382). The ratings for Antisocial PD and Passive-aggressive PD, however, were not significantly different from one another, (APD-PAPD, p = .4332, See Table 21).

Narcissistic PD with Antisocial Features Case Without DSM-III-R Criterion Checklist. For the Narcissistic PD with Antisocial features case without the DSM-III-R criterion checklist, when a male client was presented, subjects' ratings for Narcissistic PD were significantly different from their ratings for all of the other PD diagnostic categories at p = .0001. The ratings for Histrionic PD were significantly different from the ratings for Antisocial PD (HPD-APD, p = .0006) but did not differ significantly from subjects' ratings for Borderline PD (HPD-BPD, p = .2735) or Passive-Aggressive PD (HPD-PAPD, p = .0754). Subjects' ratings for Borderline PD also differed significantly from their ratings for Antisocial PD (BPD-APD, p = .0138) but were not significantly different from their ratings for Passive-Aggressive PD (BPD-PAPD, p = .6252). In addition, ratings for Antisocial PD differed significantly from ratings for Passive-Aggressive PD (APD-PAPD, p = .0371).

When a female client was presented subjects' ratings

for Narcissistic PD were significantly different from all of the other PD diagnostic categories at p = .0001. Ratings for Histrionic PD, however, did not differ significantly from ratings for Borderline PD (HPD-BPD, p = .5308), Antisocial PD (HPD-APD, p = .3208), and Passive-aggressive PD (HPD-PAPD, p = .9034). Subjects' ratings for Borderline PD also were not significantly different from their ratings for Antisocial PD (BPD-APD, p = .7235) and Passive-aggressive PD (BPD-PAPD, p = .5605). In addition, ratings for Antisocial PD did not differ significantly from ratings for Passive-aggressive PD (APD-PAPD, p = .3192).

Narcissistic PD with Antisocial Features Case with DSM-III-R Checklist When the client's sex was neutral, subjects' ratings for Narcissistic PD also were significantly different from their ratings for all of the other PD diagnostic categories at p = .0001. Ratings for Histrionic PD differed significantly from ratings for Borderline PD (HPD-BPD, p = .0064) and Antisocial PD (HPD-APD, p = .0004) but were not significantly different from ratings for Passive-aggressive PD (HPD-PAPD, p = .6108). Subjects' ratings for Borderline PD did not differ significantly from their ratings for Antisocial PD (BPD-APD, p = .4582) but were significantly different from ratings for Passive-aggressive PD (BPD-PAPD, p = .0107). In addition, ratings for Antisocial PD differed significantly from ratings for Passive-aggressive PD (APD-

PAPD, p = .0005).

For subjects who completed the DSM-III-R criterion checklist prior to making a diagnosis, when the client's sex was male, subjects' ratings for Narcissistic PD were significantly different from their ratings for the rest of the PD diagnostic categories at p = .0001. Ratings for Histrionic PD also differed significantly from ratings for Borderline PD (HPD-BPD, p = .0218) and Antisocial PD (HPD-APD, p = .0057) but were not significantly different from ratings for Passive-aggressive PD (HPD-PAPD, p = .8987). Subjects' ratings for Borderline PD were not significantly different from their ratings for Antisocial PD (BPD-APD, p = .7106) but did not differ significantly from their ratings for Passive-aggressive PD (BPD-PAPD, p = .0150). In addition, ratings for Antisocial PD differed significantly from ratings for Passive-aggressive PD (APD-PAPD, p = .0028) (See Table 22).

Histrionic PD with Narcissistic Features Case Without DSM-III-R Criterion Checklist. For the Histrionic PD with Narcissistic features case without the DSM-III-R criterion checklist, when a male client was presented, subjects' ratings for Narcissistic PD were significantly different from their ratings for the rest of the PD diagnostic categories (NPD-HPD, p = .0012; NPD-BPD, p = .0001, NPD-APD, p = .0001; and NPD-PAPD, p = .0001). Ratings for

Histrionic PD were also significantly different from the ratings for the rest of the PD diagnostic categories (HPD-BPD, p = .0057; HPD-APD, p = .0003; and HPD-PAPD, p = .0001). Subjects' ratings for Borderline PD differed significantly from Passive-aggressive PD (BPD-APD, p = .0240) but were not significantly different from their ratings for Antisocial PD (BPD-APD, p = .4691). In addition, ratings for Antisocial PD did not differ significantly from ratings for Passive-aggressive PD (APD-PAPD, p = .0980).

When a female client was presented subjects' ratings for Narcissistic PD were significantly different from their ratings for Borderline PD, Antisocial PD, and Passive-aggressive PD at p = .0001. The ratings for Narcissistic PD, however, did not differ significantly from their ratings for Histrionic PD (NPD-HPD, p = .1692). Ratings for Histrionic PD were significantly different from ratings for Borderline PD (HPD-BPD, p = .0017), Antisocial PD (HPD-APD, p = .0001), and Passive-aggressive PD (HPD-PAPD, p = .0001). Subjects' ratings for Borderline PD differed significantly from their ratings for Antisocial and Passive-aggressive PD at p = .0001. Ratings for Antisocial PD, however, were not significantly different from ratings for PAPD (APD-PAPD, p = .8075).

When the client's sex was neutral, subjects' ratings for Narcissistic PD were significantly different from their

ratings for Borderline PD, Antisocial PD, and Passive-aggressive PD at $p = .0001$ Their ratings for Narcissistic PD, however, did not differ significantly from their ratings for Histrionic PD (NPD-HPD, $p = .5126$). Ratings for Histrionic PD were significantly different from ratings for Borderline PD (HPD-BPD, $p = .0029$), Antisocial PD (HPD-APD, $p = .0001$), and Passive-aggressive PD (HPD-PAPD, $p = .0001$). Subjects' ratings for Borderline PD differed significantly from their ratings for Antisocial PD (BPD-APD, $p = .0008$) and Passive-aggressive PD (BPD-PAPD, $p = .0001$). Ratings for Antisocial PD, however, were not significantly different from ratings for Passive-aggressive PD (APD-PAPD, $p = .5239$).

Histrionic PD with Narcissistic Features Case with DSM-III-R Criterion Checklist. For the Histrionic PD with Narcissistic PD case with the DSM-III-R criterion checklist, when the client's sex was male, subjects' ratings for Narcissistic PD were significantly different from their ratings for the rest of the PD diagnostic categories (NPD-HPD, $p = .0161$; NPD-BPD, $p = .0001$; NPD-APD, $p = .0001$; and NPD-PAPD, $p = .0001$). Ratings for Histrionic PD were significantly different from the ratings for Borderline PD (HPD-BPD, $p = .0033$), Antisocial PD (HPD-APD, $p = .0001$), and Passive-aggressive PD (HPD-PAPD, $p = .0001$). Ratings for Borderline PD, however, did not differ

significantly from ratings for Antisocial PD (BPD-APD, p = .0642) or Passive-aggressive PD (BPD-PAPD, p = .1797). Ratings for Antisocial PD also were not significantly different from ratings for Passive-aggressive PD (APD-PAPD, p = .6013) (See Table 23).

Antisocial PD with Narcissistic Features Case Without DSM-III-R Criterion Checklist. For the Antisocial PD with Narcissistic features case without the DSM-III-R criterion checklist, when a male client was presented, subjects' ratings for Narcissistic PD were significantly different from their ratings for Histrionic PD, Borderline PD, and Passive-aggressive PD at p = .0001. Their ratings for Narcissistic PD, however, did not differ significantly from their ratings for Antisocial PD (NPD-APD, p = .5244). Ratings for Histrionic PD were significantly different from ratings for Borderline PD (HPD-BPD, p = .0143), Antisocial PD (HPD-APD, p = .0001), and Passive-aggressive PD (HPD-PAPD, p = .0187). Subjects' ratings for Borderline PD differed significantly from their ratings for Antisocial PD (BPD-APD, p = .0001) but not from their ratings for Passive-aggressive PD (APD-PAPD, p = .6336). Ratings for Antisocial PD were significantly different from ratings for Passive-aggressive PD (APD-PAPD, p = .0001).

When a female client was presented, subjects' ratings for Narcissistic PD were significantly different from their ratings for the rest of the PD diagnostic categories (NPD-

HPD, p = .0001; NPD-BPD, p = .0001; NPD-APD, p = .0003; and NPD-PAPD, p = .0001). Ratings for Histrionic PD were significantly different from ratings for Antisocial PD (HPD-APD, p = .0005) but did not differ significantly from ratings for Borderline PD (HPD-BPD, p = .3360) or Passive-aggressive PD (HPD-PAPD, p = .2641). Subjects' ratings for Borderline PD differed significantly from their ratings for Antisocial PD (BPD-APD, p = .0082) and Passive-aggressive PD (BPD-PAPD, p = .0325). Ratings for Antisocial PD also were significantly different from ratings for Passive-aggressive PD (APD-PAPD, p = .0001).

When the client's sex was neutral, subjects' ratings for Narcissistic PD were significantly different from their ratings for Histrionic PD (NPD-HPD, p = .0001) and Passive-aggressive PD (NPD-PAPD, p = .0020). Their ratings for Narcissistic PD, however, did not differ significantly from their ratings for Borderline PD (NPD-BPD, p = .3459) or Antisocial PD (NPD-APD, p = .5244). Ratings for Histrionic PD were significantly different from ratings for Borderline PD (HPD-BPD, p = .0143) and Antisocial PD (HPD-BPD, p = .0024) but did not differ significantly from ratings for Passive-aggressive PD (HPD-PAPD, p = .3849). Subjects' ratings for Borderline PD were not significantly different from their ratings for Antisocial PD (BPD-APD, p = .6293) or Passive-aggressive PD (BPD-PAPD, p = .0571). Ratings

for Antisocial PD were significantly different from ratings for Passive-aggressive PD (APD-PAPD, p = .0111).

Antisocial PD with Narcissistic Features Case with DSM-III-R Criterion Checklist. For the Antisocial PD with Narcissistic features case with the DSM-III-R criterion checklist, when the client's sex was female, subjects' rating for Narcissistic PD were significantly different from the rest of the PD diagnostic categories (NPD-HPD, p = .0001; NPD-BPD, p = .0246; NPD-APD, p = .0008; and NPD-PAPD, p = .0001). Ratings for Histrionic PD differed significantly from ratings for Borderline PD (HPD-BPD, p = .0023) and Antisocial PD (HPD-APD, p = .0081) but were not significantly different from ratings for Passive-aggressive PD (HPD-PAPD, p = .8987). Subjects' ratings for Borderline PD were significantly different from their ratings for Passive-aggressive PD (APD-PAPD, p = .0004) but did not differ significantly from their ratings for Antisocial PD (BPD-APD, p = .5364). In addition, ratings for Antisocial PD were significantly different from ratings for Passive-aggressive PD (APD-PAPD, p = .0018) (See Table 24).

POST-EXPERIMENTAL QUESTIONNAIRES ANALYSES

Subjects completed three post-experimental questionnaires. The first asked them to estimate the total number and kinds of patients to whom they had given certain diagnoses (or combination of diagnoses) in the last two years. The purpose of this questionnaire was to determine

if subjects' actual experiences with personality disordered clients might explain differences in their diagnostic practices, if differences occurred. However, due to the fact that a large number of subjects (i.e., less than half of the subjects for most cells) did not fully complete this questionnaire, a meaningful analysis of the responses could not be made. However, given these limitations, these data do provide some useful speculative information. For example, clinicians indicated that they diagnosed over twice as many males with Narcissistic PD compared to females. Antisocial PD was diagnosed over four times more often for males than female clients. Histrionic PD was diagnosed almost twice as often for females compared to males. Interestingly, although Borderline PD was also diagnosed at a higher rate for females compared to males, the difference did not appear significant. Furthermore, the pairing of two personality disorder diagnoses also yielded interesting results. For example, when the two personality disorders associated with females (i.e., Histrionic PD and Borderline PD) were paired together, twice as many females were given this diagnosis compared to males. Likewise, when the personality disorder most commonly associated with males (i.e., Antisocial PD) was paired with Narcissistic PD (which was diagnosed for males at a higher rate for males than females in this study),

clinicians diagnosed this combination twice as often for males compared to females. Mean ratings and standard deviations of subjects who did respond is provided in Table 25.

The second post-experimental questionnaire asked subjects to estimate the percentage of people in the general population they believed would qualify for the provided diagnoses (or combination of diagnoses). Unfortunately, a large number of subjects (e.g., less than half of subjects for most cells) also did not fully complete this questionnaire which made any further analyses meaningless. However, given these limitations, some speculative information is also available from these data. In contrast to the findings of the first questionnaire, the percentage of males and females whom clinicians thought would qualify for the Narcissistic diagnosis were not noticeably different. However, the percentage rates for Histrionic PD continued to noticeably favor females and the rates for Antisocial PD strongly favored males. The combination diagnoses also followed the trend in the first questionnaire with the combination of Histrionic and Borderline personality disorder diagnoses favoring females and the combination of Antisocial and Narcissistic PD favoring males. Mean percentages and standard deviations of subjects who did respond to this questionnaire are provided in Table 26.

The third post-experimental questionnaire asked subjects: (a) how often they referred back to the case history when making their diagnosis; (b) if they referred to a copy of the DSM-III-R while completing the experimental task; (c) to rate their familiarity with the DSM-III-R on a one to seven scale; and (d) to rate how often they actually use the DSM-III-R when making diagnoses on a one to seven scale. Over half of the subjects indicated that they referred back to the case history once or not at all. Only 21% of the subjects referred back to the case history more than three times. Approximately 75% of the subjects did not refer to a copy of the DSM-III-R when completing the experimental task. Furthermore, most subjects indicated that they were both familiar with and used the DSM-III-R when actually making a diagnosis. Subjects' ratings for both of these questions had a mean of 5 on a 1 to 7 scale. Subjects' responses are provided in Table 27.

POST-HOC ANALYSES

After planned analyses were performed, additional analyses were conducted, post-hoc, in order to examine if differences in subjects' demographics might help explain the differences in their diagnostic practices found in this study. Specifically, for each of the four versions of the

case history, subjects' diagnoses were coded as: (a) correct (i.e., gave the correct diagnosis alone or with other diagnoses); (b) close (i.e., did not give the correct diagnosis but gave the secondary diagnosis alone or with other diagnoses); (c) wrong (i.e., gave neither the correct diagnosis or the secondary diagnosis).

For the case history of Narcissistic Personality Disorder with Histrionic features, descriptive data for subjects who gave correct, close, and wrong diagnoses are provided in Tables 28, 29, and 30. The only noticeable difference is that 48% (53 out of 110) of the subjects who gave a correct diagnosis referred back to the case history at least twice. In contrast, only 10% (1 out of 10) of the subjects who gave a wrong diagnosis referred back to the case history at least twice.

For the case history of Narcissistic Personality Disorder with Antisocial features, descriptive data for subjects who gave correct or wrong diagnoses are provided in Tables 31 and 32. No subjects gave diagnoses coded as close for this case history. Similar to the difference noted above, a higher percentage (36% - 26 out of 73) of subjects who gave the correct diagnosis referred to the case history at least twice compared to the percentage (11% - 1 out of 9) who gave the wrong diagnosis and referred to the case history at least twice. However, a much higher percentage (89% - 8 out of 9) of subjects who gave the

wrong diagnosis actually used the DSM-III-R during the experimental task. Only 27% (20 out of 73) of those subjects who gave the correct diagnosis actually used the DSM-III-R during the experimental task. However, subjects who gave the wrong diagnosis rated their familiarity and use of the DSM-III-R at least one point lower than those subjects who gave the correct diagnosis. For the case history of Histrionic Personality Disorder with Narcissistic features, descriptive data for subjects who gave correct, close, and wrong diagnoses are provided in Tables 33, 34, and 35. No noticeable differences were apparent for this version of the case history.

For the case history of Antisocial Personality Disorder with Narcissistic features, descriptive data for subjects who gave correct, close, and wrong diagnoses are provided in Tables, 36, 37, and 38. The only noticeable difference was that subjects who gave the correct diagnosis actually referred to the DSM-III-R during the experimental task at a much higher rate (65% - 24 out of 37) than those subjects who gave a close (19% - 6 out of 31) or wrong diagnosis (6% - 1 out of 15).

CHAPTER IV

DISCUSSION

This chapter first presents the study's major conclusions regarding the existence of an overall diagnostic sex bias for the personality disorder categories examined in the study. The study's findings regarding the existence of a diagnostic sex bias for these disorders, when each version of the case history is considered separately, are then presented. Next, the study's conclusions about differences in subjects' certainty ratings for the personality disorders examined in the study are addressed. The influence of the DSM-III-R criterion checklist on subjects' personality disorder diagnoses is also discussed, along with differences in certainty ratings across personality disorder diagnostic categories by sex. In addition, the implications of the information gathered from subjects' post-experimental questionnaire responses and post-hoc analyses are addressed. Lastly, the significance and limitations of the study's findings, as well as suggestions for future research on diagnostic sex bias research, are addressed.

OVERALL DIAGNOSTIC SEX BIAS

Although this study did not specifically hypothesize any overall diagnostic sex biases for personality disorders, the results support the existence of such biases for some of the personality disorders. Specifically, subjects underdiagnosed Narcissistic PD for female clients and overdiagnosed Narcissistic PD for male clients. That is, diagnostic rates for females, for Narcissistic PD, were significantly lower than what would be expected statistically. Diagnostic rates for gender neutral clients were within the statistically predicted range. However, diagnostic rates for males, for Narcissistic PD, were significantly higher than what would be expected statistically.

Furthermore, subjects underdiagnosed Borderline PD for male clients and overdiagnosed Borderline PD for gender neutral clients. That is, the diagnostic rates for males, for Borderline PD, were significantly lower than what would be expected statistically. For example, based on chi-square statistics, it was expected that 34 of the subjects would give the Borderline PD diagnosis for male clients, but only 24 of the subjects gave this diagnosis for male clients, which was statistically significant. Diagnostic rates for females, for Borderline PD, were within the statistically predicted range. In contrast, diagnostic rates for gender neutral clients, for Borderline PD, were

significantly higher that what would be expected statistically.

The finding of an underdiagnosis of Narcissistic PD for female clients and the overdiagnosis of Narcissistic PD for male clients supports the primary hypothesis for the study. That is, a diagnostic sex bias can not simply be explained by the position that clinicians are basing their diagnoses on differential sex base rate information. As predicted, clinicians displayed a diagnostic sex bias for Narcissistic PD even though there was no reliable source of a differential sex base information available. The DSM-III-R states that there is no information on the sex ratio for Narcissistic PD. Thus, reliable gender base rate information could not have entered into clinicians' diagnostic decisions. This clearly refutes the base rate explanation for diagnostic sex bias.

Only one previous study (i.e., Adler et al., 1990) has suggested that a diagnostic sex bias exists for Narcissistic PD. That study found that male clients were more likely to be given the Narcissistic PD diagnosis because this diagnosis was largely overlooked when the client was identified as female. The findings of the Adler et al. study are not directly comparable to the findings of this study, because their case history met DSM-III criteria for histrionic, narcissistic, borderline, and dependent

personality disorders. However, their findings lend support to the results of this study which suggest that a diagnostic sex bias exists for Narcissistic PD, favoring males.

Additional support for the finding of this study of a diagnostic sex bias for Narcissistic PD, favoring males, can be found in the newest edition of the Diagnostic and Statistical Manual of Mental Disorder - Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). According to the DSM-IV, "Of those diagnosed with Narcissistic Personality Disorder, 50%-75% are male" (APA, 1994, p. 660). Since this edition of the DSM was published subsequent to the collection of the data in this study, subjects in this study presumably could not have used this information when making their diagnoses. However, the gender ratio information provided in the DSM-IV for Narcissistic Personality Disorder concurs with the results of this study.

Several possible reasons for the differential gender diagnostic rates for NPD found in this study are plausible. First, in previous studies where varying numbers of features of only two personality disorders were used to construct the case histories, the two personality disorders were Histrionic PD and Antisocial PD (e.g., Ford & Widiger, 1989; Hamilton et al., 1986; Warner, 1978). According to the DSM-III-R, the sex ratio for Histrionic PD favors

females while the sex ratio for Antisocial PD favors males. In general, these studies found a strong tendency for females to be diagnosed with Histrionic PD at higher rates than males and a weaker, though typically significant, tendency for males to be diagnosed with Antisocial PD at higher rates than females.

In contrast, in this study, which also constructed case histories with varying numbers of only two personality disorders, only one of the personality disorders in the case history had a sex ratio that favored either males (Antisocial PD) or females (Histrionic PD). The other personality disorder included in the case histories was Narcissistic PD, which has no sex ratio information, according to the DSM-III-R. Thus, in this study, there was not the sharp contrast between two disorders with opposite sex ratios, as in previous similar studies. This likely dampened the activation of clinicians' critical sets for sex stereotypes and helps explain why this study did not find an overall diagnostic sex bias for Histrionic or Antisocial PD. In addition, because in this study, in all four versions of the case histories, features of Narcissistic PD were included, it is not surprising that this was the most common diagnosis given to all (male, female, and gender neutral) versions of the case history.

Furthermore, by the process of elimination, it is not

surprising that clinicians' overdiagnosed Narcissistic PD for males and underdiagnosed this disorder for females. It seems likely that clinicians largely ruled out the Antisocial PD diagnosis because, in all but one version of the case history, there were not enough of the more behaviorally explicit criteria present that are necessary to make that diagnosis. In fact in two of the four versions of the case history, none of the features of Antisocial PD was included. This left clinicians with the choice of diagnosing Borderline PD, Narcissistic PD, Histrionic PD, and/or Passive-Aggressive PD. Since Passive-Aggressive PD is not in the same DSM-III-R cluster as Borderline PD, Narcissistic PD, and Histrionic PD, and thus is the most dissimilar, it was probably also ruled out as a diagnosis. These conclusions are supported by the data which found Passive-Aggressive PD to be least common diagnosis given and Antisocial PD the second least common diagnosis given. This left clinicians with the possible diagnostic categories of Borderline PD, Narcissistic PD, and Histrionic PD. Assuming that clinicians' critical sets regarding sex stereotypes were activated to some extent by the sex of the client in the case scenario, clinicians' may have ruled out Borderline PD and Histrionic PD as possible diagnoses for male clients, due their reported association with the female sex stereotype. Thus, clinicians were left with the diagnosis of Narcissistic PD for male clients.

Regardless, because the DSM-III-R does not provide sex ratio information for Narcissistic PD, the underdiagnosis for females and overdiagnosis for males does not support the base rate explanation for diagnostic sex bias. Thus, other explanations for diagnostic sex bias need to be explored. One explanation, previously proposed, that the sex of the client elicits the clinicians' personal expectations (i.e., "critical set") about what behaviors a client of a particular sex might display and that the clinician then largely bases their diagnostic decisions on these expectations, appears particularly applicable. Specifically, the results from the post-experimental questionnaires, although speculative, indicated that clinicians based their diagnostic decisions on their own clinical experiences. For example, in one post-experimental questionnaire, clinicians estimated that they had given the Narcissistic PD diagnosis almost twice as often to male clients compared to female clients in the past two years. However, in another post-experimental questionnaire, where clients were asked to estimate the percentage of people in the general population who would qualify for the Narcissistic PD diagnosis, clinicians' ratings for males versus females were not noticeably different. This difference suggests that clinicians may be basing their diagnostic decisions on their own personal

base rate for Narcissistic PD, derived from their clinical experiences. The fact that clinicians sex ratio estimations for Narcissistic PD for the general population were not noticeably different further supports this position if one assumes that clinicians typically diagnose people from the clinical subset of the population rather than the general population at large. Thus, clinicians are likely to have sex ratio expectations for Narcissistic PD that are elicited when asked to diagnose a "client", but probably haven't yet developed such expectations for the general population since no reliable source of sex ratio base rate information for Narcissistic PD has been available.

Of course, other factors, such as the way the case histories were constructed, the limitation of what DSM-III-R diagnoses could be assigned, and the use of clinical vignettes as opposed to real life therapist-client interactions, could also be possible explanations for the finding of a diagnostic sex bias for Narcissistic PD. It is also possible that this bias reflects real differences in nature in the sex ratio base rates for this disorder. However, it is clear that the base rate hypothesis, at least based on DSM-III-R, can not explain this finding.

The finding of an underdiagnosis of Borderline PD for male clients is consistent with the base rate explanation for diagnostic sex bias. That is, clinicians may have

relied on the base rate information provided in the DSM-III-R that Borderline PD is more frequently diagnosed for females than for males. Thus, when making a differential diagnosis, they may have used this information to rule out Borderline PD diagnosis for males. This would account for the overall underdiagnosis of Borderline PD for male clients.

The finding of an overdiagnosis of Borderline PD for gender neutral clients is consistent with previous research (e.g., Ford & Widiger, 1989). However, the significance of this finding for the base rate hypothesis is unclear. Due to the fact that clinicians were not provided with sex of the client, one might assume that they could not have used gender base rate information when making their diagnosis. However, they may have assigned the client a sex even though one was not provided in the case history. It is possible that more clinicians assumed the client to be female, since the majority of therapy clients are female, and subsequently used the base rate information provided in the DSM-III-R that Borderline PD is more commonly diagnosed for females. However, since clients who were actually identified as female in the case history were not overdiagnosed with Borderline PD, this explanation does not seem adequate. A more plausible explanation is that gender neutrals were overdiagnosed with Borderline PD because of

the popularity of this diagnostic category and its relatively nonspecific, overlapping criteria (Gunderson, 1984; Widiger & Frances, 1985). Ford and Widiger (1989) also found that Borderline PD was the most common personality disorder diagnosis given for gender neutral clients. However, it is still not clear how the finding of an overdiagnosis of Borderline PD for gender neutral clients relates to the gender base rate hypothesis.

DIAGNOSTIC SEX BIAS BY CASE HISTORY

The specific hypotheses offered regarding diagnostic sex bias for each version of the case history generally were not supported by the results of this study. This finding is not surprising, since most of the hypotheses were partially based on the belief that NPD was not differentially associated with either sex. As previously discussed, this belief was found to be incorrect. That is, the results of this study indicated that NPD has a stronger association to males than females. With that in mind, the results of the study did generally support the reasoning behind the specific hypotheses previously made. Overall, the results indicated that clinicians' sex stereotypes were activated by the sex of the client and that clinicians made diagnoses consistent with those stereotypes. However, the gender base rate hypothesis could also reasonably explain most of the results discussed in this section. That is, the hypothesis that clinicians based their diagnoses on

gender base rate information when presented with a client exhibiting ambiguous symptoms (i.e., gender base rate hypothesis) could not be ruled out as an explanation for most of the results from this section of the study.

Narcissistic PD with Histrionic Features. For this version of the case history, it was predicted that clinicians would correctly diagnose NPD for males. The categorical and dimensional analyses of this study supported the prediction that males would be correctly diagnosed with NPD. Since NPD was the correct diagnosis and no gender base rate information on NPD was available in the DSM-III-R, this finding can not comment on the gender base rate hypothesis.

For females it was predicted that they would be significantly less likely to be correctly diagnosed with NPD. Instead, it was predicted that they would be misdiagnosed with HPD. As predicted females were significantly less likely to receive the NPD diagnosis. However, instead of misdiagnosing females with HPD as predicted, clinicians more frequently misdiagnosed females with Borderline PD.

Several reasons for this finding seem plausible. First, in addition to the fact that both Histrionic and Borderline PD are more frequently diagnosed for females than males, the degree of overlap between these two

disorders is considerable. For example, Pfohl et al. (1986), based on the findings of two separate studies, stated, "Given the strength and magnitude of this overlap ... , it is quite possible that histrionic PD and borderline PD as defined in the DSM-III are indistinguishable." (p. 32). Second, since the features of HPD were coupled with the features of a disorder (NPD) that has previously not been strongly associated with either sex, the saliency of the HPD features may have been reduced due to a lack of contrast. This may have also reduced the activation of clinicians' sex role stereotypes. For example, on the one hand, HPD is frequently represented in the literature (e.g., Kaplan, 1983) as a "caricature" of females. Borderline PD, on the other hand, while still being diagnosed more frequently for females than males, is seen as more of a "catch-all" category with relatively nonspecific, overlapping criteria (Gunderson, 1984; Widiger & Frances, 1985). Due to these factors, clinicians may have chosen the Borderline PD diagnosis for females compared to HPD because it is still associated with females but is not as stereotypic of females as the HPD diagnosis. Regardless, BPD is more strongly associated with females than males, and was not the correct diagnosis. Thus, the hypothesis that the sex of the client activates a critical set related to gender stereotypes for that sex and that clients will be given a diagnosis that most closely

corresponds to those stereotypes was supported. However, the gender base rate hypothesis also can not be ruled out as an explanation for this finding.

Narcissistic PD with Antisocial Features. For this version of the case history, it was predicted that clinicians would be more likely to misdiagnose APD for males compared to females. Although the results did not directly support this hypothesis, the results did indicate that the sex of the client (or sex role stereotypes) did play a role in clinicians' diagnostic practices. Specifically, according to categorical analyses, females were less likely to receive both the Antisocial and Narcissistic PD diagnoses compared to males and gender neutrals. Furthermore, the dimensional analyses found that females received significantly higher Histrionic PD certainty ratings than males. Females also received the lowest certainty ratings for the Antisocial PD diagnosis, which was significantly different from gender neutrals but not males.

The original hypothesis, that males, compared to females, would be more likely to be misdiagnosed with APD was based on the reasoning that APD's strong association with males would elicit clinicians' gender stereotypes. Furthermore, it was proposed that the activation of these stereotypes would cause clinicians to diagnose APD more

frequently for males, compared to females, because this would be in agreement with their stereotypes. The diagnosis of NPD, it was hypothesized, would be largely overlooked for males because it was not a male stereotyped disorder. However, the results of the study indicated that NPD is strongly associated with males, compared to females. Therefore, it is not surprising that clinicians did not diagnose APD more frequently for males, compared to females, because both NPD and APD are strongly associated with males. However, although the original hypothesis was not supported, the reasoning behind that hypothesis was supported. That is, that the sex of the client activates a critical set related to gender stereotypes, which subsequently influences clinicians diagnostic decisions. Specifically, clinicians were less likely to give females, compared to males, both the NPD and APD diagnoses, which are more strongly associated with males. Furthermore, although the gender base rate hypothesis was not ruled out by this finding, since most clinicians gave the correct diagnosis of NPD, it can not easily explain why females would be less likely to receive the NPD diagnosis, compared to males, since no gender base rate information for NPD is available in the DSM-III-R.

Histrionic PD with Narcissistic Features. For this version of the case history, it was predicted that clinicians would be more likely to correctly diagnose

females with HPD and misdiagnose males with NPD. The categorical analyses found no statistically significant differences. The dimensional analyses, however, found that males received significantly lower certainty ratings for HPD compared to females and gender neutrals. Thus, the hypothesis that HPD's strong association with females would cause clinicians to misdiagnose males with NPD, because it would be less discrepant with their sex role stereotypes, was not supported. However, there was some evidence that the way the case history was constructed may have interfered in this process. That is, clinicians actually diagnosed NPD at higher rates than HPD, for males, females, and gender neutrals. This suggests that the NPD criteria may have made a stronger impression on clinicians than the HPD criteria, included in the case history and made the possibility of finding gender differences in diagnostic rates for NPD less likely. However, when comparisons between certainty ratings for NPD and HPD are looked at separately for each sex, the original hypothesis for this version of the case history did receive some support. That is, ratings for NPD and HPD were significantly different for males (with higher ratings for NPD), but were not significantly different for females. Furthermore, "eyeballing" the diagnostic rates parallels this finding, with males having a greater difference between the

percentage of clinicians who diagnosed NPD versus HPD, compared to females. Specifically, 76% of clinicians diagnosed males with NPD and 52% diagnosed HPD. In contrast, 83% of clinicians diagnosed females with NPD and 70% diagnosed HPD. Thus, it appears that as predicted, clinicians sex role stereotypes were activated and as a result fewer of them gave males the more female stereotyped HPD diagnosis and that when they did give this diagnosis they were significantly less certain of their decision than when they gave this diagnosis to females. However, the gender base rate hypothesis can also explain this finding.

Antisocial PD with Narcissistic Features. For this version of the case history, it was predicted that clinicians would be more likely to misdiagnose NPD for females than for males. Instead, the categorical analyses found that clinicians were significantly more likely to misdiagnose Histrionic PD for females compared to males. The subtler dimensional analyses did not support this finding, although these analyses did find that females received higher certainty ratings for Narcissistic PD than gender neutrals. Once again, although the original hypothesis was not supported, the reasoning behind that hypothesis was supported. Specifically, clinicians' sex role stereotypes were activated and they made diagnoses consistent with those stereotypes. Since the study found that both APD and NPD are strongly associated with males,

compared to females, clinicians misdiagnosed females with HPD, a female stereotyped disorder, consistent with their sex role stereotypes. The gender base rate hypothesis would also support this finding. However, it does not readily explain why clinicians would chose HPD, over NPD, as a diagnosis for females when no HPD criteria was even present in the case history, especially since NPD would seem to be an acceptable choice since the DSM-III-R does not give gender base rate information for NPD.

CERTAINTY RATINGS BY SEX FOR THE PD DIAGNOSTIC CATEGORIES

The certainty ratings by sex for each of the PD diagnostic categories provided a more fine-tuned examination of sex differences in personality disorder diagnoses. However, these ratings are less externally meaningful than the categorical analyses because those latter analyses looked at whether a particular diagnosis would be assigned or not. In contrast, there could be a statistically significant difference in certainty ratings between the sexes for a particular diagnostic category even though neither sex would have actually received that diagnosis. Keeping that in mind, the certainty ratings for the PD diagnostic categories were generally consistent with the results already discussed previously. The one notable exception is that no differences were found in the certainty ratings for Narcissistic PD. Although this

finding is inconsistent with the previously reported results, it is not all that surprising since overall the ratings for NPD for males, females, and gender neutrals were fairly high. This makes sense since NPD was the correct diagnosis in two of the four versions of the case history, and features of NPD were present in the other two versions of the case history. Thus, the yes/no categorical analyses may have detected differences between males and females for the diagnosis of Narcissistic PD while the more fine-tuned dimensional analyses may have been unable to make such a distinction. For example, suppose a female was given a 4.9 certainty rating for NPD, and a male a certainty rating of 5.1. The female would be placed in the "no" category and the male in the "yes" category for the NPD diagnosis according to the categorical analyses. However, it would seem plausible that dimensional analyses would not find a statistically significant difference between these two ratings.

The certainty ratings for the other personality disorder categories were generally consistent with the previously reported results. For example, males were given significantly lower certainty ratings for both Histrionic and Borderline PD categories, compared with females and gender neutrals. Also, certainty ratings for Antisocial PD approached significance, with females receiving the lowest rating. No significant differences in certainty ratings by

sex were found for Passive-Aggressive PD.

CATEGORICAL VS. DIMENSIONAL ANALYSES

In general, the findings from the categorical and dimensional analyses were consistent with one another, where comparisons could be made. The few inconsistencies that emerged, such as statistical differences for the NPD diagnosis from the categorical analyses but not from the dimensional analyses, appear to have logical explanations which have already been discussed. Thus, given the high level of agreement between these two different types of analyses, one might assert that the two types of analyses were redundant. However, as the previous sections attest, the dimensional analyses were also independently informative. In many cases, they detected that the sex of the client played a role in clinicians' diagnostic practices which the more broad based categorical analyses could not necessarily detect. For example, the significant difference between certainty ratings for NPD and HPD, for males, compared to the non-significant difference between certainty ratings for these two disorders for females, supported the prediction that clinicians would be less likely to diagnose HPD for males, compared to females. This information, while not directly refuting or supporting the gender base rate hypothesis, did provide more insight into the role that the sex of the client may play in

diagnostic decisions.

INFLUENCE OF DSM-III-R CRITERION CHECKLIST ON PD DIAGNOSES

Overall, the DSM-III-R criterion checklist had a minimal effect on clinicians' PD diagnoses. In some cases, there was no difference in the ratings for the various PD categories between those who completed the criterion checklist prior to making a diagnosis and those who did not (e.g., the Histrionic PD with NPD features case history). In other cases, those who completed the criterion checklist did not display a diagnostic sex bias for a particular personality disorder category whereas those who did not complete the checklist did display such a bias (e.g., NPD diagnosis for the NPD with APD features case history). Often, however, the reverse was true (e.g., BPD diagnosis for the APD with NPD features case history).

There does not appear to be any discernable pattern to these findings. It is apparent, however, that the DSM-III-R criterion checklist, did little, if anything, to alter the diagnostic process. It seems probable that clinicians formed a diagnosis after reading the case history (even though they did not actually list their diagnosis until after completing the criterion checklist) and filled out the criterion checklist in keeping with that diagnosis. This finding adds support to the research that there is often little agreement between clinical diagnoses and the appropriate diagnosis according to DSM-III-R criteria. For

example, Morey and Ochoa (1989) found a diagnostic inconsistency rate of 72% of the 291 sampled cases in their study. That is, clinicians in their sample gave diagnoses to their clients, that when matched against the actual DSM-III-R criteria for those diagnoses, were not appropriate. Although it is not known whether clinicians in the Morey and Ochoa (1989) study actually consulted the DSM-III-R prior to making their diagnoses, the findings from their study are consistent with the results of the present study.

DIFFERENCES IN CERTAINTY RATINGS ACROSS PD DIAGNOSTIC CATEGORIES BY SEX

One of the most interesting findings from this section of the results was that certainty ratings for Histrionic PD were significantly different from certainty ratings for Antisocial PD in all versions of the case history. This provides further evidence that these two disorders are seen as highly dissimilar, even perhaps, mutually exclusive. This also helps explain the results of previous studies that found sex differences in the diagnostic rates for these disorders when features of the two disorders were combined into one case history. It appears that if clinicians assign one of these two diagnoses they are unlikely to assign the other diagnosis.

Another interesting finding from this section of the results pertained to the two versions of the case history

(i.e., HPD with NPD features, APD with NPD features) where the correct diagnosis was one associated with a particular sex (i.e., HPD with females, APD with males) for clinicians who did not complete the DSM-III-R checklist. Certainty ratings for the personality disorders presented in the case history were not significantly different for the sex that was associated with the primary diagnosis. That is, for the HPD with NPD features case history, certainty ratings for HPD and NPD were not significantly different from one another for females but were for males. Similarly, for the APD with NPD features case history, certainty ratings for APD and NPD were not significantly different from one another for males but were for females. The meaning of these findings is not clear, although one explanation seems plausible. When the correct diagnosis was consistent with both the sex of the client and gender base rate information, clinicians may have been more likely to examine the criteria for the secondary diagnosis less critically. In contrast, when the correct diagnosis was inconsistent with the sex of the client presented, clinicians may have examined the criteria more critically and thus given different certainty ratings for the primary and secondary diagnoses.

IMPLICATIONS FROM POST-EXPERIMENTAL QUESTIONNAIRES

Although the information gathered from the post-experimental questionnaires is only speculative, this

information is interesting because it tends to parallel the findings of this study and previous research on sex differences in diagnoses. Clinicians tended to strongly associate males with Antisocial PD and females with Histrionic PD. Males also received higher ratings for Narcissistic PD and females received higher ratings for Borderline PD, although these differences were not as strong as those seen for Antisocial PD and Histrionic PD. Moreover, when the diagnoses favoring males were paired together (i.e., Antisocial and Narcissistic PD), clinicians continued to give higher ratings for this combination for males than females. The same was true when the diagnoses favoring females were paired together (i.e., Histrionic and Borderline PD), with clinicians giving higher ratings for this combination for females than males.

These findings suggest that clinicians believe that there are differential diagnostic rates, based on sex, for several personality disorders. This study can not address whether or not these differential diagnostic rates are due to differences in social-cultural influences on males as compared to females, or whether they actually represent real differences in nature. However, even if these differences in diagnostic rates accurately reflect reality, the fact that clinicians give males and females different diagnoses even when they present with the same symptoms,

indicates that a diagnostic sex bias does exist.

IMPLICATIONS FROM POST-HOC ANALYSES

Data from the post-hoc analyses suggested that subjects who referred back to the case history at least twice when making their diagnosis, tended to be more likely to make the correct diagnosis compared to subjects who referred to the case history only once or not at all. This indicates that when clinicians spend more time studying the information they are basing their diagnosis on, they are more likely to make the correct diagnosis. Furthermore, the data from the post-hoc analyses also suggested that actually referring to the DSM-III-R when making a diagnosis, if the clinician is fairly familiar with and often uses the DSM-III-R in their practice, more often leads to a correct diagnosis. This is a particularly interesting finding since having clinicians complete the DSM-III-R checklist prior to making a diagnosis did not appear to necessarily lead to the correct diagnosis. It may be that there was a subset of clinicians who completed the DSM-III-R checklist and referred to the DSM-III-R when making their diagnosis. This subset may have been better at making the correct diagnosis than clinicians who completed the DSM-III-R checklist but did not actually refer to the DSM-III-R. Additional studies in this area may help solve this apparent discrepancy.

Another interesting finding from this section of the

results was that of those who gave a diagnosis that was coded as "wrong" for any of the four versions of the case history, approximately 75% gave no diagnosis at all. That is, they did not give a rating of 5 or above to any of the personality disorder categories. The other 25% gave Borderline PD as the diagnosis. These findings suggest two things. First, subjects who give "wrong" diagnoses may not typically diagnose their clients with personality disorders at all. Thus, sex bias in diagnosis would not apply to this group of clinicians. Second, further evidence is provided for the view of Borderline PD as a "catch-all" category that is diagnosed when an individual appears to meet criteria for several different personality categories.

SUMMARY OF SIGNIFICANT FINDINGS

Several significant findings emerged from the results of the study. First, the overdiagnosis of Narcissistic PD for males and underdiagnosis of this disorder for females clearly supports the primary hypothesis of the study that the gender rate hypothesis is not an adequate explanation for diagnostic sex bias. As predicted, clinicians displayed a diagnostic sex bias for Narcissistic PD even though there was no reliable source of a differential sex base information available. The DSM-III-R states that there is no information on the sex ratio for Narcissistic PD. Thus, reliable gender base rate information could not

have entered into clinicians' diagnostic decisions. This clearly refutes the base rate explanation for diagnostic sex bias. It is possible that clinicians used their own personal experiences with clients to form their own base rate for this disorder. Support from the post-experimental questionnaires was found for this possibility. Information provided in the DSM-IV (1994) that, "Of those diagnosed with NPD, 50%-75% are male" (p. 660) lends additional support to this conclusion. Although the DSM-IV was not published and thus not available for clinicians to consult at the time this study was conducted, it seems probable that clinicians were basing their diagnostic decisions on their clinical experiences since this is where the information published in the DSM-IV was gathered.

Second, the underdiagnosis of Borderline PD for males can be easily explained by the gender base rate hypothesis. Specifically, it seems reasonable that since the DSM-III-R reports that Borderline PD is more frequently diagnosed for females, clinicians, when faced with ambiguous information, may have decided based on the information provided in the DSM-III-R, that other diagnoses were more appropriate for male clients. However, this finding can also be explained by the alternative hypothesis offered previously, that the sex of the client activates clinicians' sex role stereotypes and that they make diagnoses consistent with those stereotypes. Moreover, in general, when the results

for each of the four versions of the case history were looked at separately, both the alternative hypothesis and the gender base rate hypothesis appeared to be fairly equal in being able to explain the results. However, in some cases, this alternative hypothesis seemed to be a more viable explanation for the results than the gender base rate hypothesis. For example, for the Antisocial PD with Narcissistic features case history, the gender rate hypothesis can not readily explain why clinicians chose HPD, over NPD, as a diagnosis for females when no HPD criteria was even present in the case history. This is especially true since NPD would have seemed to be an acceptable choice since the DSM-III-R does not give gender base rate information for NPD. The sex expectations hypothesis, however, could explain these results, since based on the results of this study, both NPD and APD are more strongly associated with males, while the criteria for the HPD diagnosis are more stereotypic of females.

It seems important to note however, that the gender base rate hypothesis, when mentioned in this study, actually refers to base rate differences as reported in the DSM-III-R. In actuality, the DSM-III-R is only one of several types of base rate that exist. Another type of base rate, mentioned previously, is clinicians' personal base rate, formed from their personal clinical and general

life experiences. In other words, a clinician's personal base rate is their personal prejudices about how frequently males versus females display symptoms that meet criteria for a certain personality disorder. A third type of base rate is the ratio that actually occurs in nature. This type of base rate, however, is basically unknowable with our current methods of science. This study, in general, found a great deal of agreement between the first two types of base rates, which is not surprising since the DSM manual is based on clinicians' reports. However, it is not known whether the first two types of base rates would agree with the third type, real differences in nature. If they did agree, then no sex bias in diagnosis would exist because gender based difference in diagnoses would be valid.

However, without knowing the gender base rates in nature for personality disorders, the results of this study do indicate that clinicians are generally not using DSM-III-R base rates when making diagnostic decisions for Narcissistic personality disorder. Other investigations are needed to determine if this is also true for other personality disorder diagnoses, although the results of this study suggest that such is the case. Instead of using DSM-III-R criteria, clinicians appear to be using their own personal gender base rates, which is the analagous to saying that they are using information based on their personal prejudices or gender stereotypes. In a way, this

is not particularly surprising since most studies indicate that clinicians rarely incorporate clinical research data into their clinical work. Furthermore, since there was little variability in the data, it appears that these findings apply to most clinicians who resemble the participants' demographics, instead of just a few clinicians with extreme views.

Another point, not specifically addressed previously, deserves mention in this section of the discussion. Specifically, what impact does, or should, the gender base rate have on the diagnosis of individual clients? One would hope that gender base rates would have little impact on the diagnosis of individual clients since one would think that in face-to-face contact with a client, the unique qualities of the client would have more impact than simply the gender of the client. Base rate information is most useful when no information is known. However, with face-to-face interactions with clients, the gender of the client is almost always known. Thus, gender base rate information should have little importance, since other information available in a face-to-face interaction with an individual client would appear to be more salient and more useful diagnostically. Since this study did not employ face-to-face interactions, the findings of this study can not be extrapolated to that medium. However, since the

findings of this study suggest that it is not base rate information, but sex role stereotypes that may be influencing clinicians' diagnostic decisions, the role of base rates in clinicians' diagnostic decisions may be less important; instead, a better understanding of the influence of sex role stereotypes on clinicians' diagnostic decisions may be the most relevant point to be further explored.

Third, across a variety of analyses, strong evidence was found for the association of Histrionic PD with females and Antisocial PD with males. Weaker, but typically significant, evidence was found for the association of Borderline PD with females and Narcissistic PD with males. With the exception of Narcissistic PD, these associations could reflect clinicians' use of knowledge about the differential sex ratios for these disorders. However, all of these associations can be explained by the primary hypothesis of this study, that the sex of client elicits clinicians' critical sets regarding sex roles and behavior and that clinicians make diagnoses consistent with these critical sets. It is also possible that the diagnostic sex biases found in this study accurately reflects real differences in nature or are the result of differences in social-cultural influences on males versus females. Clearly more research is needed in this area, possible looking at personality disorder diagnostic rates across a

variety of cultures, in order to understand why differential sex ratios exist for the diagnosis of these disorders.

Fourth, the DSM-III-R criterion checklist appeared to have no discernable effect on clinicians' diagnoses, contrary to predictions. This is a disturbing finding because it suggests that clinicians are making their diagnosis based on information other than DSM-III-R criteria. This would make it more likely that such things as clinicians' personal sex role stereotypes would influence their diagnostic decisions as hypothesized.

However, there was some evidence that clinicians who actually consulted the DSM-III-R when making their diagnosis in the study were more likely to make a correct diagnosis than clinicians who did not consult the DSM-III-R. Since the DSM-III-R criterion checklist was taken verbatim from the DSM-III-R, it is not clear why the DSM-III-R criterion checklist did not have the same effect as actually consulting the DSM-III-R. One possibility is that clinicians who filled out the DSM-III-R criterion checklist did not recognize it as coming from the DSM-III-R and simply filled it out so that it agreed with the diagnosis they had already formed after reading the case history. Moreover, more clinicians who were not provided with the DSM-III-R checklist may have actually consulted the DSM-

III-R and followed its criteria more closely when making a diagnosis. Further research may help clear up this discrepancy.

MAJOR LIMITATIONS OF THE STUDY

One of the primary limitations of the study was the paradigm that it employed. The use of case histories for assessing clinicians' diagnostic practices has been criticized for being too transparent and weakly correlated with actual clinical practice, although it is also said to provide the most direct test of diagnostic prejudice. Another limitation of the study was the limitation of possible diagnoses that clinicians' were allowed to make. Only five of the eleven personality disorders were listed as possible diagnoses. It may be that clinicians may have made other personality disorder diagnoses if they had been allowed to do so. The way the case histories were constructed may have also limited the results of the study. For example, the relatively high ratings for Narcissistic PD across all four version of the case history, compared to the lower ratings for the other PD diagnostic categories, suggested that the criteria used to portray NPD were more salient than the criteria used to portray the other personality disorders. Livesley et al.'s (1987) study on the prototypicality ratings of DSM-III criteria for personality disorders provides some support for this position. Specifically, it may be that the criteria used

to portray NPD were more prototypical of NPD in comparison to the prototypicality of the criteria used to portray HPD and APD, which would have made NPD more salient. For example, Livesley et al. (1987) found that that a sense of entitlement was rated as the most prototypical of NPD. This criterion was included in all four case versions of the case history. In contrast, Livesly et al. (1987) found that a failure to learn from experience, which is not even listed as one of the DSM-III-R (or DSM-III) criteria for APD, received the second highest prototypicality rating for APD. This criterion was not included in any version of the case histories. Thus, it appears that including a more prototypical feature of NPD across all versions of the case history may have made this diagnostic category more salient in comparision to APD and HPD.

SUGGESTIONS FOR FUTURE RESEARCH

Clearly, more research is needed to investigate why a differential diagnostic sex bias exists for Narcissistic PD. Furthermore, since the gender base rate hypothesis was unable to explain the differential diagnostic sex ratio for Narcissistic PD, other explanations need to be explored. Replication of the overall confirmation of the hypothesis that clinicians' critical sets regarding sex roles and behaviors are activated by the sex of the client and that

clinicians then make diagnoses consistent with their critical sets, is also needed. In addition, cross-cultural research is needed to explore whether differential diagnostic rates based on sex are due to social-cultural influences or whether they are simply accurate reflections of real differences in nature.

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APPENDIX A:

Number of Male and Female Respondents in Each Experimental Condition

Experimental Condition	Sex of Respondent: Female	Male
NPD with HPD features *m	7	13
NPD with HPD features *f	10	10
NPD with HPD features *n	8	13
NPD with HPD features #m	10	10
NPD with HPD features #f	10	11
NPD with HPD features #n	7	13
NPD with APD features *m	9	11
NPD with APD features *f	10	12
NPD with APD features *n	9	11
NPD with APD features #m	11	9
HPD with NPD features *m	7	14
HPD with NPD features *f	9	14
HPD with NPD features *n	9	12
HPD with NPD features #m	10	10
APD with NPD features *m	9	12
APD with NPD features *f	10	11
APD with NPD features *n	8	13
APD with NPD features #f	7	13

* = did not complete DSM-III-R criterion checklist
\# = did complete DSM-III-R criterion checklist
m = male client version
f = female client version
n = gender neutral client version

Appendix B:

Narcissistic Personality Disorder with Histrionic Features Case History (male version)

M is a 30-year-old single, white male who was referred to an outpatient clinic by his physician with the chief complaint of feeling discouraged and tired. He states he has been feeling this way for the past several years, off and on, with no particular pattern to his changes in mood. He specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, M immediately reports that he became very upset with the clinic receptionist when he tried to make an appointment because he was told he would have to wait a week before he could see anyone. M thought this was very unfair because his problems were certainly more urgent than anyone else's. (#6 NPD) M then states that perhaps it was worth the wait to get to see a therapist who is so physically attractive. (#2 HPD)

M reports that he is currently employed as a salesperson for a computer company. When asked how he likes his job, M begins discussing how he recently became quite upset at work after working on a group project and not being singled out for individual praise. (#3NPD) To add insult to injury, M states that he actually received a reprimand from his supervisor for not being more

cooperative with his co-workers on the project. M reports that he is currently not speaking to his supervisor or co-workers because of this (#1NPD), and is thinking of looking for another job where his talents are better appreciated.

When asked about his relationships in general, M reports that people frequently tell him he is too "theatrical". (#4HPD) He states he doesn't really have any close friends except for a couple of people that he pretends to be friends with because they can help him out. His neighbor, for example, who takes care of his dog for free when M has to go out of town. (#2NPD) M reports he dates several times a month, but is not involved in a steady relationship. M states that after a few times of going out with someone they usually do something to disappoint him. For example, he couldn't understand why his last date cancelled at the last minute just because she had the flu. (#8NPD)

When asked about other interests, M admits he likes to go out and spend money, even though this has caused him to develop a bad credit history. (#7HPD) M states that he isn't really concerned about this though because he knows that his fantasies of winning the lottery will soon come true. M admits to spending a lot of time daydreaming about how powerful he will be when when he wins all that money. (#5 NPD)

At the end of the interview, M is referred to an experienced therapist associated with the clinic who charges a nominal fee M can afford. However, M requests a referral to someone more "prestigious" because M states only someone special would be able to help him. (#4NPD)

Appendix C:

Narcissistic Personality Disorder with Histrionic Features Case History (female version)

M is a 30-year-old single, white female who was referred to an outpatient clinic by her physician with the chief complaint of feeling discouraged and stressed. She states she has been feeling this way for the past several years, off and on, with no particular pattern to her changes in mood. She specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, M immediately reports that she became very upset with the clinic receptionist when she tried to make an appointment because she was told she would have to wait a week before she could see anyone. M thought this was very unfair because her problems were certainly more urgent than anyone else's. M then states that perhaps it was worth the wait to get to see a therapist who is so physically attractive.

M reports that she is currently employed as a salesperson for a computer company. When asked how she likes her job, M begins discussing how she recently became quite upset at work after working on a group project and not being singled out for individual praise. To add insult to injury, M states that she actually received a reprimand from her supervisor for not being more cooperative with her

co-workers on the project. M reports that she is currently not speaking to her supervisor or co-workers because of this, and is thinking of looking for another job where her talents are better appreciated.

When asked about her relationships in general, M reports that people frequently tell her she is too "theatrical". She states she doesn't really have any close friends except for a couple of people that she pretends to be friends with because they can help her out, her neighbor, for example, who takes care of her dog for free when M has to go out of town. M reports she dates several times a month, but is not involved in a steady relationship. M states that after a few times of going out with someone they usually do something to disappoint her. For example, she couldn't understand why her is last date cancelled at the last minute just because he had the flu.

When asked about other interests, M admits she likes to go out and spend money, even though this has caused her to develop a bad credit history. M states that she isn't really concerned about this though because she knows that her fantasies of winning the lottery will soon come true. M admits to spending a lot of time daydreaming about how powerful she will be win when she wins all that money.

At the end of the interview, M is referred to an experienced therapist associated with the clinic who

charges a nominal fee M can afford. However, M requests a referral to someone more "prestigious" because M states only someone special would be able to help her.

Appendix D:

Narcissistic Personality Disorder with Histrionic Features Case History (gender neutral version)

The client is 30-years-old single, white, who was referred to an outpatient clinic by their physician with the chief complaint of feeling discouraged and stressed. The client states they have been feeling this way for the past several years, off and on, with no particular pattern to their changes in mood. The client specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, the client immediately reports that they became very upset with the clinic receptionist when they tried to make an appointment because they were told they would have to wait a week before they could see anyone. The client thought this was very unfair because their problems were certainly more urgent than anyone else's. The client then states that perhaps it was worth the wait to get to see a therapist who is so physically attractive.

The client reports that they are currently employed as a salesperson for a computer company. When asked how they like their job, the client begins discussing how they recently became quite upset at work after working on a group project and not being singled out for individual praise. To add insult to injury, the client states that

they actually received a reprimand from their supervisor for not being more cooperative with their co-workers on the project. The client reports that they are currently not speaking to their supervisor or co-workers because of this, and are thinking of looking for another job where their talents are better appreciated.

When asked about their relationships in general, the client reports that people frequently tell them they are too "theatrical". The client states they don't really have any close friends except for a couple of people that the client pretends to be friends with because they can help the client out, their neighbor, for example, who takes care of the client's dog for free when the client has to go out of town. The client reports they date several times a month, but are not involved in a steady relationship. The client states that after a few times of going out with someone they usually do something to disappoint the client. For example, the client couldn't understand why their last date cancelled at the last minute just because they had the flu.

When asked about other interests, the client admits they like to go out and spend money, even though this has caused them to develop a bad credit history. The client states that they aren't really concerned about this though because they know that their fantasies of winning the

lottery will soon come true. The client admits to spending a lot of time daydreaming about how powerful they will be win when they win all that money.

At the end of the interview, the client is referred to an experienced therapist associated with the clinic who charges a nominal fee the client can afford. However, the client requests a referral to someone more "prestigious" because the client states only someone special would be able to help them.

Appendix E:

Narcissistic Personality Disorder with Antisocial Features Case History (male version)

M is a 30-year-old single, white male who was referred to an outpatient clinic by his physician with chief complaint of feeling discouraged and tired. He states he has been feeling this way for the past several years, off an on, with no particular pattern to his changes in mood. He specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, M immediately reports that he became very upset with the clinic receptionist when he tried to make an appointment because he was told he would have to wait a week before he could see anyone. M thought this was very unfair because his problems were certainly more urgent than anyone else's. (#6 NPD)

When asked about his childhood, M reports that he frequently got suspended from school for skipping (#1B-APD) and starting fights. (#3B-APD) M notes that these behaviors led to some difficulties with his parents.

M reports that he is currently employed as a salesperson for a computer company. When asked how he likes his job, M begins discussing how he recently became quite upset at work after working on a group project and not being singled out for individual praise. (#3NPD) To

add insult to injury, M states that he actually received a reprimand from his supervisor for not being more cooperative with his co-workers on the project. M reports that he is currently not speaking to his supervisor or co-workers because of this (#1NPD), and is thinking of looking for another job where his talents are better appreciated. M states that this is his fifth job in the last six years but that he isn't worried about finding another position because "something will turn up". (#1C-APD) He adds that he can always lie about his background and/or experience to get another job because "it's always worked before". (#6C-APD)

When asked about his relationships, M states that he doesn't really have any close friends except for a couple of people that he pretends to be friends with because they can help him out. His neighbor, for example, who takes care of his dog for free when M has to go out of town, and a co-worker who drives him back and forth to work. (#2NPD) M reports that he dates several times a month, but is not involved in a steady relationship. M states that after a few times of going out with someone they usually do something to disappoint him. For example, he couldn't understand why his last date cancelled at the last minute just because she had the flu. (#8NPD)

When asked about other interests, M admits to frequent

fantasies about winning the lottery. He states that he spends a lot of time daydreaming about how powerful he will be when he wins all that money. (#5NPD)

At the end of the interview, M is referred to an experienced therapist associated with the clinic who charges a nominal fee M can afford. However, M requests a referral to someone more "prestigious" because, according to M, only someone special would be able to help him.

Appendix F:

Narcissistic Personality Disorder with Antisocial Features Case History (female version)

M is a 30-year-old single, white female who was referred to an outpatient clinic by her physician with chief complaint of feeling discouraged and tired. She states she has been feeling this way for the past several years, off an on, with no particular pattern to her changes in mood. She specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, M immediately reports that she became very upset with the clinic receptionist when she tried to make an appointment because she was told she would have to wait a week before she could see anyone. M thought this was very unfair because her problems were certainly more urgent than anyone else's. (#6 NPD)

When asked about her childhood, M reports that she frequently got suspended from school for skipping (#1B-APD) and starting fights. (#3B-APD) M notes that these behaviors led to some difficulties with her parents.

M reports that she is currently employed as a salesperson for a computer company. When asked how she likes her job, M begins discussing how she recently became quite upset at work after working on a group project and not being singled out for individual praise. (#3NPD) To

add insult to injury, M states that she actually received a reprimand from her supervisor for not being more cooperative with her co-workers on the project. M reports that she is currently not speaking to her supervisor or co-workers because of this (#1NPD), and is thinking of looking for another job where her talents are better appreciated. M states that this is her fifth job in the last six years but that she isn't worried about finding another position because "something will turn up". (#1C-APD) She adds that she can always lie about her background and/or experience to get another job because "it's always worked before". (#6C-APD)

When asked about her relationships, M states that she doesn't really have any close friends except for a couple of people that she pretends to be friends with because they can help her out. Her neighbor, for example, who takes care of her dog for free when M has to go out of town, and a co-worker who drives her back and forth to work. (#2NPD) M reports that she dates several times a month, but is not involved in a steady relationship. M states that after a few times of going out with someone they usually do something to disappoint her. For example, she couldn't understand why her last date cancelled at the last minute just because he had the flu. (#8NPD)

When asked about other interests, M admits to frequent

fantasies about winning the lottery. She states that she spends a lot of time daydreaming about how powerful she will be when she wins all that money. (#5NPD)

At the end of the interview, M is referred to an experienced therapist associated with the clinic who charges a nominal fee M can afford. However, M requests a referral to someone more "prestigious" because, according to M, only someone special would be able to help her.

Appendix G:

Narcissistic Personality Disorder with Antisocial Features Case History (gender neutral version)

The client is 30-years-old single, white, who was referred to an outpatient clinic by their physician with chief complaint of feeling discouraged and stressed. The client states they have been feeling this way for the past several years, off an on, with no particular pattern to their changes in mood. The client specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, the client immediately reports that they became very upset with the clinic receptionist when they tried to make an appointment because they were told they would have to wait a week before they could see anyone. The client thought this was very unfair because their problems were certainly more urgent than anyone else's.

When asked about their childhood, the client reports that they frequently got suspended from school for skipping and starting fights. The client notes that these behaviors led to some difficulties with their parents.

The client reports that they are currently employed as a salesperson for a computer company. When asked how the client likes their job, the client begins discussing how they recently became quite upset at work after working on a

group project and not being singled out for individual praise. To add insult to injury, the client states they actually received a reprimand from their supervisor for not being more cooperative with their co-workers on the project. The client reports that they are currently not speaking to their supervisor or co-workers because of this and are thinking of looking for another job where their talents are better appreciated. The client states that this is their fifth job in the last six years but that they aren't worried about finding another position because "something will turn up". The client adds that they can always lie about their background and/or experience to get another job because "it's always worked before".

When asked about their relationships, the client states that they don't really have any close friends except for a couple of people that they pretend to be friends with because they can help the client out, the client's neighbor, for example, who takes care of the client's dog for free when the client has to go out of town, and a co-worker who drives the client back and forth to work. The client reports that they date several times a month, but are not involved in a steady relationship. The client states that after a few times of going out with someone they usually do something to disappoint the client. For example, the client couldn't understand why their last date

cancelled at the last minute just because they had the flu.

When asked about other interests, the client admits to frequent fantasies about winning the lottery. The client states that they spend a lot of time daydreaming about how powerful they will be when they win all that money.

At the end of the interview, the client is referred to an experienced therapist associated with the clinic who charges a nominal fee the client can afford. However, the client requests a referral to someone more "prestigious" because, according to the client, only someone special would be able to help them.

Appendix H:

Histrionic Personality Disorder with Narcissistic Features Case History (male version)

M is a 30-year-old single, white male who presents to an outpatient clinic with the chief complaint of feeling discouraged and tired. He states he has been feeling this way for the past several years, off and on, with no particular pattern to his changes in mood. He specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, M immediately reports that he became very upset with the clinic receptionist when he tried to make an appointment because he was told he would have to wait a week before he could see anyone. M thought this was very unfair because his problems were certainly more urgent than anyone else's. (#6 NPD) M then states that perhaps it was worth the wait to get to see a therapist who is so physically attractive. (#2 HPD)

M reports that he is employed as a salesperson for a computer company. When asked how he likes his job, M states he is currently on probation for being too flirtatious with the customers. (#2 HPD) While explaining why he views this reprimand as unfair, and throughout the remainder of the interview, M repeatedly asks the therapist, "I'm right, aren't I?" (#1 HPD)

When asked about his relationships in general, M

reports that people frequently tell him he is too "theatrical". (#4HPD) He states he doesn't really have any close friends. When asked about his relationship with his family, he simply states, "they're beautiful people". (#8 HPD) M reports that he dates several times a month, but is not involved in a steady relationship. M states that after a few times of going out with someone they usually do something to disappoint him. For example, he couldn't understand why his last date cancelled at the last minute just because she had the flu. (#8NPD)

When asked about other interests, M admits he likes to go out and spend money, even though this has caused him to develop a bad credit history. (#7HPD) M states that he isn't really concerned about this though because he know that his fantasies of winning the lottery will soon come true. M admits to spending a lot of time daydreaming about how powerful he will be win he wins all that money. (#5NPD)

At the end of the interview, M checks his reflection one last time in the two-way mirror. (#3HPD) He is referred to an experienced therapist associated with the clinic who charges a nominal fee M can afford.

Appendix I:

Histrionic Personality Disorder with Narcissistic Features Case History (female version)

M is a 30-year-old single, white female who was referred to an outpatient clinic by her physician with the chief complaint of feeling discouraged and stressed. She states she has been feeling this way for the past several years, off and on, with no particular pattern to her changes in mood. She specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, M immediately reports that she became very upset with the clinic receptionist when she tried to make an appointment because she was told she would have to wait a week before she could see anyone. M thought this was very unfair because her problems were certainly more urgent than anyone else's. M then states that perhaps it was worth the wait to get to see a therapist who is so physically attractive.

M reports that she is employed as a salesperson for a computer company. When asked how she likes her job, M states she is currently on probation for being too flirtatious with the customers. While explaining why she views this reprimand as unfair, and throughout the remainder of the interview, M repeatedly asks the therapist, "I'm right, aren't I?"

When asked about her relationships in general, M reports that people frequently tell her she is too "theatrical". She states she doesn't really have any close friends. When asked about her relationship with her family, she simply states, "they're beautiful people". M reports that she dates several times a month, but is not involved in a steady relationship. M states that after a few times of going out with someone they usually do something to disappoint her. For example, she couldn't understand why her last date cancelled at the last minute just because he had the flu. When asked about other interests, M admits she likes to go out and spend money, even though this has caused her to develop a bad credit history. M states that she isn't really concerned about this though because she knows that her fantasies of winning the lottery will soon come true. M admits to spending a lot of time daydreaming about how powerful she will be win she wins all that money.

At the end of the interview, M checks her reflection one last time in the two-way mirror. She is referred to an experienced therapist associated with the clinic who charges a nominal fee M can afford.

Appendix J:

Histrionic Personality Disorder with Narcissistic Features Case History (gender neutral version)

The client is 30-years-old single, white, who was referred to an outpatient clinic by a physician with the chief complaint of feeling discouraged and stressed. The client states they have been feeling this way for the past several years, off and on, with no particular pattern to their changes in mood. The client specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, the client immediately reports that they became very upset with the clinic receptionist when they tried to make an appointment because they were told they would have to wait a week before they could see anyone. The client thought this was very unfair because their problems were certainly more urgent than anyone else's. The client then states that perhaps it was worth the wait to get to see a therapist who is so physically attractive.

The client reports that they are employed as a salesperson for a computer company. When asked how they like their job, the client states they are currently on probation for being too flirtatious with the customers. While explaining why they view this reprimand as unfair, and throughout the remainder of the interview, the client

repeatedly asks the therapist, "I'm right, aren't I?"

When asked about their relationships in general, the client reports that people frequently tell them they are too "theatrical". The client states they don't really have any close friends. When asked about their relationship with their family, the client simply states, "they're beautiful people". The client reports that they date several times a month, but are not involved in a steady relationship. The client states that after a few times of going out with someone they usually do something to disappoint the client. For example, the client couldn't understand why their last date cancelled at the last minute just because they had the flu.

When asked about other interests, the client admits they like to go out and spend money, even though this has caused them to develop a bad credit history. The client states that they aren't really concerned about this though because they know that their fantasies of winning the lottery will soon come true. The client admits to spending a lot of time daydreaming about how powerful they will be when they win all that money.

At the end of the interview, the client checks their reflection one last time in the two-way mirror. The client is referred to an experienced therapist associated with the clinic who charges a nominal fee the client can afford.

Appendix K:

Antisocial Personality Disorder with Narcissistic Features Case History (male version)

M is a 30-year-old single, white male who was referred to an outpatient clinic by his physician with the chief complaint of feeling discouraged and tired. He states he has been feeling this way for the past several years, off and on, with no particular pattern to his changes in mood. He specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, M immediately reports that he became very upset with the clinic receptionist when he tried to make an appointment because he was told he would have to wait a week before he could see anyone. M thought this was very unfair because his problems were certainly more urgent than anyone else's. (#6 NPD)

When asked about his childhood, M reports that he frequently got suspended from school for skipping, (#1B-APD) and starting fights. (#3B-APD) He states he also got in trouble once for putting sugar in the gasoline tank of a car belonging to a teacher who had flunked him. (#8B -APD) M reports that these behaviors led to some difficulties with his parents and that he frequently ran away from home and stayed with friends for a couple of days. (#2B-APD)

M reports that he is currently employed as a

salesperson for a computer company. When asked how he likes his job, M begins discussing how he recently became quite upset at work after working on a group project and not being singled out for individual praise. (#3NPD) To add insult to injury, M states that he actually received a reprimand from his supervisor for not being more cooperative with his co-workers on the project. M reports that he hasn't spoken to his supervisor or co-workers for the past week because of this (#1NPD), and is thinking of looking for another job where his talents are better appreciated. M states that this is his fifth job in the last six years but that he isn't worried about finding another position because "something will turn up". (#1C-APD) He adds that he can always lie about his background and/or experience to get another job because "it's always worked before". (#6APD)

When asked about his relationships, M reports that he has few friends. M dates several times a month, but is not involved in a steady relationship. He states he has never been able to be faithful to a woman for longer than a couple of months. (#9C-APD) M reports that this inevitably leads to problems and that most of time he ends up getting into a "knock-down drag out fight" with his partner at the time. (#3C-APD)

M also reports that his financial position is somewhat

precarious because of too many debts, and that he probably will soon be filing for bankruptcy. (#4C-APD) M states that he isn't really concerned about this because he knows that his fantasies of winning the lottery will soon come true. M admits to spending a lot of time daydreaming about how powerful he will be when he wins all that money. (#5NPD)

At the end of the interview, M is referred to an experienced therapist associated with the clinic who charges a nominal fee M can afford.

Appendix L:

Antisocial Personality Disorder with Narcissistic Features Case History (female version)

M is a 30-year-old single, white female who was referred to an outpatient clinic by her physician with the chief complaint of feeling discouraged and stressed. She states she has been feeling this way for the past several years, off and on, with no particular pattern to her changes in mood. She specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, M immediately reports that she became very upset with the clinic receptionist when she tried to make an appointment because she was told she would have to wait a week before she could see anyone. M thought this was very unfair because her problems were certainly more urgent than anyone else's.

When asked about her childhood, M reports that she frequently got suspended from school for skipping and starting fights. She states she also got in trouble once for putting sugar in the gasoline tank of a car belonging to a teacher who had flunked her. M reports that these behaviors led to some difficulties with her parents and that she frequently ran away from home and stayed with friends for a couple of days.

M reports that she is currently employed as a

salesperson for a computer company. When asked how she likes her job, M begins discussing how she recently became quite upset at work after working on a group project and not being singled out for individual praise. To add insult to injury, M states that she actually received a reprimand from her supervisor for not being more cooperative with her co-workers on the project. M reports that she hasn't spoken to her supervisor or co-workers for the past week because of this, and is thinking of looking for another job where her talents are better appreciated. M states that this is her fifth job in the last six years but that she isn't worried about finding another position because "something will turn up". She adds that she can always lie about her background and/or experience to get another job because "it's always worked before".

When asked about her relationships, M reports that she has few friends. M dates several times a month, but is not involved in a steady relationship. She states she has never been able to be faithful to a man for longer than a couple of months. M reports that this inevitably leads to problems and that most of time she ends up getting into a "knock-down drag out fight" with her partner at the time.

M also reports that her financial position is somewhat precarious because of too many debts, and that she probably will soon be filing for bankruptcy. M states that she

isn't really concerned about this because she knows that her fantasies of winning the lottery will soon come true. M admits to spending a lot of time daydreaming about how powerful she will be when she wins all that money.

At the end of the interview, M is referred to an experienced therapist associated with the clinic who charges a nominal fee M can afford.

Appendix M:

Antisocial Personality Disorder with Narcissistic Features Case History (gender neutral version)

The client is 30-years-old single, white, who was referred to an outpatient clinic by their physician with the chief complaint of feeling discouraged and stressed. The client states they have been feeling this way for the past several years, off and on, with no particular pattern to their changes in mood. The client specifically denies persistent depressed mood, sleep disturbance, appetite disturbance, and suicidal or homicidal ideation.

After meeting the therapist, the client immediately reports that they became very upset with the clinic receptionist when they tried to make an appointment because the client was told they would have to wait a week before they could see anyone. The client thought this was very unfair because their problems were certainly more urgent than anyone else's.

When asked about their childhood, the client reports that they frequently got suspended from school for skipping and starting fights. The client states they also got in trouble once for putting sugar in the gasoline tank of a car belonging to a teacher who had flunked them. The client reports that these behaviors led to some difficulties with their parents and that they frequently ran away from home and stayed with friends for a couple of

days.

The client reports that they are currently employed as a salesperson for a computer company. When asked how the client likes their job, the client begins discussing how they recently became quite upset at work after working on a group project and not being singled out for individual praise. To add insult to injury, the client states that they actually received a reprimand from their supervisor for not being more cooperative with their co-workers on the project. The client reports that they haven't spoken to their supervisor or co-workers for the past week because of this, and are thinking of looking for another job where their talents are better appreciated. The client states that this is their fifth job in the last six years but that they aren't worried about finding another position because "something will turn up". The client adds that they can always lie about their background and/or experience to get another job because "it's always worked before".

When asked about their relationships, the client reports that they have few friends. The client dates several times a month, but is not involved in a steady relationship. The client states they have never been able to be faithful to a partner for longer than a couple of months. The client reports that this inevitably leads to problems and that most of time they end up getting into a

"knock-down drag out fight" with their partner at the time.

The client also reports that their financial position is somewhat precarious because of too many debts, and that they probably will soon be filing for bankruptcy. The client states that they aren't really concerned about this because they knows that their fantasies of winning the lottery will soon come true. The client admits to spending a lot of time daydreaming about how powerful they will be when they win all that money.

At the end of the interview, the client is referred to an experienced therapist associated with the clinic who charges a nominal fee the client can afford.

Appendix N:

Ratings of Descriptor Statements for Representativeness of DSM-III-R Criteria and Gender Specificity

I. Narcissistic Personality Disorder

1.) DSM-III-R criteria - reacts to criticism with feelings of rage, shame, or humiliation (even if not expressed)
representative statement - after receiving a bad review from their supervisor, refuses to talk to them for a week.
representativeness rating = 5.3
male applicability rating = 5.4
female applicability rating = 5.4

2.) DSM-III-R criteria - is interpersonally exploitative: takes advantage of others to achieve his or her own ends.
representative statement - pretends to be friends with a neighbor so they have someone to look after their pets for free when they go away on trips.
representativeness rating = 5.4
male applicability rating = 5.2
female applicability rating = 5.6

3.) DSM-III-R criteria - has a grandiose sense of self-importance, e.g., exaggerates acheivements and talents, expects to be noticed as "special" without appropriate achievement.
representative statement - after contributing to a group project at work, becomes depressed for not being singled out for individual praise.
representativeness rating = 6.2
male applicability rating = 6.1
female applicability rating = 6.2

4.) DSM-III-R criteria - believes that his or her problems are unique and can be understood only by other special people. representative statement - tells the therapist only someone "special" can understand them.
representativeness rating = 5.9
male applicability rating = 5.9
female applicability rating = 5.9

5.) DSM-III-R criteria - is preoccupied with fantasies of unlimited success, power,

brilliance, beauty, or ideal love.
representative statement - constantly daydreams about winning the lottery.
representativeness rating = 5.5
male applicability rating = 5.6
female applicability rating = 5.9

6.) DSM-III-R criteria - has a sense of entitlement: unreasonable expectation of especially favorable treatment, e.g., assumes that he or she does not have to wait in line when others must do so.
representative statement - states they were very upset with the clinic receptionist when told they would have to wait a week before getting an appointment because they felt their problems were more urgent than anyone else's.
representativeness rating = 5.3
male applicability rating = 5.4
female applicability rating = 5.4

7.) DSM-III-R criteria - lack of empathy: inability to recognize and experience how others feel.
representative statement - couldn't understand why their date cancelled at the last minute "just because they had the flu."
representativeness rating = 5.7
male applicability rating = 5.4
female applicability rating = 5.8

II. Histrionic Personality Disoder

1.) DSM-III-R criteria - constantly seeks or demands reassurance, approval, or praise.
representative statement - repeatedly asks the therapist, "I'm right, aren't I?"
representativeness rating = 6.0
male applicability rating = 5.2
female applicability rating = 5.9

2.) DSM-III-R criteria - is inappropriately sexually seductive in appearance or behavior.
representative statement - comments on the therapist's physical attractiveness.
representativeness rating = 5.4
male applicability rating = 5.9
female applicability rating = 5.2

3.) DSM-III-R criteria - is overly concerned with physical attractiveness.
representative statement - checks their reflection in the one-way mirror several times

during the interview.
representativeness rating = 5.5
male applicability rating = 5.1
female applicability rating = 5.6

4.) DSM-III-R criteria - expresses emotion with inappropriate exaggeration.
representative statement - states people frequently tell them they are "too theatrical."
representativeness rating = 5.3
male applicability rating = 5.4
female applicability rating = 5.4

5.) DSM-III-R criteria - is self-centered, actions being directed toward obtaining immediate satisfaction; has no tolerance for the frustration of delayed gratification.
representative statement - frequently spends money impulsively even though they can't afford to.
representativeness rating = 5.8
male applicability rating = 5.9
female applicability rating = 6.1

6.) DSM-III-R criteria - has a style of speech that is excessively impressionistic and lacking in detail.
representative statement - when asked about their relationship with their sister, can be no more specific than, "She was a beautiful person."
representativeness rating = 5.3
male applicability rating = 5.4
female applicability rating = 5.4

III. Antisocial Personality Disorder

1.) DSM-III-R criteria - (onset before age 15) - was often truant
representative statement - frequently got suspended from school for skipping
representativeness rating = 6.8
male applicability rating = 6.8
female applicability rating = 6.8

2.) DSM-III-R criteria - (onset before age 15) - often initiated physical fights representative statement - frequently got
suspended from school for starting fights.
representativeness rating = 6.5
male applicability rating = 6.7

female applicability rating = 6.4

3.) DSM-III-R criteria - (onset before age 15) - ran away from home overnight at least twice while living in parental or parental surrogate home (or once without returning).
representative statement - reports that these behaviors led to some difficulties with his parents and that he frequently ran away from home and stayed with friends for a couple of days.
representativeness rating = 6.3
male applicability rating = 6.4
female applicability rating = 6.2

4.) DSM-III-R criteria - (onset before age 15) - deliberately destroyed others' property (other than by fire-setting).
representative statement - also got in trouble once for putting sugar in the gasoline tank of a car belonging to a teacher who had flunked him.
representativeness rating = 5.7
male applicability rating = 5.8
female applicability rating = 5.2

5.) DSM-III-R criteria - (after age 15) - is unable to sustain consistent work behavior, as indicated by any of the following (including similar behavior in academic settings if the person is a student):
(a) significant unemployment for six months or more within five years when expected to work and work was available.
(b) repeated absences from work unexplained by illness in self or family.
(c) abandonment of several jobs without realistic plans for others.
representative statement - states that this is her fifth job in the last six years but that he isn't worried about finding another position because "something will turn up."
representativeness rating = 5.8
male applicability rating = 5.6
female applicability rating = 5.4

6.) DSM-III-R criteria - (after age 15) - is irritable and aggressive, as indicated by repeated physical fights or assaults (not required by one's job or to defend someone or oneself), includes spouse-or child-beatings.
representative statement - reports that this

inevitably leads to problems and that most of the time she ends up getting into a "knock-down drag out fight" with her partner at the time.
representativeness rating = 5.8
male applicability rating = 5.7
female applicability rating = 5.4

7.) DSM-III-R criteria - (after age 15) - has no regard for the truth, as indicated by repeated lying, use of aliases, or "conning" others for personal profit or pleasure.
representative statement - adds that he can always lie about his background and/or experience to get another job because "it's always worked before."
representativeness rating = 5.5
male applicability rating = 5.4
female applicability rating = 5.2

8.) DSM-III-R criteria - (after age 15) - repeatedly fails to honor financial obligations, as indicated by defaulting on debts or failing to provide child support or support for other dependents on a regular basis.
representative statement - reports that his financial position is somewhat precarious because of too many debts, and that he probably will soon be filing for bankruptcy.
representativeness rating = 6.1
male applicability rating = 5.8
female applicability rating = 5.7

9.) DSM-III-R criteria - has never sustained a totally monogamous relationship for more than one year.
representative statement - states he has never been able to be faithful to a woman for longer than a couple of months.
representativeness rating = 6.3
male applicability rating = 6.4
female applicability rating = 6.2

Appendix O: DSM-III-R Criterion Checklist

Please read the following checklist for selected DSM-III-R disorders. Rate the extent, from 1 for totally absent to 7 for totally present, to which you believe each criteria was met in the case history you just read. Ratings of 5 and above will indicate that you believe the criteria has definitely been met.

totally absent totally present
1----2----3----4----5----6----7

I. Dysthymia

A. Depressed mood for most of the day, more days than not, as indicated either by subjective report or observation by others, for at least two years.
1----2----3----4----5----6----7

B. Presence, while depressed, of at least two of the following:

(1) poor appetite or overeating
1----2----3----4----5----6----7

(2) insomnia or hypersomnia
1----2----3----4----5----6----7

(3) low energy or fatigue
1----2----3----4----5----6----7

(4) low self-esteem
1----2----3----4----5----6----7

(5) poor concentration or difficulty making decisions
1----2----3----4----5----6----7

(6) feelings of hopelessness
1----2----3----4----5----6----7

C. During a two year period of the disturbance, never without the symptoms in A for more than two months at a time.
1----2----3----4----5----6----7

D. No evidence of an unequivocal Major Depressive Episode during the first two years of the disturbance.
1----2----3----4----5----6----7

E. Has never had a Manic Episode or an unequivocal Hypomanic Episode
1----2----3----4----5----6----7

F. Not superimposed on a chronic psychotic disorder, such as Schizophrenia or a Delusional Disorder.

1----2----3----4----5----6----7

G. It cannot be established that an organic factor initiated and maintained the disturbance.
1----2----3----4----5----6----7

II. Generalized Anxiety Disorder

A. Unrealistic or excessive anxiety and worry about two or more life circumstances for a period of 6 months or longer, during which the person has been bothered more days than not by these concerns.
1----2----3----4----5----6----7

B. If another Axis I disorder is present, the focus of the anxiety and worry in A is unrelated to it.
1----2----3----4----5----6----7

C. The disturbance does not occur only during the course of a Mood Disorder or a psychotic disorder
1----2----3----4----5----6----7

D. At least 6 of the following 18 symptoms are often present when anxious:
(1) trembling, twitching, or feeling shaky
1----2----3----4----5----6----7
(2) muscle tension, aches, or soreness
1----2----3----4----5----6----7
(3) restlessness
1----2----3----4----5----6----7
(4) easy fatigability
1----2----3----4----5----6----7
(5) shortness of breath or smothering sensations
1----2----3----4----5----6----7
(6) palpitations or accelerated heart rate
1----2----3----4----5----6----7
(7) sweating, or cold clammy hands
1----2----3----4----5----6----7
(8) dry mouth
1----2----3----4----5----6----7
(9) dizziness or lightheadedness
1----2----3----4----5----6----7
(10) nausea, diarrhea, or other abdominal distress
1----2----3----4----5----6----7
(11) flushes (hot flashes) or chills
1----2----3----4----5----6----7
(12) frequent urination
1----2----3----4----5----6----7
(13) trouble swallowing or "lump in the throat"
1----2----3----4----5----6----7

(14) feeling keyed up or on edge
1----2----3----4----5----6----7
(15) exaggerated startle response
1----2----3----4----5----6----7
(16) difficulty concentrating or "mind going blank" because of anxiety
1----2----3----4----5----6----7
(17) trouble falling or staying asleep
1----2----3----4----5----6----7
(18) irritability
1----2----3----4----5----6----7

E. It cannot be established that an organic factor initiated and maintained the disturbance
1----2----3----4----5----6----7

III. Adjustment Disorder

A. A reaction to an identifiable psychosocial stressor (or multiple stressors) that occurs within three months of onset of the stressor(s).
1----2----3----4----5----6----7

B. The maladaptive nature of the reaction is indicated by either of the following:
(1) impairment in occupational functioning or in usual social activities or relationships with others
1----2----3----4----5----6----7
(2) symptoms that are in excess of a normal and expectable reaction to the stressor(s).
1----2----3----4----5----6----7

C. The disturbance is not merely one instance of a pattern of overreaction to stress or an exacerbation of one of the mental disorders previously described.
1----2----3----4----5----6----7

D. The maladaptive pattern has persisted for no longer than six months.
1----2----3----4----5----6----7

E. The disturbance does not meet the criteria for any specific mental disorder and does not represent Uncomplicated Bereavement.
1----2----3----4----5----6----7

IV. Bipolar Disorder

A. Current (or most recent) episode involves the

full symptomatic picture of both Manic and Major Depressive Episodes (except for the duration requirement of two weeks for depressive symptoms), intermixed or rapidly alternating every few days.

1----2----3----4----5----6----7

B. Prominent depressive symptoms lasting at least a full day.

1----2----3----4----5----6----7

V. Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), lack of empathy, and hypersensitivity to the evaluation of others, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) reacts to criticism with feelings of rage, shame, or humiliation (even if not expressed).

1----2----3----4----5----6----7

(2) is interpersonally exploitative: takes advantage of others to achieve his or her own ends.

1----2----3----4----5----6----7

(3) has a grandiose sense of self-importance, e.g., exaggerates achievements and talents, expects to be noticed as "special" without appropriate achievement.

1----2----3----4----5----6----7

(4) believes that his or her problems are unique and can be understood only by other special people.

1----2----3----4----5----6----7

(5) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.

1----2----3----4----5----6----7

(6) has a sense of entitlement: unreasonable expectation of especially favorable treatment.

1----2----3----4----5----6----7

(7) requires constant attention and admiration.

1----2----3----4----5----6----7

(8) lack of empathy: inability to recognize and experience how others feel.

1----2----3----4----5----6----7

(9) is preoccupied with feelings of envy.

1----2----3----4----5----6----7

VI. Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention-seeking, beginning by early adulthood and present

in a variety of contexts, as indicated by at least four of the following:

(1) constantly seeks or demands reassurance, approval, or praise.
1----2----3----4----5----6----7

(2) is inappropriately sexually seductive in appearance or behavior.
1----2----3----4----5----6----7

(3) is overly concerned with physical attractiveness.
1----2----3----4----5----6----7

(4) expresses emotion with inappropriate exaggeration.
1----2----3----4----5----6----7

(5) is uncomfortable in situations in which he or she is not the center of attention.
1----2----3----4----5----6----7

(6) displays rapidly shifting and shallow expressions of emotions.
1----2----3----4----5----6----7

(7) is self-centered, actions being directed toward obtaining immediate satisfaction; has no tolerance for the frustration of delayed gratification.
1----2----3----4----5----6----7

(8) has a style of speech that is excessively impressionistic and lacking in detail.
1----2----3----4----5----6----7

VII. <u>Antisocial Personality Disorder</u>

A. Current age at least 18
1----2----3----4----5----6----7

B. Evidence of Conduct Disorder with onset before age 15, as indicated by a history of three or more of the following:

(1) was often truant.
1----2----3----4----5----6----7

(2) ran away from home overnight at least twice while living in parental or parental surrogate home.
1----2----3----4----5----6----7

(3) often initiated physical fights.
1----2----3----4----5----6----7

(4) used a weapon in more than one fight.
1----2----3----4----5----6----7

(5) forced someone into sexual activity with him or her.
1----2----3----4----5----6----7

(6) was physically cruel to animals.

1----2----3----4----5----6----7

(7) was physically cruel to other people

1----2----3----4----5----6----7

(8) deliberately destroyed others' property (other than by fire-setting).

1----2----3----4----5----6----7

(9) deliberately engaged in fire-setting.

1----2----3----4----5----6----7

(10) often lied (other than to avoid physical or sexual abuse).

1----2----3----4----5----6----7

(11) has stolen without confrontation of a victim on more than one occasion (including forgery).

1----2----3----4----5----6----7

(12) has stolen with confrontation of a victim.

1----2----3----4----5----6----7

C. A pattern of irresponsible and antisocial behavior since the age of 15, as indicated by at least four of the following:

(1) is unable to sustain consistent work behavior, as indicated by any of the following:

(a) significant unemployment for six months or more within five years when expected to work and work was available.

(b) repeated absences from work unexplained by illness in self or family.

(c) abandonment of several jobs without realistic plans for others.

1----2----3----4----5----6----7

(2) fails to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing antisocial acts that are grounds for arrest (whether arrested or not), e.g., destroying property, harassing others, stealing, pursuing an illegal occupation.

1----2----3----4----5----6----7

(3) is irritable and aggressive, as indicated by repeated physical fights or assaults, including spouse - or child-beating.

1----2----3----4----5----6----7

(4) repeatedly fails to honor financial obligations, as indicated by defaulting on debts or failing to provide child support or support for other dependents on a regular basis.

1----2----3----4----5----6----7

(5) fails to plan ahead, or is impulsive, as indicated by one or both of the following:

(a) traveling to place to place without a prearranged job or clear goal for the period of travel or clear idea about when the travel will terminate.

(b) lack of a fixed address for a month or more.

1----2----3----4----5----6----7

(6) has no regard for the truth, as indicated by repeated lying, use of aliases, or "conning" others for personal profit or pleasure.

1----2----3----4----5----6----7

(7) is reckless regarding his or her own or others' personal safety, as indicated by driving while intoxicated, or recurrent speeding.

1----2----3----4----5----6----7

(8) if a parent or guardian, lacks ability to function as a responsible parent, as indicated by one or more of the following:

(a) malnutrition of a child.

1----2----3----4----5----6----7

(b) child's illness resulting from lack of minimal hygiene.

1----2----3----4----5----6----7

(c) failure to obtain medical care for a seriously ill child.

1----2----3----4----5----6----7

(d) child's dependence on neighbors or nonresident relatives for food or shelter.

1----2----3----4----5----6----7

(e) failure to arrange for a caretaker for young child when parent is away from home.

1----2----3----4----5----6----7

(f) repeated squandering, on personal items, of money required for household necessities.

1----2----3----4----5----6----7

(9) has never sustained a totally monogamous relationship for more than one year.

1----2----3----4----5----6----7

(10) lacks remorse.

1----2----3----4----5----6----7

D. Occurrence of antisocial behavior not exclusively during the course of Schizophrenia or Manic Episodes.

1----2----3----4----5----6----7

VIII. Borderline Personality Disorder

A pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation.

1----2----3----4----5----6----7

(2) impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance abuse, shoplifting, reckless driving, binge eating.
1----2----3----4----5----6----7

(3) affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days.
1----2----3----4----5----6----7

(4) inappropriate, intense anger or lack of control of anger.
1----2----3----4----5----6----7

(5) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior.
1----2----3----4----5----6----7

(6) marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals, or career choice, type of friends desired, preferred values.
1----2----3----4----5----6----7

(7) chronic feelings of emptiness or boredom.
1----2----3----4----5----6----7

(8) frantic efforts to avoid real or imagined abandonment.
1----2----3----4----5----6----7

IX. Passive-Aggressive Personality Disorder

A pervasive pattern of passive resistance to demands for adequate social and occupational performance, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) procrastinates, i.e., puts off things that need to be done so that deadlines are not met.
1----2----3----4----5----6----7

(2) becomes sulky, irritable, or argumentative when asked to do something he or she does not want to do.
1----2----3----4----5----6----7

(3) seems to work deliberately slowly or to do a bad job on tasks that he or she really does not want to do.
1----2----3----4----5----6----7

(4) protests, without justification, that others make unreasonable demands on him or her.
1----2----3----4----5----6----7

(5) avoids obligations by claiming to have "forgotten"

1----2----3----4----5----6----7

(6) believes that he or she is doing a much better job than others think he or she is doing.

1----2----3----4----5----6----7

(7) resents useful suggestions from others concerning how he or she could be more productive.

1----2----3----4----5----6----7

(8) obstructs the efforts of others by failing to do his or her share of the work.

1----2----3----4----5----6----7

(9) unreasonably criticizes or scorns people in positions of authority.

1----2----3----4----5----6----7

Appendix P: DSM-III-R Diagnosis Checklist

Please rate on a one to seven scale the extent to which you believe the person described in the case history you just read, should receive one or more of the following diagnoses. Ratings of five and above will indicate that you believe the person fully meets the criteria for that diagnosis.

1----2----3----4----5----6----7
no features of this disorder — definitely diagnosable

1. Dysthymic Disorder

1-----2-----3-----4-----5-----6-----7

2. Generalized Anxiety Disorder

1-----2-----3-----4-----5-----6-----7

3. Adjustment Disorder

1-----2-----3-----4-----5-----6-----7

4. Bi-Polar Disorder

1-----2-----3-----4-----5-----6-----7

5. Narcissistic Personality Disorder

1-----2-----3-----4-----5-----6-----7

6. Histrionic Personality Disorder

1-----2-----3-----4-----5-----6-----7

7. Borderline Personality Disorder

1-----2-----3-----4-----5-----6-----7

8. Antisocial Personality Disorder

1-----2-----3-----4-----5-----6-----7

Appendix Q: Solicitation Letter

Dear Clinician,

I am a doctoral candidate in the clinical psychology program at the University of North Carolina at Greensboro. I am conducting a dissertation research project that depends upon the participation of practicing doctoral level psychologists. The study is a survey of clinicians' diagnostic practices. The survey is designed to take no longer than 20 to 30 (45 to 60) minutes to complete. If you choose to participate, you will read a one page case history, make a diagnosis of the hypothetical client, and complete a post-experimental questionnaire. This study has been fully reviewed and approved by both my departmental dissertation committee and the Human Subjects Review Committee at UNCG. It has been judged to satisfy the American Psychological Association's ethical guidelines, and there is no misinformation or discomfort involved. Each individual participant's responses will be kept strictly confidential.

If you return the survey within by July 15, 1993, your name will be entered in a lottery drawing with a first prize of $50, a second prize of $40, and a third prize of $20. A cashier's check will be sent to you by mail if you are one of the winners in the lottery.

So that your individual responses can be kept strictly confidential, they will be identified only by a code number. This code number is already written on each of your data sheets. Only the primary investigator, Jeanette Kolker, has access to the list matching code numbers and names. This list will only be used to note whether or not each participant's data have been received and to enter the participant in the lottery if their data is received on time. To ensure the confidentiality of your data, please do not write your name on the actual data sheets.

Please try to complete the entire survey uninterrupted and in the order it is stapled together. Please mail back the packet in the envelope that has been provided. Once all the participants have returned their responses, you will receive a debriefing statement, explaining the exact nature of this study. A summary of the general experimental results will also be mailed to you if requested.

If you have any questions about the study, please do not hesitate to contact me or my dissertation chairperson, Rosemery O. Nelson-Gray, Ph.D., at the UNCG Psychology Department, (919) 334-5013. We hope to publish the study's findings and implications, while maintaining the confidentiality of the individual data. Recalling your own years as a graduate student, I am sure you know how

grateful I would be if you participate in this study. Thank you for your consideration.

Sincerely,

Jeanette I. Kolker, M.A.
Doctoral Candidate

Rosemery O. Nelson-Gray, Ph.D.
Dissertation Chairperson

Appendix R: Consent Form

I agree to participate in the present investigation on psychological diaganosis with the understanding that I will be free to terminate my participation at any time. I understand that the information I provide in this study will be assigned an anonymous subject identification number and will be treated as confidential material. I have been informed as to the nature of the experimental procedures. I understand that I will be assigning diagnos(es) for one case history. I understand that the present investigation is in no way meant to represent an evaluation of my diagnostic skills, but is instead a survey of practicing clinicians' clinical impressions. I understand that I will be fully debriefed as to the details of the study as soon as I mail the enclosed materials back to the principal investigator.

Signature:_____

Date:_____

Appendix S: Post-Experimental Questionnaire #1

Please estimate the total number and kinds of patients to whom you have given the following diagnoses (or combination of diagnoses) in the last two years:

		SEX		RACE			SES		
	Total #	M	F	Black	White	Other	Lo	Mid	High
1)	Dysthymic Disorder								
2)	Generalized Anxiety Disorder								
3)	Adjustment Disorder								
4)	Bi-Polar Disorder								
5)	Narcissistic PD								
6)	Histrionic PD								
7)	Borderline PD								
8)	Antisocial PD								
9)	Passive-Aggressive PD								
10)	Histrionic & Borderline PD								
11)	Histrionic & Narcissistic PD								
12)	Histrionic & Antisocial PD								
13)	Antisocial & Narcissistic PD								

Appendix T: Post-Experimental Questionnaire #2

Please estimate the percentage of people in the general population you believe would currently qualify for the following diagnoses (or combination of diagnoses:

		SEX		RACE			SES		
	Total #	M	F	Black	White	Other	Lo	Mid	High
1)	Dysthymic Disorder								
2)	Generalized Anxiety Disorder								
3)	Adjustment Disorder								
4)	Bi-Polar Disorder								
5)	Narcissistic PD								
6)	Histrionic PD								
7)	Borderline PD								
8)	Antisocial PD								
9)	Passive-Aggressive PD								
10)	Histrionic & Borderline PD								
11)	Histrionic & Narcissistic PD								
12)	Histrionic & Antisocial PD								
13)	Antisocial & Narcissistic PD								

Appendix U: Post-Experimental Questionnaire #3

1.) How many times did you refer back to the case history when making your diagnosis for the person presented in the case history?

Not at all _____

Once _____

Twice _____

More than three times _____

2.) Did you refer to a copy of the Diagnostic and Statistical Manual of Mental Disorders - Version III-R (DSM-III-R) while completing the experimental task?

Yes _____ No _____

3.) Please rate your familiarity with the DSM-III-R

1----2----3----4----5----6----7
not at all familiar ... very familiar

4.) Please rate how often you actually use the DSM-III-R when making diagnoses.

1----2----3----4----5----6----7
never use ... always use

Appendix V: Debriefing Letter

Dear Clinician,

Thank you for responding to my survey of clinicians' diagnostic practices. I apologize for the delay between your response and this debriefing letter. Financial difficulties interfered with a more prompt reply.

The purpose of my study was twofold. First of all, I was attempting to determine if an assessment sex bias exists in the diagnosis of selected personality disorders. A random nationwide sample of approximately 2,000 clinicians was extracted from the National Register of Health Service Providers in Psychology. Each clinician was sent one hypothetical case scenario to read and rate on nine DSM-III-R diagnostic categories, five of those categories being personality disorders. Four versions of a case scenario were constructed, which differed according to the number of criteria met for selected personality disorders. In addition, the case scenarios varied by the sex of the client, who was identified as either male or female or not identified according to sex.

The second purpose of my study was to attempt to determine if having clinicians rate the hypothetical client by the specific criteria given for each of the presented diagnoses in the DSM-III-R would have any differential effect on the diagnoses they gave. To achieve this goal, a subsample of clinicians were also asked to rate the hypothetical client according to the DSM-III-R criteria for the offered diagnoses.

Thank you again for participating in my study. I also would like to express my appreciation for those of you who chose to include personal comments in your replies. They enlightened my understanding of a practicing clinician's perspective on many of the important issues facing our field today. To those of you who requested the results of my study, I will send them as soon as they are available. If you did not originally request the results of my study, but would like to receive them now, you may write to me at:

University of North Carolina at Greensboro
Psychology Department
C/O Jeanette Kolker
276 Eberhart Building
Greensboro, North Carolina 27412-5001

If you have any further questions or comments, you may reach me or my dissertation chair, Rosemery Nelson-Gray at (919-334-5013).

Sincerely,

Jeanette
Kolker

Appendix W: Experimental Design

Without DSM-III-R Criterion Checklist

Case Histories

	NPD/w HPD features	HPD/w NPD features	NPD/w APD features	APD/w NPD features
Male	X	X	X	X
Female	X	X	X	X
Gender-Neutral	X	X	X	X

With DSM-III-R Criterion Checklist

Case Histories

	NPD/w HPD features	HPD/w NPD features	NPD/w APD features	APD/w NPD features
Male	X	X	X	
Female	X			X
Gender-Neutral	X			

Appendix X:

Table I

Categorical Analysis: Differences in Diagnosis Across Case Histories

	Sex of Hypothetical Client		
Diagnostic Category	Male	Female	Neutral
Narcissistic PD	89% b	79% a	86% b
Histrionic PD	31%	38%	40%
Borderline PD	17% a	25% b	33% c
Antisocial PD	21%	17%	15%
Passive - Aggressive PD	12%	13%	9%

* Percentages with the different letter subscripts within a row are significantly different at $p < .05$.

Table 2

Narcissistic Personality Disorder with Histrionic Features Case History

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	100% a	35%	10% a	5%	15%
Female	65% b	40%	45% b	0%	10%
Neutral	90% a	66%	29% c	0%	5%

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	95%	50%	0% a	0%	0%
Female	100% a	43%	14% b	0%	5%
Neutral	90%	40%	20% b	5%	5%

Percentages with different letter subscripts within a column are significantly different at $p < .05$

Table 3

Narcissistic Personality Disorder with Antisocial Features Case History

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	100% b	5%	20%	25% b	10%
Female	68% a	23%	9%	5% a	27%
Neutral	100% b	5%	35%	35% b	5%

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	90%	20%	30%	30%	30%

Percentages with different letter subscripts within a column are significantly different at $p < .05$

Table 4

Histrionic Personality Disorder with Narcissistic Features Case History

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	76%	52%	19%	19%	0%
Female	83%	70%	26%	4%	9%
Neutral	95%	71%	48%	10%	19%

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	85%	55%	20%	10%	5%

Table 5

Antisocial Personality Disorder with Narcissistic Features Case History

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	81%	0% b	19%	57%	19%
Female	81%	29% a	14% b	48%	10%
Neutral	57%	14% a	33%	29%	14%

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Female	75%	20%	45% a	45%	15%

Percentages with different letter subscripts within a column are significantly different at $p < .05$.

Table 6

ANOVA Tables for Differences in Certainty Ratings by Sex for the Five Personality Disorder Diagnoses

Narcissistic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	3.3134	1.84	0.1602
Error	369	1.8002		

Histrionic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	12.2723	4.08	0.0176*
Error	369	3.0047		

Borderline Personality Disorder

Source Variable	df	MS	F	p
Sex	2	21.4115	7.59	0.0006*
Error	369	2.8221		

Antisocial Personality Disorder

Source Variable	df	MS	F	p
Sex	2	6.1459	2.15	0.1181
Error	369	2.8602		

Passive-Aggressive Personality Disorder

Source Variable	df	MS	F	p
Sex	2	2.3337	1.06	0.3465
Error	369	2.1957		

*$p < .05$

Table 7

Means Table for Differences in Certainty Ratings by Sex for the Five Personality Disorder Diagnoses

Narcissistic Personality Disorder

Sex of Client	Mean	Standard Error
Male	5.7746	1.4111
Female	5.5039	1.4302
Neutral	5.4951	1.1103

Histrionic Personality Disorder

Sex of Client	Mean	Standard Error
Male	3.3661 a	1.7278
Female	3.7795 b	1.7990
Neutral	3.9805 b	1.6567

Borderline Personality Disorder

Sex of Client	Mean	Standard Error
Male	2.9084 a	1.4965
Female	3.4330 b	1.7301
Neutral	3.7281 b	1.8481

Antisocial Personality Disorder

Sex of Client	Mean	Standard Error
Male	3.0422	1.7171
Female	2.6535	1.7246
Neutral	3.0291	1.6115

Passive-Aggressive Personality Disorder

Sex of Client	Mean	Standard Error
Male	2.4859	1.4814
Female	2.3543	1.5812
Neutral	2.6407	1.3493

For each personality disorder diagnostic category, ratings with different letter subscripts within each row are significantly different at $p < .05$

Table 8

ANOVA Table for Certainty Ratings for PD Diagnostic Categories, by Sex, for Narcissistic PD with Histrionic Features Case History Without DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	7.2425	4.34	0.0138*
Error	354	1.6700		

Histrionic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	3.0683	1.46	0.2343
Error	354	2.1054		

Borderline Personality Disorder

Source Variable	df	MS	F	p
Sex	2	9.0549	3.30	0.0380*
Error	354	2.7427		

Antisocial Personality Disorder

Source Variable	df	MS	F	p
Sex	2	2.3905	1.26	0.2836
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Source Variable	df	MS	F	p
Sex	2	1.5863	0.76	0.4671
Error	354	2.0794		

* $p < .05$

Table 9

Contrast Tables and Certainty Ratings for Sex Comparisons Within Each PD Diagnostic Category for Narcissistic PD with Histrionic Features Case History Without DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	14.4000	8.62	0.0035*
M v. N	1	4.7168	2.82	0.0937
F v. N	1	2.7851	1.67	0.1974
Error	354	1.6700		

Histrionic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	2.0250	0.96	0.3274
M v. N	1	6.0961	2.90	0.0897
F v. N	1	1.0583	0.50	0.4788
Error	354	2.1054		

Borderline Personality Disorder

Contrast	df	MS	F	p
M v. F	1	14.4000	5.25	0.0225*
M v. N	1	12.8281	4.68	0.0312*
F v. N	1	0.0671	0.02	0.8758
Error	354	2.7427		

Antisocial Personality Disorder

Contrast	df	MS	F	p
M v. F	1	3.6000	1.90	0.1684
M v. N	1	0.0005	0.00	0.9867
F v. N	1	3.6005	1.90	0.1684
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Contrast	df	MS	F	p
M v. F	1	3.0250	1.45	0.2286
M v. N	1	0.3010	0.14	0.7038
F v. N	1	1.4681	0.71	0.4013
Error	354	2.0794		

*p < .05
M=male, F=female, N=neutral

Table 9 (continued)

Certainty Ratings

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	6.25 a	3.8	2.5 a	2.15	2.6
Female	5.05 b	4.25	3.7 b	1.55	2.05
Neutral	5.58	4.58	3.6 b	2.14	2.43

Ratings with the different letter subscripts within a column are significantly different at $p < .05$

Table 10

ANOVA Table for Certainty Ratings for PD Diagnostic Categories, by Sex, for Narcissistic PD with Histrionic Features Case History With DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	0.8156	0.49	0.6140
Error	354	1.6700		

Histrionic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	1.6078	0.76	0.4667
Error	354	2.1054		

Borderline Personality Disorder

Source Variable	df	MS	F	p
Sex	2	7.5684	2.76	0.0647
Error	354	2.7427		

Antisocial Personality Disorder

Source Variable	df	MS	F	p
Sex	2	1.8616	0.98	0.3745
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Source Variable	df	MS	F	p
Sex	2	4.0672	1.96	0.1430
Error	354	2.0794		

Table 11

Contrast Tables and Certainty Ratings for Sex Comparisons Within Each PD Diagnostic Category for Narcissistic PD with Histrionic Features Case History With DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	0.6281	0.38	0.5401
M v. N	1	1.6000	0.96	0.3283
F v. N	1	0.2378	0.14	0.7061
Error	354	1.6700		

Histrionic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	2.7598	1.31	0.2530
M v. N	1	2.0250	0.96	0.3274
F v. N	1	0.0488	0.02	0.8790
Error	354	2.1054		

Borderline Personality Disorder

Contrast	df	MS	F	p
M v. F	1	9.1988	3.35	0.0679
M v. N	1	13.2250	4.82	0.0287*
F v. N	1	0.4195	0.15	0.6959
Error	354	2.7427		

Antisocial Personality Disorder

Contrast	df	MS	F	p
M v. F	1	0.1631	0.09	0.7691
M v. N	1	2.0250	1.07	0.3013
F v. N	1	3.4009	1.80	0.1806
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Contrast	df	MS	F	p
M v. F	1	2.5609	1.23	0.2679
M v. N	1	8.1000	3.90	0.0492*
F v. N	1	1.6390	0.79	0.3753
Error	354	2.0794		

* $p < .05$
M=male, F=female, N=neutral

Table 11 (continued)

Table 11 (continued)

Certainty Ratings

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	6.20	4.10	2.10 a	1.65	1.50 a
Female	5.95	4.62	3.05	1.52	2.00
Neutral	5.80	4.55	3.25 b	2.10	2.40 b

Ratings with the different letter subscripts within a column are significantly different at $p < .05$

Table 12

ANOVA Table for Certainty Ratings for PD Diagnostic Categories, by Sex, for Narcissistic PD with Antisocial Features Case History Without DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	1.2351	0.74	0.4781
Error	354	1.6700		

Histrionic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	8.8706	4.21	0.0155*
Error	354	2.1054		

Borderline Personality Disorder

Source Variable	df	MS	F	p
Sex	2	7.2646	2.65	0.0721
Error	354	2.7427		

Antisocial Personality Disorder

Source Variable	df	MS	F	p
Sex	2	6.7684	3.58	0.0289*
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Source Variable	df	MS	F	p
Sex	2	2.2128	1.06	0.3461
Error	354	2.0794		

* $p < .05$

Table 13

Contrast Tables and Certainty Ratings for Sex Comparisons Within Each PD Diagnostic Category for Narcissistic PD with Histrionic Features Case History Without DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	2.3411	1.40	0.2372
M v. N	1	0.2250	0.13	0.7138
F v. N	1	1.0911	0.65	0.4195
Error	354	1.6700		

Histrionic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	17.0911	8.12	0.0046*
M v. N	1	2.0250	0.96	0.3274
F v. N	1	7.1696	3.41	0.0658
Error	354	2.1054		

Borderline Personality Disorder

Contrast	df	MS	F	p
M v. F	1	2.6668	0.97	0.3248
M v. N	1	14.4000	5.25	0.0225*
F v. N	1	5.0668	1.85	0.1750
Error	354	2.7427		

Antisocial Personality Disorder

Contrast	df	MS	F	p
M v. F	1	4.1820	2.21	0.1378
M v. N	1	2.5000	1.32	0.2509
F v. N	1	13.4201	7.10	0.0081*
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Contrast	df	MS	F	p
M v. F	1	2.9629	1.42	0.2334
M v. N	1	0.0250	0.01	0.9128
F v. N	1	3.5463	1.71	0.1924
Error	354	2.0794		

* $p < .05$
M=male, F=female, N=neutral

Table 13 (continued)

Certainty Ratings

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	6.20	1.95 a	2.45 a	3.45	2.65
Female	5.73	3.23 b	2.95	2.82 a	3.18
Neutral	6.05	2.40	3.65 b	3.95 b	2.60

Ratings with the different letter subscripts within each column are significantly different at $p < .05$

Table 14

ANOVA Table for Certainty Ratings for PD Diagnostic Categories, by Sex, for Histrionic PD with Narcissistic Features Case History Without DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	0.3025	0.18	0.8344
Error	354	1.6700		

Histrionic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	7.9501	3.78	0.0238*
Error	354	2.1054		

Borderline Personality Disorder

Source Variable	df	MS	F	p
Sex	2	6.5942	2.40	0.0918
Error	354	2.7427		

Antisocial Personality Disorder

Source Variable	df	MS	F	p
Sex	2	3.827	1.63	0.1972
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Source Variable	df	MS	F	p
Sex	2	1.6386	0.79	0.4556
Error	354	2.0794		

* $p < .05$

Table 15

Contrast Tables and Certainty Ratings for Sex Comparisons Within Each PD Diagnostic Category for Histrionic PD with Narcissistic Features Case History Without DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	0.2305	0.14	0.7104
M v. N	1	0.5952	0.36	0.5509
F v. N	1	0.0952	0.06	0.8114
Error	354	1.6700		

Histrionic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	8.0649	3.83	0.0511*
M v. N	1	14.8809	7.07	0.0082*
F v. N	1	1.2196	0.58	0.4471
Error	354	2.1054		

Borderline Personality Disorder

Contrast	df	MS	F	p
M v. F	1	6.1321	2.24	0.1357
M v. N	1	12.5952	4.59	0.0328*
F v. N	1	1.3280	0.48	0.4870
Error	354	2.7427		

Antisocial Personality Disorder

Contrast	df	MS	F	p
M v. F	1	4.2067	2.23	0.1366
M v. N	1	0.0238	0.01	0.9107
F v. N	1	4.8787	2.58	0.1090
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Contrast	df	MS	F	p
M v. F	1	0.0830	0.04	0.8418
M v. N	1	1.9285	0.93	0.3362
F v. N	1	2.9174	1.40	0.2370
Error	354	2.0794		

* $p < .05$
M=male, F=female, N=neutral

Table 15 (continued)

Certainty Ratings

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.33	4.14 a	2.9 a	2.6	2.0
Female	5.48	5.0 b	3.6	2.0	1.9
Neutral	5.58	5.3 b	4.0 b	2.7	2.4

Ratings with the different letter subscripts within a column are significantly different at $p < .05$

Table 16

ANOVA Table for Certainty Ratings for PD Diagnostic Categories, by Sex, for Antisocial PD with Narcissistic Features Case History Without DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	8.1111	4.86	0.0083*
Error	354	1.6700		

Histrionic Personality Disorder

Source Variable	df	MS	F	p
Sex	2	4.6349	2.20	0.1122
Error	354	2.1054		

Borderline Personality Disorder

Source Variable	df	MS	F	p
Sex	2	4.6349	1.69	0.1860
Error	354	2.7427		

Antisocial Personality Disorder

Source Variable	df	MS	F	p
Sex	2	1.6434	0.87	0.4219
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Source Variable	df	MS	F	p
Sex	2	4.0000	1.92	0.1476
Error	354	2.0794		

* $p < .05$

Table 17

Contrast Tables and Certainty Ratings for Sex Comparisons Within Each PD Diagnostic Category for Antisocial PD with Narcissistic Features Case History Without DSM-III-R Criterion Checklist

Narcissistic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	5.3571	3.21	0.0741
M v. N	1	2.8809	1.73	0.1899
F v. N	1	16.0952	9.64	0.0021*
Error	354	1.6700		

Histrionic Personality Disorder

Contrast	df	MS	F	p
M v. F	1	6.0952	2.89	0.0897
M v. N	1	7.7142	3.66	0.0564
F v. N	1	0.0952	0.05	0.8317
Error	354	2.1054		

Borderline Personality Disorder

Contrast	df	MS	F	p
M v. F	1	0.0952	0.03	0.8523
M v. N	1	7.7142	2.81	0.0944
F v. N	1	6.0952	2.22	0.1369
Error	354	2.7427		

Antisocial Personality Disorder

Contrast	df	MS	F	p
M v. F	1	1.9285	1.02	0.3131
M v. N	1	2.8809	1.52	0.2178
F v. N	1	0.0952	0.05	0.8225
Error	354	1.8900		

Passive-Aggressive Personality Disorder

Contrast	df	MS	F	p
M v. F	1	3.4285	1.65	0.2000
M v. N	1	0.8571	0.41	0.5213
F v. N	1	7.7142	3.71	0.0549
Error	354	2.0794		

* $p < .05$
M=male, F=female, N=neutral

Table 17 (continued)

Certainty Ratings

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.05	2.14	3.24	4.81	3.05
Female	5.76 a	2.90	3.33	4.38	2.48
Neutral	4.52 b	3.0	4.09	4.28	3.33

Ratings with the different letter subscripts within a column are significantly different at $p < .05$

Table 18

Estimate Table and Certainty Ratings for Narcissistic PD with Antisocial Features Case

Narcissistic Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
+0.2500	+0.61	0.5411	0.4086

Histrionic Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.9000	-1.96	0.0506*	0.4588

Borderline Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-1.4500	-2.77	0.0059*	0.5237

Antisocial Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.6000	-1.38	0.1684	0.4347

Passive-Aggressive Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.2500	-0.55	0.5839	0.4560

Table 18 (continued)

Mean Certainty Ratings

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	6.20	1.95 a	2.45 a	3.45	2.65

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.95	2.85 b	3.90 b	4.05	2.90

Ratings with different letter subscripts within a PD diagnostic category (column) are significantly different at $p < .05$

Table 19

Estimate Tables and Certainty Ratings for Histrionic PD with Narcissistic Features Case

Narcissistic Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.1666	-0.41	0.6800	0.4037

Histrionic Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.4571	-1.01	0.3140	0.4533

Borderline Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.3452	-0.67	0.5051	0.5174

Antisocial Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
+0.1190	+0.28	0.7818	0.4295

Passive-Aggressive Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.7000	-1.55	0.1212	0.4505

Table 19 (continued

Mean Certainty Ratings

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.33	4.14	2.90	2.62	2.0

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.50	4.60	3.25	2.50	2.70

Table 20

Estimate Tables and Certainty Ratings for Antisocial PD with Narcissistic Features Case

Narcissistic Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
+0.7619	+1.89	0.0600	0.4037

Histrionic Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
+0.3547	+0.78	0.4344	0.4533

Borderline Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.6166	-1.19	0.2341	0.5174

Antisocial Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
+0.6809	+1.59	0.1138	0.4295

Passive-Aggressive Personality Disorder

Estimate	T for HO: Parameter=0	Pr > |T|	Std Error of Estimate
-0.0238	-0.05	0.9579	0.4505

Table 20 (continued)

Mean Certainty Ratings

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Female	5.76 a	2.90	3.33	4.38	2.48

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Female	5.00 b	2.55	3.95	3.70	2.50

Ratings with different letter subscripts within a column approach significance at $p < .06$

Table 21

Narcissistic Personality Disorder with Histrionic Features Case Profile

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	6.25 a	3.8 b	2.5 c	2.15 c	2.6 c
Female	5.05 a	4.25 b	3.7 b	1.55 c	2.05 c
Neutral	5.58 a	4.58 b	3.62 c	2.14 d	2.43 d

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	6.2 a	4.1 b	2.1 c	1.65 c	1.5 c
Female	5.95 a	4.62 b	3.05 c	1.52 d	2.05 d
Neutral	5.8 a	4.55 b	3.25 c	2.10 d	2.4 d

* ratings with different letter subscripts within the same row, are significantly different at $p < .05$

Table 22

Narcissistic Personality Disorder with Antisocial Features Case Version

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	6.2 a	1.95 b	2.45 b	3.45 c	2.65 b
Female	5.73 a	3.25 b	2.9 b	2.8 b	3.2 b
Neutral	6.05 a	2.4 b	3.65 c	3.95 c	2.6 b

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.95 a	2.85 b	3.9 c	4.05 c	2.9 b

* ratings with different letter subscripts within a row, are significantly different at $p < .05$

Table 23

Histrionic Personality Disorder with Narcissistic Features Case Profile

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.33 a	4.14 b	2.9 c	2.62 cd	2.0 d
Female	5.48 a	5.0 a	4.0 b	2.0 c	1.91 c
Neutral	5.58 a	5.33 a	4.0 b	2.67 c	2.43 c

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.5 a	4.6 b	3.25 c	2.5 c	2.7 c

* ratings with different letter subscripts within a row, are significantly different at $p < .05$

Table 24

Antisocial Personality Disorder with Narcissistic Features Case Profile

Without DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Male	5.05 a	2.14 b	3.24 c	4.81 a	3.1 c
Female	5.16 a	2.90 b	3.33 b	4.38 c	2.5 bd
Neutral	4.52 a	3.0 b	4.1 ac	4.28 a	3.3 bc

With DSM-III-R criterion checklist

	Diagnostic Category				
Sex of Client	NPD	HPD	BPD	APD	PAPD
Female	5.0 a	2.55 b	3.95 c	3.7 c	2.5 b

* ratings with different letter subscripts within a row, are significantly different at $p < .05$

Table 25: Post-Experimental Questionnaire #1

Please estimate the total number and kinds of patients to whom you have given the following diagnoses (or combination of diagnoses)in the last two years:

	Total #	SEX		RACE			SES		
		M	F	Black	White	Other	Lo	Mid	High
1) Dysthymic Disorder	**31.4** 49.5	**13.1** 23.5	**20.3** 30.3	**6.0** 25.8	**27.3** 39.7	**2.3** 7.3	**13** 39	**19** 26.7	**5** 8.1
2) Generalized Anxiety Disorder	**14.8** 20.1	**7** 10	**8.8** 12.3	**2.1** 6.7	**12.8** 16.5	**.88** 2.92	**4** 11	**9.4** 13.0	**2.7** 4.5
3) Adjustment Disorder	**8.5** 25.5	**10** 26.1	**2.4** 6.2	**4.2** 12.1	**8.5** 26.1	**1.2** 8.7	**8.3** 27	**4.5** 9.3	**1.1** 2.9
4) Bi-Polar Disorder	**10.1** 26.6	**7.2** 15.3	**5.9** 15.0	**2.3** 7.4	**11.1** 28.4	**.64** 2.4	**7.5** 28	**5.5** 8.3	**1.8** 3.6
5) Narcissistic PD	**7.1** 22.6	**5.9** 22.1	**2.8** 4.4	**.89** 2.91	**8.1** 24.8	**.35** 1.4	**3.3** 20	**4.1** 7.7	**2.4** 7.1
6) Histrionic PD	**4.8** 11.9	**2.7** 7.5	**5.0** 8.8	**1.02** 3.51	**6.3** 12.3	**.57** 2.30	**2.3** 6.0	**4.6** 8.2	**1.5** 4.7
7) Borderline PD	**11.0** 21.4	**5.3** 14.3	**6.8** 9.8	**2.3** 7.3	**9.6** 17.4	**.67** 2.4	**5.2** 16	**6.1** 9.9	**2.0** 4.2
8) Antisocial	**4.6** 12.5	**4.2** 8.5	**.9** 3.8	**3.5** 2.7	**2.8** 4.5	**.50** 1.2	**3.1** 8.0	**1.8** 4.3	**.4** 3.2
9) Passive-Aggressive PD	**7.2** 22.3	**6.6** 18.4	**4.4** 10.0	**2.7** 12.2	**8.5** 20.7	**.35** 1.3	**4.6** 15	**5.8** 13.2	**1.6** 6.6
10) Histrionic & Borderline PD	**6.0** 22.4	**4.1** 8.4	**9.5** 25.0	**3.7** 15.5	**11.0** 23.8	**.60** 1.93	**5.8** 17	**7.1** 16.6	**1.5** 3.7
11) Histrionic & Narcissistic PD	**5.0** 20.7	**4.2** 9.0	**7.5** 22.4	**3.5** 15.8	**8.9** 18.1	**.41** 1.02	**4.5** 11	**6.4** 16.2	**2.6** 8.8
12) Histrionic & Antisocial PD	**3.4** 19.6	**5.8** 12.6	**8.2** 28.9	**4.5** 19.7	**9.6** 22.5	**.32** .84	**4.7** 12	**7.1** 20.4	**3.6** 11
13) Antisocial & Narcissistic	**4.7** 20.8	**7.8** 23.0	**3.4** 11.1	**3.2** 15.3	**7.2** 18.6	**.27** .72	**5.0** 15	**4.1** 12.0	**2.8** 12

*top numbers (in bold) are the means for each cell.
**bottom numbers are the standard deviations.

Table 26: Post-Experimental Questionnaire #2

Please estimate the percentage of persons in the general population you believe currently would qualify for the following diagnoses:

			SEX		RACE			SES		
		Total %	M	F	Black	White	Other	Lo	Mid	High
1)	Dysthymic Disorder	12.8 13.1	11.5 13.2	18.2 21.7	13.5 14.2	14.6 15.4	7.6 9.0	12 11	13 15	8.9 8.7
2)	Generalized Anxiety Disorder	10.6 13.4	11.4 14.9	14.9 20.8	10.1 12.4	14.0 17.5	5.9 8.4	9.4 11	12 16	8.0 10
3)	Adjustment Disorder	16.4 15.8	16.4 19.0	16.4 18.6	14.2 13.8	16.3 16.5	9.3 11.1	12 12	14 15	11 12
4)	Bi-Polar Disorder	4.2 5.7	9.9 18.7	9.4 17.5	6.8 12.5	9.5 18.2	3.7 7.1	5.4 9.3	8.5 17	5.6 9.8
5)	Narcissistic PD	5.1 6.4	11.2 18.9	9.6 16.9	7.5 12.4	11.2 18.1	4.2 7.8	5.9 10	8.4 13.7	8.2 15
6)	Histrionic PD	3.9 4.7	6.9 13.6	12.4 22.9	7.0 12.7	9.7 17.6	3.6 7.4	5.7 10	7.8 14.6	5.3 9.4
7)	Borderline PD	6.3 8.3	8.9 14.9	11.8 19.1	8.2 12.5	10.9 16.9	4.5 7.9	7.3 11	8.9 14.0	5.9 8.7
8)	Antisocial PD	5.2 5.2	15.1 26.6	4.9 8.9	9.6 14.8	9.2 14.8	4.5 8.1	9.2 14	7.3 12.3	4.9 8.2
9)	Passive-Aggressive PD	5.9 7.7	10.8 18.9	10.3 17.8	7.9 13.0	10.2 16.8	3.9 7.1	7.1 13	8.1 13.7	5.1 8.4
10)	Histrionic & Borderline PD	3.4 4.8	7.9 14.7	13.2 23.0	7.5 13.6	9.9 16.9	4.0 7.7	6.6 12	8.0 15.2	4.9 8.4
11)	Histrionic & Narcissistic PD	3.4 5.3	9.2 15.9	13.1 22.5	7.6 13.3	10.5 18.2	3.9 7.9	6.8 12	8.1 14.5	5.9 10
12)	Histrionic & Antisocial PD	2.5 3.2	11.6 22.1	9.6 18.0	8.3 16.1	8.7 16.2	3.7 7.8	7.8 15	7.3 14.9	4.3 7.9
13)	Antisocial & Narcissistic PD	3.1 4.9	13.5 25.1	7.2 13.6	7.4 13.8	8.6 15.9	4.0 8.5	5.6 11	7.0 14.9	4.9 11

*top numbers (in bold) in each cell are mean percentages.
**bottom numbers in each cell are standard deviations.

Table 27: Post-Experimental Questionnaire #3

1.) How many times did you refer back to the case history when making your diagnosis for the person presented in the case history?

Not at all ----------32.1% (N= 119)
Once ----------26.5% (N= 98)
Twice ----------20.0% (N= 73)
More than three times---21.4% (N= 79)

2.) Did you refer to a copy of the Diagnostic and Statistical Manual of Mental Disorders - Version III-R (DSM-III-R) while completing the experimental task?

Yes ---24.1% (N=89)
No ----75.9% (N=281)

3.) Please rate your familiarity with the DSM-III-R

1----2----3----4----5----6----7
not at all familiar ... very familiar

Mean = 5.38 (SD = 1.13)

4.) Please rate how often you actually use the DSM-III-R when making diagnoses.

1----2----3----4----5----6----7
never use ... always use

Mean = 5.19 (SD = 1.50)

Table 28: Narcissistic Personality Disorder with Histrionic Features Case History: Demographic Data on Subjects According to Diagnosis

Correct Diagnosis

Demographic Data	#	Mean
Female	48	
Male	62	
Age		49.2 (SD = 9.10
Psychodynamic Orientation	31	
Cognitive-Behavioral Orientation	27	
Social Learning Orientation	1	
Systems Orientation	5	
Existential-Humanistic Orientation	4	
Interpersonal Orientation	6	
Rogerian Orientation	0	
Gestalt Orientation	0	
Eclectic Orientation	34	
Other Orientation	1	
Year Received Ph.D. or Psy.D.		74.6 (SD = 8.38)
Avg. Hrs. per week in Individual tx.		16.8 (SD = 11.2)
Avg. Hrs. per week in Group tx.		1.1 (SD = 2.02)
Avg. Hrs. per week in Couples tx.		1.9 (SD = 2.36)
Avg. Hrs. per week in Diagnosis		7.5 (SD = 9.64)
Avg. Hrs. per week in Consultation		2.9 (SD = 5.25)
Avg. Hrs. per week in Family tx.		1.2 (SD = 2.31)
Avg. Hrs. per week in Supervision		2.1 (SD = 3.73)
Avg. Hrs. per week in Teaching		2.7 (SD = 6.05)
Avg. Hrs. per week in Other		.3 (SD = 1.53)

Table 28 (continued)

Correct Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	95	
Practice in Hospital	24	
Practice as a Professor	15	
Practice in Counseling Center	1	
Practice in Community M. Health	10	
Practice in Other	8	
Work with Children (under 12)	55	
Work with Adolescents (age 13-17)	75	
Work with Adults (age 18-64)	109	
Work with Aged (age 65 and over)	61	
Did not refer to case history	33	
Referred to case history once	24	
Referred to case history twice	25	
Referred to case history 3x or more	28	
Referred to DSM-III-R	29	
Familiarity with DSM-III-R		5.3 (SD = 1.11)
How often use DSM-III-R		5.3 (SD = 1.37)

Table 29: Narcissistic Personality Disorder with Histrionic Features Case History: Demographic Data on Subjects According to Diagnosis

Close Diagnosis

Demographic Data	#	Mean
Female	1	
Male	0	
Age	61	
Psychodynamic Orientation	1	
Cognitive-Behavioral Orientation	0	
Social Learning Orientation	0	
Systems Orientation	0	
Existential-Humanistic Orientation	0	
Interpersonal Orientation	0	
Rogerian Orientation	0	
Gestalt Orientation	0	
Eclectic Orientation	0	
Other Orientation	0	
Year Received Ph.D. or Psy.D.		1979
Avg. Hrs. per week in Individual tx.		25
Avg. Hrs. per week in Group tx.		0
Avg. Hrs. per week in Couples tx.		4
Avg. Hrs. per week in Diagnosis		0
Avg. Hrs. per week in Consultation		1
Avg. Hrs. per week in Family tx.		0
Avg. Hrs. per week in Supervision		2
Avg. Hrs. per week in Teaching		0
Avg. Hrs. per week in Other		0

Table 29 (continued)

Close Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	1	
Practice in Hospital	0	
Practice as a Professor	0	
Practice in Counseling Center	0	
Practice in Community M. Health	0	
Practice in Other	1	
Work with Children (under 12)	1	
Work with Adolescents (age 13-17)	1	
Work with Adults (age 18-64)	1	
Work with Aged (age 65 and over)	1	
Did not refer to case history	0	
Referred to case history once	1	
Referred to case history twice	0	
Referred to case history 3x or more	0	
Referred to DSM-III-R	0	
Familiarity with DSM-III-R		6.0
How often use DSM-III-R		6.0

Table 30: Narcissistic Personality Disorder with Histrionic Features Case History: Demographic Data on Subjects According to Diagnosis

Demographic Data	#	Mean
Female	3	
Male	8	
Age		49.6 (SD = 12.6)
Psychodynamic Orientation	3	
Cognitive-Behavioral Orientation	5	
Social Learning Orientation	0	
Systems Orientation	0	
Existential-Humanistic Orientation	0	
Interpersonal Orientation	0	
Rogerian Orientation	0	
Gestalt Orientation	0	
Eclectic Orientation	3	
Other Orientation	0	
Year Received Ph.D. or Psy.D.		75.9 (SD = 10.1)
Avg. Hrs. per week in Individual tx.		17.1 (SD = 11.4)
Avg. Hrs. per week in Group tx.		3.1 (SD = 6.3)
Avg. Hrs. per week in Couples tx.		.8 (SD = 1.3)
Avg. Hrs. per week in Diagnosis		6.7 (SD = 9.2)
Avg. Hrs. per week in Consultation		2.9 (SD = 4.5)
Avg. Hrs. per week in Family tx.		1.3 (SD = 2.5)
Avg. Hrs. per week in Supervision		3.4 (SD = 7.4)
Avg. Hrs. per week in Teaching		3.4 (SD = 6.7)
Avg. Hrs. per week in Other		.5 (SD = 1.2)

Table 30 (continued)

Wrong Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	10	
Practice in Hospital	2	
Practice as a Professor	2	
Practice in Counseling Center	1	
Practice in Community M. Health	0	
Practice in Other	0	
Work with Children (under 12)	3	
Work with Adolescents (age 13-17)	6	
Work with Adults (age 18-64)	10	
Work with Aged (age 65 and over)	6	
Did not refer to case history	5	
Referred to case history once	4	
Referred to case history twice	1	
Referred to case history 3x or more	0	
Referred to DSM-III-R	1	
Familiarity with DSM-III-R		5.0 (SD = 1.6)
How often use DSM-III-R		4.2 (SD = 2.2)

Table 31: Narcissistic Personality Disorder with Antisocial Features Case History: Demographic Data on Subjects According to Diagnosis

Correct Diagnosis

Demographic Data	#	Mean
Female	34	
Male	39	
Age		51.4 (SD = 9.89)
Psychodynamic Orientation	22	
Cognitive-Behavioral Orientation	18	
Social Learning Orientation	0	
Systems Orientation	3	
Existential-Humanistic Orientation	2	
Interpersonal Orientation	2	
Rogerian Orientation	0	
Gestalt Orientation	2	
Eclectic Orientation	21	
Other Orientation	4	
Year Received Ph.D. or Psy.D.		72.7 (SD = 9.35)
Avg. Hrs. per week in Individual tx.		15.7 (SD = 10.8)
Avg. Hrs. per week in Group tx.		.8 (SD = 2.56)
Avg. Hrs. per week in Couples tx.		2.3 (SD = 2.43)
Avg. Hrs. per week in Diagnosis		4.4 (SD = 8.68)
Avg. Hrs. per week in Consultation		1.8 (SD = 4.28)
Avg. Hrs. per week in Family tx.		1.0 (SD = 2.16)
Avg. Hrs. per week in Supervision		1.6 (SD = 2.29)
Avg. Hrs. per week in Teaching		2.8 (SD = 6.45)
Avg. Hrs. per week in Other		7.4 (SD = 21.3)

Table 31 (continued)

Correct Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	57	
Practice in Hospital	6	
Practice as a Professor	14	
Practice in Counseling Center	3	
Practice in Community M. Health	14	
Practice in Other	5	
Work with Children (under 12)	38	
Work with Adolescents (age 13-17)	48	
Work with Adults (age 18-64)	71	
Work with Aged (age 65 and over)	42	
Did not refer to case history	25	
Referred to case history once	22	
Referred to case history twice	13	
Referred to case history 3x or more	13	
Referred to DSM-III-R	20	
Familiarity with DSM-III-R		5.3 (SD = 1.23)
How often use DSM-III-R		5.1 (SD = 1.64)

Table 32: Narcissistic Personality Disorder with Antisocial Features Case History: Demographic Data on Subjects According to Diagnosis

Wrong Diagnosis

Demographic Data	#	Mean
Female	5	
Male	4	
Age		52.2 (SD = 12.3)
Psychodynamic Orientation	0	
Cognitive-Behavioral Orientation	3	
Social Learning Orientation	0	
Systems Orientation	0	
Existential-Humanistic Orientation	0	
Interpersonal Orientation	1	
Rogerian Orientation	0	
Gestalt Orientation	0	
Eclectic Orientation	5	
Other Orientation	0	
Year Received Ph.D. or Psy.D.		72.6 (SD = 8.78)
Avg. Hrs. per week in Individual tx.		15.5 (SD = 13.0)
Avg. Hrs. per week in Group tx.		.7 (SD = 1.65)
Avg. Hrs. per week in Couples tx.		0
Avg. Hrs. per week in Diagnosis		10.3 (SD = 13.7)
Avg. Hrs. per week in Consultation		3.1 (SD = 6.47)
Avg. Hrs. per week in Family tx.		0
Avg. Hrs. per week in Supervision		1.8 (SD = 1.76)
Avg. Hrs. per week in Teaching		.4 (SD = 1.01)
Avg. Hrs. per week in Other		17.4 (SD = 34.6)

Table 32 (continued)

Wrong Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	8	
Practice in Hospital	2	
Practice as a Professor	1	
Practice in Counseling Center	0	
Practice in Community M. Health	0	
Practice in Other	1	
Work with Children (under 12)	2	
Work with Adolescents (age 13-17)	1	
Work with Adults (age 18-64)	7	
Work with Aged (age 65 and over)	5	
Did not refer to case history	4	
Referred to case history once	4	
Referred to case history twice	0	
Referred to case history 3x or more	1	
Referred to DSM-III-R	8	
Familiarity with DSM-III-R		4.3 (SD = 1.80)
How often use DSM-III-R		3.9 (SD = 1.61)

Table 33: Histrionic Personality Disorder with Narcissistic Features Case History: Demographic Data on Subjects According to Diagnosis

Correct Diagnosis

Demographic Data	#	Mean
Female	22	
Male	31	
Age		53.1 (SD = 9.94)
Psychodynamic Orientation	15	
Cognitive-Behavioral Orientation	10	
Social Learning Orientation	2	
Systems Orientation	4	
Existential-Humanistic Orientation	0	
Interpersonal Orientation	1	
Rogerian Orientation	2	
Gestalt Orientation	0	
Eclectic Orientation	18	
Other Orientation	0	
Year Received Ph.D. or Psy.D.		70.9 (SD = 9.95)
Avg. Hrs. per week in Individual tx.		17.9 (SD = 10.3)
Avg. Hrs. per week in Group tx.		1.2 (SD = 2.18)
Avg. Hrs. per week in Couples tx.		1.9 (SD = 3.35)
Avg. Hrs. per week in Diagnosis		4.1 (SD = 6.51)
Avg. Hrs. per week in Consultation		2.7 (SD = 3.96)
Avg. Hrs. per week in Family tx.		1.3 (SD = 2.63)
Avg. Hrs. per week in Supervision		2.2 (SD = 3.00)
Avg. Hrs. per week in Teaching		3.7 (SD = 7.88)
Avg. Hrs. per week in Other		7.1 (SD = 22.1)

Table 33 (continued)

Correct Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	44	
Practice in Hospital	16	
Practice as a Professor	9	
Practice in Counseling Center	0	
Practice in Community M. Health	2	
Practice in Other	4	
Work with Children (under 12)	21	
Work with Adolescents (age 13-17)	36	
Work with Adults (age 18-64)	53	
Work with Aged (age 65 and over)	25	
Did not refer to case history	16	
Referred to case history once	16	
Referred to case history twice	10	
Referred to case history 3x or more	11	
Referred to DSM-III-R	15	
Familiarity with DSM-III-R		5.60 (SD = 1.02)
How often use DSM-III-R		5.52 (SD = 1.15)

Table 34: Histrionic Personality Disorder with Narcissistic Features Case History: Demographic Data on Subjects According to Diagnosis

Close Diagnosis

Demographic Data	#	Mean
Female	9	
Male	15	
Age		48.2 (SD = 5.65)
Psychodynamic Orientation	8	
Cognitive-Behavioral Orientation	8	
Social Learning Orientation	0	
Systems Orientation	1	
Existential-Humanistic Orientation	0	
Interpersonal Orientation	1	
Rogerian Orientation	0	
Gestalt Orientation	0	
Eclectic Orientation	6	
Other Orientation	0	
Year Received Ph.D. or Psy.D.		73.4 (SD = 5.85)
Avg. Hrs. per week in Individual tx.		18.8 (SD = 10.8)
Avg. Hrs. per week in Group tx.		1.4 (SD = 1.69)
Avg. Hrs. per week in Couples tx.		2.7 (SD = 3.50)
Avg. Hrs. per week in Diagnosis		6.4 (SD = 9.65)
Avg. Hrs. per week in Consultation		5.6 (SD = 10.3)
Avg. Hrs. per week in Family tx.		.4 (SD = 1.28)
Avg. Hrs. per week in Supervision		.8 (SD = 1.02)
Avg. Hrs. per week in Teaching		2.0 (SD = 5.67)
Avg. Hrs. per week in Other		6.4 (SD = 9.65)

Table 34 (continued)

Close Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	21	
Practice in Hospital	6	
Practice as a Professor	3	
Practice in Counseling Center	1	
Practice in Community M. Health	2	
Practice in Other	2	
Work with Children (under 12)	9	
Work with Adolescents (age 13-17)	20	
Work with Adults (age 18-64)	24	
Work with Aged (age 65 and over)	17	
Did not refer to case history	7	
Referred to case history once	6	
Referred to case history twice	6	
Referred to case history 3x or more	5	
Referred to DSM-III-R	3	
Familiarity with DSM-III-R		5.79 (SD = .721)
How often use DSM-III-R		5.79 (SD = 1.25)

Table 35: Histrionic Personality Disorder with Narcissistic Features Case History: Demographic Data on Subjects According to Diagnosis

Wrong Diagnosis

Demographic Data	#	Mean
Female	4	
Male	4	
Age		54.6 (SD = 10.1)
Psychodynamic Orientation	3	
Cognitive-Behavioral Orientation	1	
Social Learning Orientation	0	
Systems Orientation	0	
Existential-Humanistic Orientation	0	
Interpersonal Orientation	0	
Rogerian Orientation	0	
Gestalt Orientation	0	
Eclectic Orientation	4	
Other Orientation	0	
Year Received Ph.D. or Psy.D.		70.7 (SD = 9.30)
Avg. Hrs. per week in Individual tx.		14.0 (SD = 6.69)
Avg. Hrs. per week in Group tx.		1.8 (SD = 5.30)
Avg. Hrs. per week in Couples tx.		1.7 (SD = 3.61)
Avg. Hrs. per week in Diagnosis		3.0 (SD = 2.26)
Avg. Hrs. per week in Consultation		3.2 (SD = 1.75)
Avg. Hrs. per week in Family tx.		1.6 (SD = 3.46)
Avg. Hrs. per week in Supervision		3.0 (SD = 2.20)
Avg. Hrs. per week in Teaching		5.7 (SD = 5.97)
Avg. Hrs. per week in Other		19.0 (SD = 35.2)

Table 35 (continued)

Wrong Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	7	
Practice in Hospital	0	
Practice as a Professor	4	
Practice in Counseling Center	0	
Practice in Community M. Health	1	
Practice in Other	2	
Work with Children (under 12)	2	
Work with Adolescents (age 13-17)	3	
Work with Adults (age 18-64)	8	
Work with Aged (age 65 and over)	3	
Did not refer to case history	3	
Referred to case history once	3	
Referred to case history twice	0	
Referred to case history 3x or more	2	
Referred to DSM-III-R	2	
Familiarity with DSM-III-R		5.62 (SD = .744)
How often use DSM-III-R		5.00 (SD = 1.41

Table 36: Antisocial Personality Disorder with Narcissistic Features Case History: Demographic Data on Subjects According to Diagnosis

Correct Diagnosis

Demographic Data	#	Mean
Female	13	
Male	24	
Age		49.1 (SD = 7.32)
Psychodynamic Orientation	8	
Cognitive-Behavioral Orientation	7	
Social Learning Orientation	3	
Systems Orientation	2	
Existential-Humanistic Orientation	2	
Interpersonal Orientation	2	
Rogerian Orientation	2	
Gestalt Orientation	0	
Eclectic Orientation	8	
Other Orientation	3	
Year Received Ph.D. or Psy.D.		74.9 (SD = 7.18)
Avg. Hrs. per week in Individual tx.		15.5 (SD = 8.98)
Avg. Hrs. per week in Group tx.		.8 (SD = 2.07)
Avg. Hrs. per week in Couples tx.		1.6 (SD = 1.77)
Avg. Hrs. per week in Diagnosis		3.5 (SD = 6.32)
Avg. Hrs. per week in Consultation		3.2 (SD = 6.52)
Avg. Hrs. per week in Family tx.		.9 (SD = 1.47)
Avg. Hrs. per week in Supervision		1.6 (SD = 2.61)
Avg. Hrs. per week in Teaching		2.5 (SD = 6.32)
Avg. Hrs. per week in Other		10.7 (SD = 22.6)

Table 36 (continued)

Correct Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	32	
Practice in Hospital	11	
Practice as a Professor	5	
Practice in Counseling Center	5	
Practice in Community M. Health	1	
Practice in Other	4	
Work with Children (under 12)	14	
Work with Adolescents (age 13-17)	24	
Work with Adults (age 18-64)	37	
Work with Aged (age 65 and over)	17	
Did not refer to case history	9	
Referred to case history once	6	
Referred to case history twice	9	
Referred to case history 3x or more	13	
Referred to DSM-III-R	24	
Familiarity with DSM-III-R		5.32 (SD = 1.15)
How often use DSM-III-R		5.35 (SD = 1.42)

Table 37: Antisocial Personality Disorder with Narcissistic Features Case History: Demographic Data on Subjects According to Diagnosis - Close Diagnosis

Close Diagnosis

Demographic Data	#	Mean
Female	15	
Male	16	
Age		50.7 (SD = 9.92)
Psychodynamic Orientation	8	
Cognitive-Behavioral Orientation	12	
Social Learning Orientation	2	
Systems Orientation	0	
Existential-Humanistic Orientation	4	
Interpersonal Orientation	2	
Rogerian Orientation	0	
Gestalt Orientation	0	
Eclectic Orientation	4	
Other Orientation	1	
Year Received Ph.D. or Psy.D.		73.9 (SD = 9.49)
Avg. Hrs. per week in Individual tx.		14.9 (SD = 10.3)
Avg. Hrs. per week in Group tx.		2.1 (SD = 4.10)
Avg. Hrs. per week in Couples tx.		2.4 (SD = 3.38)
Avg. Hrs. per week in Diagnosis		5.3 (SD = 8.19)
Avg. Hrs. per week in Consultation		3.4 (SD = 5.26)
Avg. Hrs. per week in Family tx.		.4 (SD = 1.91)
Avg. Hrs. per week in Supervision		2.5 (SD = 2.81)
Avg. Hrs. per week in Teaching		2.9 (SD = 7.78)
Avg. Hrs. per week in Other		9.6 (SD = 22.4)

Table 37 (continued)

Close Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	26	
Practice in Hospital	6	
Practice as a Professor	4	
Practice in Counseling Center	0	
Practice in Community M. Health	2	
Practice in Other	4	
Work with Children (under 12)	13	
Work with Adolescents (age 13-17)	18	
Work with Adults (age 18-64)	30	
Work with Aged (age 65 and over)	21	
Did not refer to case history	14	
Referred to case history once	7	
Referred to case history twice	6	
Referred to case history 3x or more	4	
Referred to DSM-III-R	6	
Familiarity with DSM-III-R		5.67 (SD = .944)
How often use DSM-III-R		5.00 (SD = 1.54)

Table 38: Antisocial Personality Disorder with Narcissistic Features Case History: Demographic Data on Subjects According to Diagnosis - Wrong Diagnosis

Wrong Diagnosis

Demographic Data	#	Mean
Female	6	
Male	9	
Age		55.4 (SD = 7.38)
Psychodynamic Orientation	3	
Cognitive-Behavioral Orientation	6	
Social Learning Orientation	1	
Systems Orientation	0	
Existential-Humanistic Orientation	0	
Interpersonal Orientation	1	
Rogerian Orientation	0	
Gestalt Orientation	0	
Eclectic Orientation	4	
Other Orientation	0	
Year Received Ph.D. or Psy.D.		66.0 (SD = 10.2)
Avg. Hrs. per week in Individual tx.		9.7 (SD = 7.71)
Avg. Hrs. per week in Group tx.		.7 (SD = 1.57)
Avg. Hrs. per week in Couples tx.		1.6 (SD = 2.26)
Avg. Hrs. per week in Diagnosis		2.1 (SD = 2.79)
Avg. Hrs. per week in Consultation		2.4 (SD = 4.74)
Avg. Hrs. per week in Family tx.		.4 (SD = .91)
Avg. Hrs. per week in Supervision		1.9 (SD = 3.12)
Avg. Hrs. per week in Teaching		9.3 (SD = 8.96)
Avg. Hrs. per week in Other		15.4 (SD = 26.4)

Table 38 (continued)

Wrong Diagnosis

Demographic Data	#	Mean
Practice in Independent Practice	12	
Practice in Hospital	2	
Practice as a Professor	6	
Practice in Counseling Center	1	
Practice in Community M. Health	1	
Practice in Other	0	
Work with Children (under 12)	4	
Work with Adolescents (age 13-17)	10	
Work with Adults (age 18-64)	14	
Work with Aged (age 65 and over)	5	
Did not refer to case history	3	
Referred to case history once	5	
Referred to case history twice	4	
Referred to case history 3x or more	3	
Referred to DSM-III-R	1	
Familiarity with DSM-III-R		5.06 (SD = 1.03)
How often use DSM-III-R		4.26 (SD = 1.91)