A Woman's View of DSM-III

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ABSTRACT: Women's treatment rates for mental illness are higher than men's. This article argues that one explanation for this sex difference is that masculine-biased assumptions about what behaviors are healthy and what behaviors are crazy are codified in diagnostic criteria and thus influence diagnosis and treatment patterns. Several theories accounting for women's higher treatment rates are reviewed. Chesler's theory of women's overconforming and underconforming to sex role stereotypes is evaluated in the light of Broverman et al.'s findings. The implications of DSM-III's definition of mental disorder, the diagnoses of Histrionic Personality Disorder and Dependent Personality Disorder, and two fictitious diagnostic categories are discussed to illustrate assumptions implicit in DSM-III diagnoses. A past diagnosis regarding women's sexuality is reviewed to specifically illustrate past assumptions resulting in the labeling of healthy women as sick.

More adult women than adult men are treated for mental illness (e.g., Gove & Tudor, 1973; Rohrbaugh, 1979). There are a variety of theories, most of which concern sex roles, that account for this sex difference. There is good reason for the sex role related explanation. According to Bem (1974) and Berzins, Welling, and Wetter (1978), most females are feminine typed and most males are masculine typed. Kelly (1983) concludes that sex differences in behavioral disorders may be associated not with sex but with sex role typing.

In this article I will review several of the popular sex role related theories on sex differences in mental illness treatment rates and then posit an additional one: A contributor to the sex differences in treatment rates is clinicians' diagnostic criteria—that is, in DSM-II (American Psychiatric Association, 1968) and now DSM-III (American Psychiatric Association, 1980). In other words, masculine-biased assumptions about what behaviors are healthy and what behaviors are crazy are codified in diagnostic criteria; these criteria then influence diagnosis and treatment rates and patterns. In my discussion of the influence of diagnostic criteria on sex differences in treatment patterns, I will look at some criteria for specific diagnoses.

Theories About Sex Differences in Treatment Rates

One theory (which has not adequately been supported by data) that accounts for the sex difference in treatment rates is that women are not sicker, they are just more willing to express symptomatology (Phillips & Segal, 1969). Another (more data-supported) theory is that women actually are sicker; their disadvantaged status in society makes them more at risk for mental illness. For instance, the Subpanel on the Mental Health of Women of the President's Commission on Mental Health (1978) documented ways in which inequality creates dilemmas for women in certain contexts (e.g., marriage, child rearing, aging, work). Carmen, Russo, and Miller (1981) add that this same inequality facilitates the occurrence of events (e.g., incest, rape, and marital violence) that heighten women's vulnerability to mental illness. They also point out the link between alienation, powerlessness, and poverty—many women's lot—and impaired mental health.

The theories that women are more willing to express symptomatology and that women's disadvantaged status makes them more vulnerable to mental illness are broad ones. Gove (1979) and Gove and Tudor (1973) formulated several more specific sex role related explanations for gender differences in disordered behavior. First they refined the finding that adult women have higher rates of mental illness and reported that women's higher rate is primarily due to the higher rate of mental illness among married women than among married men. (Widowered, divorced, and never-married men have higher rates of mental illness, respectively, than widowed, divorced, and never-married women [Gove, 1972].) Gove and Tudor offer several sex role related explanations for married women's greater vulnerability to mental illness. These are: (a) Whereas men have two sources of gratification (family and work), traditional married women have only one source of gratification (family); (b) even when a married woman works, she is discriminated against in the workplace and expected to work and be a homemaker, whereas the man is only expected to work; (c) homemaking is a frustrating, low-prestige job, unconsonant with the education and intellectual

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attainment of a large number of women; (d) the role of housewife is unstructured and invisible, allowing the individual time to brood alone; (e) expectations confronting women are unclear; for instance, women are supposed to adjust to and prepare for contingencies (Gove, 1979). (Data supporting these explanations are not supplied.)

Another sex role related theory accounting specifically for married women's higher treatment rates is based on Gilligan's (1979) work. Gilligan claims that whereas for men identity precedes intimacy (Erikson, 1950), sex roles dictate that for women identity and intimacy tasks are simultaneous. In other words, women claim an identity through intimate relationships. Bernard (1975) and Mischel (1966) suggest that women are thus more dependent on others than are men. Nadelson and Notman (1981) mention some resulting difficulties for women (and for men who marry early). For instance, those who marry before establishing identities may find their marital choices inappropriate later, and those who are "burdened by excessive dependency needs, unrealistic expectations of their partners, or unresolved psychological issues" (p. 1355) may find their intimate relationships difficult and stressful and their mental health at risk.

Sex Ratios of Specific Disorders

I turn now from the subject of women's higher treatment rates for disordered behavior in general to the subject of specific behavioral disorders. Table 1 divides those adult disorders for which (according to DSM-III) there are data on sex ratio into two categories: those more commonly diagnosed in adult women and those more commonly diagnosed in adult men. (Disorders whose onset is in adolescence are not included in the table; thus, Anorexia and Bulimia, primarily diagnosed in females, are not listed.) Inspecting Table 1 might lead one to the conclusion that women internalize conflict and that men act it out or, to use Allport's (1958) terms, that women are intropunitive and men, extropunitive.

What are some of the more specific sex role related explanations for so-called female disorders? There are two popular sex role related theories that account for depression (Weissman, 1980). One is the social status hypothesis: Sex discrimination results in "legal and economic helplessness, dependency on others, chronically low self-esteem, low aspirations, and, ultimately, clinical depression" (Weissman & Klerman, 1977, p. 106). The second sex role related popular theory that accounts for depression is the learned helplessness hypothesis (Seligman, 1973, 1975). Another theory less frequently cited than the above two is drawn from Lewinsohn (1974): Women have sex role related deficits in their capacity to obtain reinforcement from the environment. Thus, according to Kelly (1983), feminine-typed responses such as kindness, emotionality, self-subordination, and gentleness may not obtain reinforcement as effectively as masculine-typed responses such as assertiveness and forcefulness. Thus, those limited to feminine-typed responses might reach fewer goals than others might reach and thus would be more vulnerable to depression.

Table 1
Disorders for Which There Are Data on Sex Ratio

More commonly diagnosed in women	More commonly diagnosed in men
Primary degenerative dementia	Multi-infarct dementia
Depression	Alcohol hallucinosis
Cyclothymic disorder	Substance use disorders
Dysthymic disorder	Transsexualism
Agoraphobia	Paraphilias
Simple phobia	Factitious disorder
Panic disorder	Impulse control disorder
Somatization disorder	Paranoid personality disorder
Psychogenic pain disorder	Antisocial personality disorder
Multiple personality	Compulsive personality disorder
Inhibited sexual desire	
Inhibited orgasm	
Histrionic personality disorder	
Borderline personality disorder	
Dependent personality disorder	

Note. Information adapted from DSM-III.

That Dependent and Histrionic Personality Disorders, Agoraphobia, and Anorexia are more commonly diagnosed in females has been explained as follows: These disorders represent caricatures of the traditional female role. In other words, as Chesler (1972) claimed, women's high treatment rates for mental illness reflect partially a labeling of women who overconform to sex role stereotypes as pathological. Thus, the individual with Dependent Personality Disorder is passive and subordinate; the individual with Histrionic Personality Disorder is vain, dependent, and given to exaggerated expression of emotions; the agoraphobic may fear entering and coping with a man's world (Chambless & Goldstein, 1980); and the anorexic may have faithfully followed her model—the fashion model—to a society-condoned anorexic weight level.

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Many of the sex role related theories accounting for female disorders have some basis in data, but that data may be tangentially related. For instance, Hare-Mustin (1983) connected Linehan's (Note 1) study on the prevalence of behavior modification that teaches women to be thin with the prevalence of Anorexia in women. Another example of an indirect relationship between clinical and research data is the application of Seligman's (1974) learned helplessness studies to depressed women (an example of analogue studies). Most sex role related theories about women's higher treatment rates await empirical validation. Kelly (1983) suggests that a goal for the 1980s is to "integrate more directly sex role 'personality' research with research on clinical disorders" (p. 24).

Overconforming and Underconforming: A Theory Supported by Data

One might say that of all the sex role explanations for women's higher treatment rates, one explanation is more directly supported by data than the others: Chesler's (1972) assertion that women are diagnosed for both overconforming and underconforming to sex role stereotypes. Data supporting this assertion are supplied by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel's (1970) study and similar subsequent studies. Broverman et al. found that therapists' criteria for healthiness in men and healthiness in adults were the same, but their criteria for healthiness in women were different:

> healthy women differ from healthy men [and thus healthy adults] by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective, and disliking math and science. (p. 4)

Sherman (1980) reviewed 10 studies of therapists' and counselors' attitudes toward women that have been conducted since the Broverman study and found that despite the publicity of the Broverman findings and supposed changes in society's attitude toward women, stereotyping, albeit less severe than 10 years ago, still exists. Many studies showed that men stereotyped more than women; and some studies showed that older people and those with Freudian orientations stereotyped more than others.

The implications of the stereotyping described by Broverman et al. (1970) and the other researchers are that to be considered an unhealthy adult, women must act as women are supposed to act (conform too much to the female sex role stereotype); to be considered an unhealthy woman, women must act as men are supposed to act (not conform enough to the female sex role stereotype). Not only does this Catch-22 predict that women are bound to be labeled unhealthy one way or another, but also the double bind itself could drive a woman crazy.

DSM-III

Bearing in mind this discussion of sex role explanations for women's higher treatment rates, I turn to my own argument, which I advance not as an alternative to the above explanations but as an additional explanation. As previously mentioned, my thesis is that masculine-biased assumptions about what behaviors are healthy and what behaviors are crazy were codified in DSM-II and are now codified in DSM-III, and thus influenced and will continue to influence diagnosis and treatment rates. These masculine-biased assumptions are codified most explicitly in diagnostic criteria for Personality Disorders, which will be discussed in detail below. However, for the record, the assumptions are also codified in criteria for disorders other than Personality Disorders. For instance, classical Freudians would find Gender Identity Disorder of Childhood in every little girl and Atypical Gender Identity Disorder in many women, according to the Freudians' and DSM-III's (p. 263) respective assumptions about penis envy.

Definitions

DSM-III's definition of Mental Disorder and criteria for Personality Disorders is as follows:

> a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a Mental Disorder.) (p. 6)

According to DSM-III, all Personality Disorders entail "either significant impairment in social or occupational functioning or subjective distress" (p. 305), which spells out one of the criteria for Mental Disorder: "impairment in one or more important areas of functioning (disability)" (p. 6).

Problems

What does impairment in social or occupational functioning mean? I believe these criteria contain assumptions and then generate diagnoses accordingly. For instance, is a woman unemployed outside the home impaired in occupational functioning? Is a man who is employed outside the home and thus never there when his children come home from

school impaired in social functioning? Evidently users of DSM-III assume not, or many "healthy" individuals who assume traditional sex roles would have diagnoses; yet a woman who neglects her children and a man who can't hold down a job—perhaps healthy individuals who assume nontraditional roles—may be labeled *impaired* by a diagnostician.

The above examples of potential diagnoses concern individuals who may experience no primary subjective distress, that is, no distress related directly to these behaviors mentioned (although they may experience distress related to society's and thus to their own reactions to these behaviors). These nondistressed, perhaps healthy, people are labeled *unhealthy.* What about individuals who perhaps are healthy and are subjectively distressed? Through arbitrary assumptions implicit in diagnostic criteria, do they too win diagnoses? For instance, consider the woman who experiences subjective distress because of the double bind inherent in wanting to be a healthy adult—self sufficient—and also in wanting to be a healthy woman—dependent on a man. She may have very real symptoms of unhappiness; according to DSM-III she may have Major Depression. But in her unhappiness, she may be reacting to an impossible situation the way any normal, healthy person would. Her unhappiness and her label of *depressed* may be manifestations that she is a scapegoat for society's illness, its unjust sex role imperatives. In other words, in terms of DSM-III's definitions of Mental Disorder and social deviance, it is difficult, if not impossible, to say when a disturbance is only brought about by a conflict between an individual and society. It is difficult to say when society should be labeled as *unjust* and when an individual should be labeled as *crazy.* This difficulty makes one wonder what assumptions clinicians make—and which diagnostic criteria encourage and support those assumptions—when they designate the individual, as opposed to society, as the problem.

Histrionic Personality Disorder ("Hysterical Personality" in DSM-II)

To make more specific this discussion of assumptions about what is healthy and what is crazy, I will turn to a specific DMS-III diagnosis—Histrionic Personality Disorder. Compare the criteria for that diagnosis with the findings of the Broverman et al. (1970) study concerning clinicians' criteria for healthiness in women. To earn the label of Histrionic Personality Disorder, which according to DSM-III is "diagnosed far more frequently in females than in males" (p. 314), an individual must satisfy three out of five criteria in Category A and two out of five criteria in Category B (p. 315). Three Category A criteria are "self-dramatization, e.g., exaggerated expression of emotions" (cf. Broverman et al.'s [p. 3] "being more emotional"), "overreaction to minor events" (cf. Broverman et al.'s "more excitable in minor crises"), and "irrational, angry outbursts or tantrums" (cf. Broverman et al.'s "more excitable," "more emotional," "less objective," i.e., less rational). Two Category B criteria are "vain and demanding" (cf. Broverman et al.'s "more conceited about their appearance") and "dependent, helpless, constantly seeking reassurance" (cf. Broverman et al.'s "more submissive, less independent, less adventurous, more easily influenced"). It appears then that via assumptions about sex roles made by clinicians, a healthy woman automatically earns the diagnosis of Histrionic Personality Disorder or, to help female clients, clinicians encourage them to get sick.

Dependent Personality Disorder ("Passive-Dependent Personality" in DSM-II)

Look at another set of assumptions codified in DSM-III about what is healthy and what is crazy. These assumptions result in the selective application of the label *dependency.* Why is dependency considered so subjectively distressing or impairment causing that it earns in its extreme expression the diagnosis of a Personality Disorder? The diagnosed individual

> passively allows others to assume responsibility for major areas of life because of inability to function independently, . . . subordinates own needs to those of persons on whom he or she depends in order to avoid any possibility of having to rely on self. . . [and] lacks self-confidence. (pp. 325, 326)

Again, these criteria echo the clinicians' idea of healthy women as described in the Broverman et al. (1970) study; they also echo Miller's (1976) description of subordinate-group members (women) in situations of inequality (society). Thus as in the Histrionic Personality Disorder, clinicians help individuals to attain a diagnosis, or clinicians label the individual *ill* in lieu of labeling society *unjust.*

As regards dependency, there is another means, besides the assumption that women should act more dependently than men, by which DSM-III guides clinicians to label women. That is, DSM-III singles out for scrutiny and therefore diagnosis the ways in which women express dependency but not the ways in which men express dependency. For instance, DSM-III does not mention the dependency of individuals—usually men—who rely on others to maintain their houses and take care of their children. (These are the others *from whom the individuals are independent.*) DSM-III does not mention the dependency of individuals—usually men—who, when widowed, seek a new spouse to take care of them

(widowed women seek a new spouse to take care of [Troll, 1979]). DSM-III does not mention the dependency of individuals—usually men—whose mental illness rates are higher when they are alone than when they are married (women's rates are higher when they are married than when they are alone [Gove, 1972]). In short, men's dependency, like women's dependency, exists and is supported and sanctioned by society; but men's dependency is not labeled as such, and men's dependency is not considered sick, whereas women's dependency is.

To summarize, DSM-III makes three major assumptions about dependency. One is that there is something unhealthy about it. Another is that dependency's extreme expression in women is reflective not simply of women's relationship to (e.g., subordinate position in) society but also of women's behavioral, psychological, or biological dysfunction. A third assumption is that whereas women's expression of dependency merits clinicians' labeling and concern, men's expression of dependency does not.

DSM-III makes similar assumptions regarding histrionicness (as did DSM-II regarding hysteria). For instance, DSM-III assumes that the constellation of histrionic personality traits is not mostly reflective of women's subordinate position in society; however, contrast Miller's (1976) discussion of subordinate-group members carrying unsolved aspects of human experience such as childishness. Another DSM-III and DSM-II assumption is that histrionicness (hysteria) is unhealthy, but its opposite (see Restricted Personality below) is not.

Independent Personality Disorder and Restricted Personality Disorder

To underscore the above points regarding DSM-III's assumptions about dependency and histrionics, consider the following two fictitious diagnostic categories (presented in the DSM-III's format) and compare the first to the diagnosis of Dependent Personality Disorder and the second to the diagnosis of Histrionic Personality Disorder.

Diagnostic criteria for Independent Personality Disorder

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social functioning or subjective distress.

A. Puts work (career) above relationships with loved ones (e.g., travels a lot on business, works late at night and on weekends).
B. Is reluctant to take into account the others' needs when making decisions, especially concerning the individual's career or use of leisure time, e.g., expects spouse and children to relocate to another city because of individual's career plans.
C. Passively allows others to assume responsibility for major areas of social life because of inability to express necessary emotion (e.g., lets spouse assume most child-care responsibilities).

Differential diagnosis. In Compulsive Personality Disorder, there is a perfectionism and an indecisiveness that are lacking in the Independent Personality Disorder. In Avoidant Personality Disorder there is more social withdrawal; the individual with Independent Personality Disorder has relationships with people but behaves as if she or he were independent of those people. However, all three of these disorders may coexist. Restricted Personality Disorder might coexist with Independent Personality Disorder.

Diagnostic criteria for Restricted Personality Disorder

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning (though usually not the latter) or subjective distress.

A. Behavior that is overly restrained, unresponsive, and barely expressed, as indicated by at least three of the following:
   (1) limited expression of emotions, e.g., absence of crying at sad moments
   (2) repeated denial of emotional needs, e.g., of feeling hurt
   (3) constant appearance of self-assurance
   (4) apparent underreaction to major events, e.g., is often described as stoic
   (5) repeatedly choosing physical or intellectual activities over emotional experiences
B. Characteristic disturbances in interpersonal relationships as indicated by at least two of the following:
   (1) perceived by others as distant; e.g., in individual's presence others feel uncomfortable disclosing their feelings
   (2) engages others (especially spouse) to perform emotional behaviors such as writing the individual's thank-you notes or telephoning to express the individual's concern
   (3) engages in subject-changing, silence, annoyance, physical behavior, or leave taking when others introduce feeling-related conversation topics

(4) indirectly expresses resistance to answering others' expressed needs (e.g., by forgetting, falling asleep, claiming need to tend to alternate responsibilities).

The above two diagnoses share criteria with DSM-III's Compulsive Personality Disorder. For instance, three criteria for Compulsive Personality Disorder are: "restricted ability to express warm and tender emotions," . . . "insistence that others submit to his or her way of doing things, . . . [and] excessive devotion to work and productivity to the exclusion of pleasure and the value of interpersonal relationships" (pp. 327–328). But satisfying those criteria alone will not win a DSM-III diagnosis. An individual must also be a perfectionist (e.g., preoccupied with details, lists, etc.) or be indecisive. In other words, whereas behaving in a feminine stereotyped manner alone will earn a DSM-III diagnosis (e.g., Dependent or Histrionic Personality Disorder), behaving in a masculine stereotyped manner alone will not. A masculine stereotyped individual, to be diagnosed, cannot just be remarkably masculine. Masculinity alone is not clinically suspect; femininity alone is.

Women's Sexuality

As a final illustration of my argument that masculine-biased assumptions shape diagnosis and treatment patterns, I turn to the past literature on and conceptions of women's sexuality. Freud's classic theory that vaginal orgasms are different from and more mature than clitoral orgasms caused clinicians, their clients, and the public to believe that women who experienced clitoral orgasms were arrested in their psychological development. It was not until Masters and Johnson published *Human Sexual Response* in 1966 and claimed that there is only one female orgasm, and it is clitoral, that women who experienced clitoral orgasms were considered cured. In other words, women who before 1966 were immature or even dysfunctional were suddenly, in 1966, mature and functional. The women's sexual behavior did not change, but diagnostic criteria did. The DSM-III is compiled mostly by men, and the Psychosexual Disorder Advisory Committee is made up of approximately two-thirds men. That the DSM-III currently identifies Inhibited Orgasm and Inhibited Sexual Desire as (a) disorders, and (b) disorders more commonly found in females, in the light of psychiatry's past mistake regarding women's sexuality, should encourage some thought when one is considering women's sexual pathology. (The diagnostic criteria of Inhibited Female Orgasm acknowledge that diagnosis requires a "difficult judgment" [p. 279].)

Conclusion

Evidence discussed in this article should give one pause when one is considering women's pathology in general, sexual or otherwise. Our diagnostic system, like the society it serves, is male centered. In a female-centered system and society, the public mental health profile might be different. All young macho males seeking psychotherapy might tempt clinicians to award a diagnosis of restricted Personality Disorder (cf. clinicians' current generosity with the labels *histrionic* or *hysterical*). A Broverman study might discover the belief that healthy adult traits were dependence and emotionality; men might be caught in the double bind of choosing between male and adult healthiness; men's treatment rates might be higher than women's.

What is the significance of women's higher rates? As discussed earlier, Chesler (1972) asserts (and the Broverman et al. [1970] study supports the assertion) that one reason healthy women are labeled disordered is that they refuse to play the traditional female role. But Franks and Rothblum (1983) claim that women are disordered; that is, they are depressed, agoraphobic, and experience sexual dysfunction. If Franks and Rothblum are correct, then the demands of traditional sex roles may be more maladaptive for women than they are for men. Another explanation and the one explored in this article is that adaptiveness and maladaptiveness are arbitrarily defined. In other words, not only are women being punished (by being diagnosed) for acting out of line (not acting like women) and not only are traditional roles driving women crazy, but also male-centered assumptions—the sunglasses through which we view each other—are causing clinicians to see normal females as abnormal.

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