CURING FEMININITY

By WRAY HERBERT

Illustrations: Emotions from 1763 Encyclopédie, Diderot & Le Rond, Olin Lib. Cornell Univ. From *Seeing the Insane*, Brunner/Mazel, N.Y., 1982

Consider a psychological interview in which an adult male reports these personality traits: He puts work and career above personal relationships, travels a lot and works long hours; he makes career decisions (relocating, for example) without considering others' needs; he passively allows others to take responsibility for much of his social life because he is unable to express emotions. How would he be diagnosed?

He might, according to Rutgers University psychologist Marcie Kaplan, be diagnosed as suffering from Independent Personality Disorder. He might, but he wouldn't, because there is no such thing as Independent Personality Disorder; instead, he would most likely be viewed as typically male and left undiagnosed. In contrast, Kaplan says, a healthy adult woman who shows up in the clinic with personality traits considered typically female would automatically earn a diagnosis — most likely Dependent Personality Disorder—and be labeled sick and in need of treatment.

Writing in the July AMERICAN PSYCHOLOGIST, Kaplan takes on an enduring question — why are more women than men

treated for psychiatric disorders? — and she answers it by arguing that the very rules of diagnosis, as codified in the so-called DSM III, the bible of psychiatric diagnosis, are stacked against women. The male-dominated committees that wrote the *Diagnostic and Statistical Manual,* she says, have arbitrarily defined what is maladaptive, so that healthy feminine attitudes and behaviors (or what are stereotypically viewed as feminine attitudes and behaviors) match those that are officially psychopathological.

Several theories have been put forth to explain why women are more frequently diagnosed as mentally ill. It has been suggested that women are more willing than men to express symptoms, so that they are more often diagnosed. Alternatively, it has been suggested that there is indeed more mental illness among women — that because of their underprivileged position in society women are at greater risk for emotional disturbance. But the most convincing theory, Kaplan argues, is that women are diagnosed as mentally ill both for overconforming and for underconforming to female stereotypes. According to several studies of therapists' attitudes, Kaplan notes, most therapists have the same criteria for healthy men and for healthy adults, but they tend to use different criteria in defining healthy women; the typical psychologically healthy woman is more submissive, less independent, less aggressive, more emotional and more

emotionally expressive, more excitable and more concerned about appearance. If a woman rejects this stereotype, she is an unhealthy woman; if she conforms to it, she is an unhealthy adult, as defined in several parts of the DSM III.

The part of the diagnostic manual most heavily stacked against women is the chapter on personality disorders, Kaplan claims. Histrionic Personality Disorder (what use to be called hysteria) is defined by the presence of self-dramatization, overreaction, irrational and angry outbursts, vanity and dependence — traits that, Kaplan notes, are not all that different from those of the female stereotype.

Similarly, Dependent Personality Disorder is defined by characteristics that echo the clinicians' ideal of a healthy woman — passivity and a tendency to subordinate one's needs to the needs of others. Some-

one with this personality disorder, the DSM III says for example, might tolerate an abusive spouse. But the manual ignores the dependency of people — usually men, Kaplan argues — who rely on others to maintain their houses and raise their children, or of those people — again usually men — who remarry only to replace the original caretaker. "In short," Kaplan con-

cludes, "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 make her point, Kaplan invented two fictitious personality disorders based on stereotypically male traits: Independent Personality Disorder, described earlier, and Restricted Personality Disorder, which is defined by such traits as appearance of self-assurance, limited emotional expression, resistance to answering others' emotional needs and stoicism. Without these diagnostic categories, Kaplan says, a male with such traits — the counterparts of histrionics and dependency in women — would go undiagnosed and un-

treated. "Masculinity alone is not clinically suspect;" she concludes, "femininity alone is."

A charge such as Kaplan's is bound to provoke debate, and in fact the same issue of AMERICAN PSYCHOLOGIST carries a reply by Columbia University psychiatrist Robert L. Spitzer, who directed the development of DSM III, and Janet B. W. Williams of the New York State Psychiatric Institute,

Twice as many women as men are under psychiatric care. Is there really more mental illness among women? Or are the rules of psychiatry biased so as to guarantee that healthy women appear to be sick?

who assisted him. Spitzer and Williams challenge what they say is a basic assumption of Kaplan's — that a mental problem lies either with society or with the individual; recognizing a societal problem, sexism, does not mean that an individual's problem should not be diagnosed. They ask: "Would Kaplan really argue that if unemployment and poverty contributed to someone's becoming physiologically dependent on alcohol, it would be wrong for a clinician to diagnose him or her as having alcoholism?"

More to the point, they say, Kaplan has ignored DSM III where the evidence doesn't support her charge. It is not true, they say, that the manual contains only examples of female dependency: such criteria as "lets spouse decide what kind of job he or she should have" or "tolerates abusive spouse" are equally applicable to males or females, they argue. In addition, they say that the manual includes other diagnostic categories — Antisocial and Schizoid Personality Disorders — which could be seen as caricatures of masculine stereotypes and in fact are more often applied to men. If there were a sexual bias written into the book, Spitzer and Williams conclude, females would be expected to be overrepresented in all diagnostic categories, which they are not.

Spitzer and Williams point to the well-known findings from the studies of Amish families in Pennsylvania, where in the absence of alcoholism (a taboo in Amish society) equal numbers of men and women are diagnosed as depressed. In the larger community, women are twice as likely to be labeled depressed, suggesting (they say) that alcoholism is masking depression in men (and presumably that other disorders are similarly masked). But according to Kaplan, such evidence supports her position rather than refutes it. When women express depression, they are called depressed; when men express depression, clinicians see alcoholism, she says. If women express fear of autonomy through dependency, they are called sick; if men express the same fear of autonomy through counter-dependence (or masked dependency) they are undiagnosed. It may be true that men and women express emotional symptoms differently, Kaplan says, but it also may be that the diagnostic rules tend to pick up one kind of expression rather than another. The result, she reiterates, is that women have higher treatment rates than do men. □

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