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Effects of gender bias and gender inversion stereotypes on assessment of personality traits and diagnosis of personality disorders

Beatrice Charmaine Mosier

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**EFFECTS OF GENDER BIAS AND GENDER INVERSION
STEREOTYPES ON ASSESSMENT OF PERSONALITY
TRAITS AND DIAGNOSIS OF PERSONALITY
DISORDERS**

by

Beatrice Charmaine Mosier, M.S., M.A.

A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

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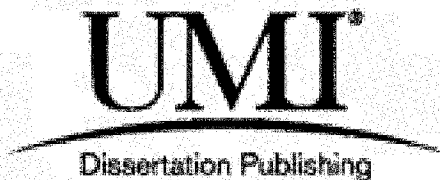
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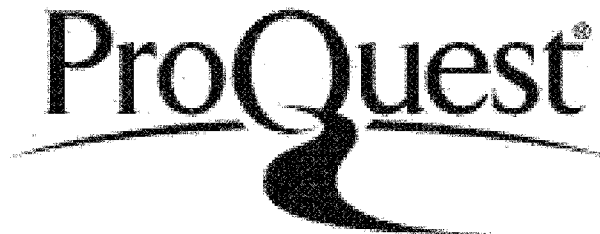


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We hereby recommend that the dissertation prepared under our supervision
by Beatrice Charmaine Mosier

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Personality Traits and Diagnosis of Personality Disorders

be accepted in partial fulfillment of the requirements for the Degree of
Doctor of Philosophy

Alfred H Ford
Supervisor of Dissertation Research
Tommy Thomas
Head of Department
Dept. of Psychology & Behavioral Sciences
Department

Recommendation concurred in:

Tommy Thomas
JH

Advisory Committee

Approved:

[Signature]
Director of Graduate Studies

[Signature]
Dean of the College

Approved:

Sheryl S. Shoemaker
Dean of the Graduate School

ABSTRACT

Past research has shown the results of gender and gender role biases on the diagnostic decision-making process, particularly with regard to personality disorders. This bias has implications for homosexual individuals, as they often are viewed as displaying traits of opposite sex individuals. With regard to personality assessment, current research continuously supports a more dimensional conceptualization of personality pathology. In the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, a hybrid model of personality assessment, which utilizes both categorical methods and dimensional approaches, has been added as an alternative model. The study explored the effects of gender role stereotypes and attitudes toward homosexual individuals on the diagnosis of personality pathology, using both a categorical model and a dimensional model. In the study, 204 trainees in clinical and counseling psychology doctoral programs completed one of five diagnostic vignettes, each of which described individuals displaying identical symptoms of both Borderline Personality Disorder and Antisocial Personality Disorder, but that was altered by gender and sexual orientation, as well as measures of attitudes toward women and toward homosexual individuals. Participants were asked to provide a diagnostic impression of the individual from both a categorical perspective (consistent with *DSM-IV-TR* nosology) and a dimensional trait perspective (similar to the alternative model in *DSM-5*) in order to determine if views of women and homosexual individuals impacted the diagnostic decision-making process. As predicted, women were diagnosed with Borderline

Personality Disorder more than men, and men were diagnosed with Antisocial Personality Disorder more than women. This trend was observed in categorical diagnostic impressions, but not in dimensional assignment of traits. However, the current study failed to support other predictions, such as the presence of inversion stereotypes of homosexual individuals. Potential causes of these unexpected findings are presented. Findings support the use of a dimensional model of personality assessment, as results suggest such a model is less vulnerable to the effects of gender bias in diagnostic decision making. Implications for future research, as well as the importance of a continued focus on multiculturalism in psychology training programs, are discussed.

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Date June 19, 2014

TABLE OF CONTENTS

ABSTRACT.....	iii
LIST OF TABLES.....	ix
LIST OF FIGURES	x
ACKNOWLEDGEMENTS.....	xi
CHAPTER ONE INTRODUCTION.....	1
Problems in Clinical Diagnosis.....	4
Effects of Stereotypes on the Diagnostic Process.....	6
History of Homosexuality in the DSM	9
The Relationship between Homosexuality and Mental Health	16
Gender Bias in Assessment and Diagnosis.....	23
Gender Bias in the Diagnosis of Personality Disorders.....	29
Gender Role Bias in Assessment and Diagnosis	38
Inversion Stereotype Bias in Assessment and Diagnosis	43
Assessment of Personality Disorders in DSM-5.....	50
The Current Study.....	54
Hypotheses.....	57
Hypothesis 1	57
Hypothesis 2	59
Hypothesis 3	60

Hypothesis 4	61
Justification for Hypotheses.....	62
CHAPTER TWO METHOD.....	64
Pilot Study.....	64
Participants.....	67
Measures	67
Demographic Questionnaires.....	68
Clinical Vignette	68
DSM-IV-TR Diagnostic Impression Form	69
Brief Assessment of Traits—37.....	70
Attitudes Toward Women Scale-Short Version	72
Attitudes Toward Lesbians and Gay Men Scale-Revised.....	72
Procedure	73
CHAPTER THREE RESULTS.....	76
Participants.....	76
Distribution	80
Brief Assessment of Traits—37.....	81
Attitudes Toward Women Scale	82
Attitudes Toward Lesbians and Gay Men Scale-Revised.....	83
Diagnostic Impressions.....	85
Tests of Hypotheses	86
Additional Analyses.....	97
Demographic Factors and Attitudes Toward Women and Homosexuals.....	98

Demographic Factors and Diagnostic Decision-Making.....	102
CHAPTER FOUR DISCUSSION.....	104
Findings and Implications.....	105
Diagnostic Impressions.....	105
Personality Trait Impressions	107
Attitudes Toward Women.....	109
Attitudes Toward Lesbians and Gay Men	110
Additional Analyses.....	111
Attitudes and Trait Relationships	111
Attitudes and Political/Religious Orientation	112
Demographic Variables and Diagnostic Decision-Making	112
Limitations.....	113
Future Research	115
Conclusion	118
REFERENCES	120
APPENDIX A HUMAN USE COMMITTEE APPROVAL	136
APPENDIX B PRE-VIGNETTE QUESTIONNAIRE	138
APPENDIX C VIGNETTES	143
APPENDIX D <i>DSM-IV-TR</i> DIAGNOSTIC IMPRESSION FORM.....	154
APPENDIX E BRIEF ASSESSMENT OF TRAITS – 37	156
APPENDIX F ATTITUDES TOWARD WOMEN SCALE – SHORT VERSION	161
APPENDIX G ATTITUDES TOWARD LESBIANS AND GAY MEN SCALE – REVISED.....	165
APPENDIX H POST-VIGNETTE QUESTIONNAIRE.....	167

LIST OF TABLES

Table 1	<i>Pilot Study Results</i>	66
Table 2	<i>Scale Scores for the Brief Assessment of Traits - 37</i>	82
Table 3	<i>Scale Scores for the Attitudes Toward Women Scale (ATW)</i>	83
Table 4	<i>Scale Scores for the Attitudes Toward Lesbians and Gay Men Scale (ATLG)</i>	84
Table 5	<i>Correlations between Borderline and Antisocial Traits on the BAT-37</i>	97
Table 6	<i>Relationship between Political Party Affiliation and Scores on the Attitude Toward Women Scale (ATW)</i>	99
Table 7	<i>Relationship between Political Party Affiliation and Scores on the Attitude Toward Lesbians and Gay Men Scale (ATLG)</i>	100
Table 8	<i>Relationship between Religious Views and Scores on the Attitude Toward Women Scale (ATW)</i>	101
Table 9	<i>Relationship between Religious Views and Scores on the Attitude Toward Lesbian and Gay Men Scale (ATLG)</i>	101

LIST OF FIGURES

Figure 1	<i>Differences in Initial Diagnostic Impressions for Each Vignette</i>	87
Figure 2	<i>Differences in Forced-Choice Diagnostic Selection for Each Vignette</i>	88
Figure 3	<i>Differences in Initial Diagnostic Impressions for Each Vignette</i>	89
Figure 4	<i>Differences in Initial Diagnostic Impressions of Borderline Personality Disorder for Males and Females.....</i>	90
Figure 5	<i>Differences in Initial Diagnostic Impressions of Antisocial Personality Disorder for Males and Females.....</i>	91
Figure 6	<i>Differences in Traits of Negative Affectivity for Each Vignette.....</i>	92
Figure 7	<i>Differences in Traits of Antagonism and Disinhibition for Each Vignette</i>	93
Figure 8	<i>Differences in Traits of Negative Affectivity for Males and Females</i>	94
Figure 9	<i>Differences in Traits of Antagonism and Disinhibition for Males and Females.</i>	95

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CHAPTER ONE

INTRODUCTION

The relationship between homosexuality and psychology has been a confusing and unsettled one. Homosexuality has been added to, and removed from, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, and a review of the literature indicates that although homosexuality is no longer considered a mental disorder, mental health professionals continue to provide assessment and diagnosis that is influenced by bias against homosexual individuals (Lehavot & Lambert, 2007; Taylor, 1983). This bias is closely related to the bias that has been shown to occur when mental health professionals allow gender and gender stereotype biases to influence diagnostic decisions during the assessment of heterosexual men and women, as gender stereotypes are often reversed and applied to homosexual individuals in a form of inversion stereotype bias (Kite and Deaux, 1987). These forms of diagnostic bias have been shown to occur extensively in the diagnosis of personality disorders (Eubanks-Carter & Goldfried, 2006). Personality disorder diagnosis is a topic of current importance secondary to the fact that the method by which personality disorders are assessed and diagnosed is being re-evaluated, and a proposed new system was added to the Emerging Measures and Models section of the updated version of the *DSM, DSM-5*, which was released in October of 2013. The new system has received much empirical support, and it is referred to within *DSM-5* as an alternative model for personality disorders (APA, 2013). The current study

explored the effects of gender stereotype and inversion biases in the diagnosis of discrete personality disorders (which is consistent with the method of *DSM-IV-TR*), as well as in the assessment of personality traits along continua (which is consistent with the alternative method of *DSM-5*).

This introduction chronicles the history of the fluctuating relationship between psychology and homosexuality. Specifically, a discussion of how traditional gender role expectations have affected the assessment and diagnosis of heterosexual individuals is followed by a discussion of how an inverted version of these gender stereotypes has affected the assessment and diagnosis of homosexual individuals. Traditional gender role expectations and gender role stereotypes have influenced diagnostic criteria to the point that there are personality disorders in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* that are considered by many professionals to be primarily “male” (i.e., Antisocial Personality Disorder) or “female” (i.e., Borderline Personality Disorder) disorders (Crosby & Sprock, 2004). The inversion theory of homosexuality (i.e., the theory that states gay men are similar to heterosexual women, and lesbian women are similar to heterosexual men) has affected the assessment and diagnosis of homosexual men and women in much the same way that traditional gender role stereotypes have affected the diagnosis of heterosexual men and women. Psychology’s views toward homosexuality can be seen as mirroring society’s views, in that although it is true that some advancements have been made in understanding homosexual individuals, and rates of pathologizing individuals solely based on their sexual orientation has decreased, bias and discrimination based on stereotypes still exist and affect the assessment and diagnosis of this large portion of the population (Lehavot & Lambert, 2007).

The purpose of the current study was to explore the extent to which individuals' gender and sexual orientation affect the ways that their personality traits and psychiatric symptomatology were conceptualized and categorized by psychology graduate students at the doctoral level. Specifically, the study attempted to determine if, when all other client variables were held equal, individuals' sexual orientation resulted in lesbian women's symptoms being viewed as reflective of traditionally "masculine" symptoms and gay men's symptoms being viewed as reflective of traditionally "feminine" symptoms. Although past research has shown that more "feminine" males and more "masculine" females have been assumed to be homosexual, and that lesbian women and gay men are believed to possess and display attributes of the opposite gender (Blashill & Prowlishta, 2009), no research has attempted to determine if inversion stereotypes, specifically, result in psychiatric symptoms being assessed and diagnosed differently.

In addition, this study assessed participants' views of reported Axis II personality symptomatology from both a categorical and a dimensional perspective, which is consistent with the alternative system of assessing personality disorders added to the most recent version of the *DSM*. *DSM-5* was released in October of 2013, and as an alternative model for personality disorders, personality disorders are no longer exclusively diagnosed as distinct categories. In the alternative model, personality disorder symptomatology is assessed from a dimensional perspective with all individuals receiving ratings across five broad domains of personality functioning, which are derived from 25 more specific personality facets. Given the history of certain domains of personality being viewed as primarily "masculine" (e.g., antagonism) or "feminine" (e.g., negative affect), this method seems particularly well-suited for attempting to determine if

individuals' symptoms are assessed and categorized based on inversion stereotypes of homosexual individuals (Basow, 1992).

Problems in Clinical Diagnosis

Although the purpose of the current study was to explore issues related to the influences of gender and inversion stereotypes on the assessment and diagnosis of homosexual individuals presenting for mental health treatment, it is important to first explore and understand the history of studies that have examined the reliability of diagnosis in general, as well as those that have explored the presence of general clinical bias. These studies have shown the effects of the subjectivity of the diagnostic process and how mental health professionals' personal opinions and characteristics compromise the accuracy and precision of the diagnostic process.

One of the earliest of these studies was conducted by Beck, Ward, Mendelson, Mock, and Erbaugh in 1962. The researchers discovered that agreement between two psychiatrists for 153 patients evaluated was between 32% and 54%, and it was stated that the differences were frequently due to vague diagnostic criteria. Cooper et al. (1972) provided psychiatrists in New York and London with the same videotaped clinical interviews. Results indicated that psychiatrists in New York were twice as likely to diagnose schizophrenia than psychiatrists in London, and that psychiatrists in London were twice as likely to diagnose mania or depression than psychiatrists in New York. In a now famous study, Rosenhan (1973) had eight mentally healthy individuals arrange appointments at various hospitals, complaining that they were experiencing unclear auditory hallucinations. The individuals acted healthy when presenting for their appointments, and they stated that they were experiencing no further symptoms.

However, results indicated that all but one of the pseudo-patients were admitted to the hospitals and given a diagnosis of schizophrenia. Upon their release, all of the individuals were given a diagnosis of schizophrenia in remission, which indicates that they had never been detected as mentally healthy during their stays at the various hospitals, which ranged from 7 days to 52 days.

Similar studies, which evaluated the reliability of more recent diagnostic systems, have been conducted throughout the last 30 years as well. For example, Lipton and Simon (1985) randomly selected 131 patients from a New York hospital. The researchers conducted assessment procedures and determined a diagnosis for each of the 131 patients. Results were then compared to the original diagnoses that the patients had received upon being admitted to the hospital. These comparisons indicated that although 89 of the 131 patients had received a diagnosis of schizophrenia upon being admitted to the hospital, only 16 received the diagnosis when evaluated for the study. In addition, 50 of the patients were diagnosed with a mood disorder when assessed for the study; however, only 15 had received a mood disorder diagnosis when they were originally hospitalized. DiNardo, Moras, Barlow, Rapee, and Brown (1993) explored the reliability of *DSM-III* for the diagnosis of anxiety disorders. In the study, two clinicians were asked to assess and diagnose 267 individuals who were presenting anxiety and stress-related disorders. The two independent raters had low reliability for assessing generalized anxiety disorder among the patients. Researchers indicated that the low reliability may have been due to difficulties in interpreting, and agreeing upon, how excessive the patients' worries were. Regardless of the reason for the low reliability between the

diagnoses of two independent assessors, this study again illustrated the more generalized problem of the subjectivity of assessment and diagnosis.

Some areas of potential therapist bias have received much empirical attention, while other areas have received little recognition in research. One area that has failed to gain a great deal of exploration is the area of clinical bias that is based on gender inversion stereotypes of homosexual individuals. It is important to study all areas of bias because, according to Stricker (2002), personal biases and attitudes shape observations made of clients by mental health professionals and influence the diagnostic impressions and hypotheses that are developed. This has important implications for the treatment of individuals because, as Morrow and Deidan (1992) asserted, such errors in judgment can lead to improper diagnoses and treatment, which could worsen the client's presenting problem, causing harm as opposed to help. It is important to fully explore and more completely understand specific biases in clinical judgment. In fact, according to Garb (1998), research into the area of clinical bias can help to educate and guide the work of mental health professionals, as well as training programs, with the final goal being the reduction of bias and improvement of the reliability and validity of clinical decisions.

Effects of Stereotypes on the Diagnostic Process

Stereotypes are generalizations, or assumptions that people make about the characteristics of all members of a group, based on an image about what people in that group are like. Stereotypes are often incorrect; however, they are strongly held beliefs that exist within a larger social consciousness. Therefore, they are quite difficult to remove, even in the face of information or knowledge that disconfirms the belief.

Particularly damaging are stereotypes about the mental health functioning of groups of

people, as these stereotypes have the power to affect the treatment of individuals in the stereotyped group. According to Corrigan (2004), it is important to be aware of mental health stereotypes about any group because such stereotypes can lead to public discrimination and prejudice, which can lead to self-hatred and increased psychological distress. According to Vogel, Epting, and Wester (2003), it is quite important to examine the commonly held stereotypes of individuals in training to become mental health professionals because endorsement of stereotypes by future professionals can affect expectations about clients' mental health issues, which could then affect the assessment, diagnosis, and treatment of individuals in the stereotyped group.

There is a history of minority group members being harmed by the stereotypes held by mental health professionals. For example, according to Adebimpe (1981), the stereotype that African Americans are more happy and jovial than European Americans resulted in the belief that they did not experience the sadness that is associated with depression. Similarly, there is a long history of negative mental health stereotypes about homosexual individuals. Simmons (1965) found that gay men were perceived by others to be perverted and lonely individuals. Levitt and Klassen (1974) found that people perceived gay men as being dangerous to youth and as having strong sex drives. Staats (1978) found a large number of stereotypes about gay men among a sample of college students, including descriptors such as cowardly and shy. There has also been a large amount of research showing that gay men are often presumed to be feminine or woman-like (Madon, 1997). According to Prentice and Carranza (2003), despite the fact that cultural changes have improved the overall acceptance of homosexual individuals within

society, mental health stereotypes about homosexual individuals have been consistent over the last few decades.

Boysen, Vogel, Madon, and Wester (2006) described several ways that stereotypes held by mental health professionals about homosexual individuals could have negative implications, not only for homosexual individuals seeking mental health treatment, but also for all homosexual individuals, as well as for the field of psychology. According to the researchers, stereotypes help to maintain social stigma and to increase discrimination. Also, stereotypes, and acting toward stigmatized individuals based on stereotypical thinking about those individuals, have the potential to lead to self-fulfilling prophecies, in that stereotyped individuals may start acting in ways that fulfill the stereotypes because they come to feel as if nothing else is expected of them.

As stated by Boysen et al. (2006), stereotypes about the mental health of certain groups of people can affect the quality of mental health treatment that those individuals receive in several ways, including diagnostic influence. Mental health stereotypes have the potential to lead to the over-pathologizing of behaviors. For example, one belief is that gay men are more likely than straight men to exhibit certain symptoms, such as characteristics of borderline and histrionic personality disorders. This could lead to the behaviors being over-pathologized in gay men, while being ignored in straight men. In addition, the researchers state that the under-pathologizing of behaviors is also a possible result of mental health stereotypes. For example, stereotypes of behavior in gay men include them being viewed as anxious, nervous, or panicky. These behaviors may be viewed by mental health professionals as “typical” for gay men, and, therefore, there is the possibility that an anxiety disorder could be overlooked.

History of Homosexuality in the DSM

The history of the relationship between psychology and homosexuality has been a long and too often confusing one. Ancient societies, in their attempts to understand psychopathology, were often times generally accepting of homosexuality (Mendelson, 2003). However, eventually, homosexuality began to be categorized as a mental illness in both the *International Classification of Diseases (ICD)* and in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Despite the fact that homosexuality was removed as a distinct disorder from the *DSM* in 1973, and from the *ICD* in 1990, many therapists continue to consider homosexuality a form of psychopathology. Furthermore, some therapists continue to practice “reparative therapies” (attempts to therapeutically change an individual’s sexual orientation), despite the fact that the American Psychological Association stated in 1998 that such practices are considered unethical and potentially harmful. Currently, despite the fact that society’s views toward homosexual individuals are becoming more positive, and training programs in psychology and other mental health professions are beginning to stress the importance of acceptance of diversity and appreciation of multicultural factors, research shows that homosexual individuals continue to be stigmatized based on stereotypes and biases, both within society as a whole and within the field of psychology. As a result, these stereotypes and biases continue to prevent the unbiased diagnosis and assessment of these individuals.

Simon (1978) and Mendelson (2003) provide a history of the various ways homosexuality was conceptualized in early diagnostic systems. Among Greek aristocracy in the fifth and fourth centuries in Athens, homosexuality was institutionalized and considered part of the formal education and rearing of adolescent

boys. Additionally, Hippocrates and Plato, despite the fact that they discussed and listed mental illnesses, did not include homosexuality as a mental illness. In fact, it was not until the nineteenth century that homosexuality began to receive scientific scrutiny and be labeled a mental disorder (Simon, 1978). In 1883, Kraepelin published his listing of mental illnesses and listed homosexuality as a psychological weakness. Other individuals during this time also began to list homosexuality as a mental illness. For example, Karl Westphal, in 1869, listed homosexuality as a “contrary sexual feeling.” Despite the fact that homosexuality was beginning to be considered a mental illness during this time, there were researchers who held primarily positive beliefs regarding homosexuality, viewing it as a natural expression of sexuality. The relationship between homosexuality and psychiatric nosology was a conflictual and too often confusing one, which can be seen through the various changes that have been made in categorizing homosexual individuals. In the various editions of Kraepelin’s work, for example, homosexuality changed from being considered a psychological weakness (1883), to an abnormality of development (1887), to a “psychopathic” condition (1896), and finally to a “mental condition of constitutional origin” (1915) (Mendelson, 2003).

Psychoanalysts of the early 20th century, guided by Sigmund Freud, asserted that homosexuality was the result of abnormal psychosocial development (Herek & Garnets, 2007). However, there was also confusion regarding the way homosexuality was viewed even within the field of psychoanalysis. For example, although Freud believed that homosexuality was not an optimal result of psychosocial development, he also asserted that all individuals are born bisexual. In addition, in a letter written by Freud in response to an American woman who was concerned about her homosexual son, Freud stated, “It

is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness” (Freud, 1951, p. 786).

Adding further uncertainty to the matter is the fact that American psychoanalysts of the mid 20th century broke with Freud’s beliefs about homosexuality. These analysts considered homosexuality a negative result of development; they stated that heterosexuality is normal and that homosexuality is an attempt to achieve sexual pleasure when heterosexuality is too threatening; they proposed theories of the cause of homosexuality, all of which were based on illness models and asserted that homosexuality was a sickness (Herek & Garnets, 2007). Psychoanalysis was the dominant psychological view during the majority of the 20th century in the United States, and, therefore, these views penetrated the American consciousness and societal values. As a result, as part of the psychological screening process for recruits in World War II, there were formal procedures for screening out homosexual individuals. Not surprisingly, when the first version of the *DSM* was released after World War II, homosexuality was listed within it as a sociopathic personality disturbance (American Psychiatric Association, 1952).

As a result of homosexuality being categorized as a psychological disorder, many therapists began to attempt to cure individuals of homosexuality. However, when traditional therapeutic techniques proved to be unsuccessful at changing individuals’ sexual orientation, therapists used a number of alternative, primarily harmful, “treatments,” such as castration, lobotomy, hormone administration, aversive conditioning, and electroshock treatments (Herek & Garnets, 2007). It was not until Kinsey, Pomeroy, and Martin (1948) and Kinsey, Pomeroy, Martin, and Gebhard (1953)

published their sex studies, *Sexual Behavior in the Human Male* and *Sexual Behavior in the Human Female*, that society and therapists began to question the validity of categorizing homosexuality as a psychological disorder. In Kinsey's studies, he and his assistants provided statistical findings of the prevalence of homosexual behavior in the United States, and in addition, Kinsey specifically challenged the mental health profession's categorization of homosexuality as a psychological illness. However, many psychiatrists, primarily psychoanalytically trained psychiatrists, challenged Kinsey, stating that discovering the prevalence of a phenomenon does not indicate its normality. Nevertheless, Kinsey's work had a significant influence on beginning the field of psychology's changing views toward homosexual individuals (Chiang, 2008).

Another individual who contributed significantly to the mental health field's changing views (i.e., de-pathologizing) of homosexuality was clinical psychologist Emily Hooker. Hooker was the first psychologist to study the behavior and social psychological functioning of homosexual individuals, and she presented her findings in *The Journal of Psychology* in 1956. In this initial study, Hooker showed that homosexual individuals are members of a victimized social minority group and that many of the stressors they encounter as a result of their minority status, as well as many of the individual and group protective factors that they employ in order to thwart the negative effects of the discrimination they are faced with, mirror the experiences of other minority groups within society, such as racial minority groups.

It was Hooker's later works, however, that had the greatest effect on helping to change many psychiatrists' and psychologists' views of homosexuality. In 1957 and 1958, Hooker published the results of two studies in which she compared the

psychological functioning of homosexual men and heterosexual men. The studies were incredibly influential, as well as the first examples of studies that sought to scientifically measure the psychological functioning of homosexual individuals. In the studies, Hooker administered the Rorschach and Thematic Apperception Test to both homosexual men and heterosexual men. A comparison of the results indicated that the performance of the two groups did not differ significantly. In addition, Hooker questioned the validity of using projective tests to diagnose homosexuality because her findings suggested that the assessment of homosexuality based on projective test results was inconsistent amongst the professional assessment interpreters used in her research (Chiang, 2008). All of this contributed to the changing view of homosexuality as mental illness in the field of psychology.

During the same time that Hooker and other psychologists were beginning to question, and eventually challenge, the appropriateness of categorizing homosexuality as a mental illness, the beginnings of the Gay Civil Rights Movement began in the United States. Following the riots that took place at Stonewall Inn in New York City in 1969, when gay and lesbian patrons stood up against the physical and emotional abuse they had been experiencing at the hands of law enforcement, the gay and lesbian community in the United States began to join together to fight the discrimination that had become an accepted part of American society. Many gay and lesbian activists specifically targeted the field of psychology as adding to the discrimination toward gay and lesbian individuals through its labeling of homosexuality as a psychological disorder. Targeting the mental health community's views of homosexuality was of paramount importance in attempting to gain rights and freedom from discrimination because, "although sexual

stigma has long been expressed through cultural institutions such as the law and religion, much of its legitimacy during the past century derived from homosexuality's status as psychopathology" (Herek & Garnets, 2007, p. 354).

In February of 1973, the Nomenclature Committee of the American Psychiatric Association met with a committee of gay and lesbian activists with the goal of discussing the removal of homosexual acts between two consenting adults from the list of mental disorders in the *DSM* (Silverstein, 2009). Additional goals that were of interest to the committees were to make attempts to change sexual orientation by psychologists unacceptable, even if requested by the patient, as well as to help establish civil rights protection for homosexual individuals, including non-discrimination in housing and employment. The result of this meeting was a decision by the Board of Directors of the *DSM* to remove homosexuality from the second edition of the classification system. In *DSM-II*, it was stated that only some individuals suffered from Sexual Orientation Disorder and required treatment.

By the time *DSM-III* was released in 1980, homosexuality was classified in one of two ways. Ego-syntonic homosexual individuals were seen as having no problem with their homosexual orientation (i.e., their sexual orientation was not causing them distress) and, therefore, not in need of treatment. Ego-dystonic homosexual individuals were classified as suffering from a mental disorder because their homosexual orientation was causing them some degree of distress. Therefore, ego-dystonic homosexual individuals were viewed as requiring treatment. *DSM-III* did not specify whether treatment for ego-dystonic homosexual individuals should have the purpose of attempting to change the client's sexual orientation to heterosexual, or if the goal should be to help the individual

develop ego-syntonic homosexuality, and the decision was left to the discretion of the therapist and his or her patient (American Psychiatric Association, 1980). In the revised version of *DSM-III*, *DSM-III-R*, which was released in 1987, the diagnosis of ego-dystonic homosexuality was removed. What remained in *DSM-III-R* was the diagnostic category of Sexual Disorder Not Otherwise Specified, which was defined as persistent and significant distress regarding one's sexual orientation (American Psychiatric Association, 1987).

In 1994, *DSM-IV* was released. In it, the group of sexual disorders was renamed Sexual and Gender Identity Disorders, and in addition, the diagnosis of Sexual Disorder Not Otherwise Specified was retained. However, *DSM-IV* stated the importance of noting that thoughts about sexual deviance, sexual performance, and appropriate gender role vary from culture to culture. In addition, *DSM-IV* stated that the category of Sexual Disorder Not Otherwise Specified includes problems such as feelings of inadequacy regarding sexual performance, distress about a pattern of sexual relationships, and persistent and significant distress regarding one's sexual orientation (American Psychiatric Association, 1994). When the text revision version, *DSM-IV-TR*, was released in 2000, no changes were made to the category of sexual disorders, generally, or to the categorization of homosexuality, specifically (American Psychiatric Association, 2000).

Despite the fact that homosexuality has been removed as a mental illness from the *DSM*, gay men and lesbians continue to suffer the effects of discrimination based on their sexual orientation, both in society as a whole and in the field of mental health. According to Herek and Garnets (2007), "Today, the mainstream position among clinicians and

researchers is that homosexuality is a normal variant of human sexual expression and is no more inherently associated with psychopathology than is heterosexuality” (p. 357). However, there is research within the field which indicates that homosexual individuals are viewed as displaying higher rates of psychological disorders, and that they are often subject to the effects of inversion stereotypes when they are being assessed and diagnosed by mental health professionals. One study has shown homophobic attitudes and behaviors among physicians, social workers, therapists, nurses, and medical students (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). In addition, students in professional training programs may not be receiving adequate education regarding homosexual individuals. Another study has shown that experience with gay and lesbian faculty and participation in educational activities geared toward education regarding homosexuality and homophobia influence students to develop more positive attitudes toward homosexual individuals (Stevenson, 1988). However, according to Friedman and Downey (1994), “It is likely that many students enter professional schools with antihomosexual values that go unchallenged during their education” (p. 925).

The Relationship between Homosexuality and Mental Health

According to Herek (2010), “The history of Psychology’s stance toward homosexuality and sexual minorities illustrates not only how cultural institutions play a central role in legitimizing stigma, but also how such institutions can recognize their mistakes, reverse their policies, and become agents for societal change” (p. 693). However, Herek also points out that the field of mental health still has much to do in assuring adequate treatment of lesbian and gay individuals when he states, “Despite Psychology’s repudiation of its former legitimation of heterosexism, the differences-as-

deficits model persists and still warrants an ongoing response” (p. 696). In a review of national health data, Cochran and Mays (2006) found that gay men and lesbian women do not display heightened incidences of psychopathology, suicidal behavior, distress, or substance-related disorders. However, some research indicates that gay men and lesbian women are at a greater risk of anxiety and mood disorders, as well as suicide attempts. According to Gordon and Castro (2007), the higher incidences of mood and anxiety disorders among gay and lesbian individuals may be due to factors such as increased experiences with discrimination, prejudice, and anti-gay violence, as well as less access to beneficial psychological services, as opposed to being the direct result of individuals’ sexual orientation. The authors state that this hypothesis is reinforced by the fact that research shows a decrease in the discrepancy between psychopathology and homosexual sexual orientation when the experiences of discrimination in participants’ lives are controlled for statistically.

In addition to studies that indicate there is no difference in the psychological functioning of heterosexual and homosexual individuals, in 2000, the American Psychological Association published guidelines for engaging in treatment with homosexual individuals. As part of the guidelines, APA’s statement from 1975 regarding homosexual individuals is highlighted: “Homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities . . . and mental health professionals should take the lead in removing the stigma of mental illness long associated with homosexual orientation” (Conger, p. 1). Further, the guidelines assert that psychologists should not consider homosexuality to be an indicator of mental illness, should not attribute distress or impairment to the client’s sexuality but to the

discriminatory experiences that are often associated with having a homosexual orientation, and that they should educate themselves on common gay and lesbian issues and on individual differences within the gay and lesbian community. Additionally, in a survey of lesbian and gay therapy clients, it was determined that two thirds of participants asserted that their sexual orientation had nothing to do with the psychological problems they were experiencing (Gordon & Castro, 2007). Despite these advances in the field of psychology, there is still research that indicates that many mental health professionals hold biases and stereotypes toward gay and lesbian individuals, which are incorporated into their assessment, diagnosis, and treatment of these individuals.

It has been established that therapists who maintain negative attitudes towards gay men and lesbians are less effective, and potentially harmful, in their delivery of services to homosexual clients and their family members (Ben-Ari, 2001). However, negative attitudes do persist among mental health professionals. It is true that an affirmative model of therapy with gay and lesbian individuals has become the requested and preferred model; however, it has been slow to be implemented into actual practice. For example, despite the fact that homosexuality was removed from the *DSM* in 1973, and that an affirmative model was provided as the model of choice in 1975, Herek & Garnets (2007) reported that studies continued to indicate that many therapists practiced in ways that were perceived by gay and lesbian clients to be biased, insensitive, not helpful, and potentially harmful. Gays and lesbians in these studies indicated that they had felt as if the importance of their same-sex relationships were minimized, that they were debased because of their sexual orientation, that they were denied therapeutic services based on their sexual orientation, and that they were encouraged to become straight, despite the

fact that both the American Psychiatric Association and the American Psychological Association have determined that conversion therapy is unethical, not effective, and harmful to clients. A portion of the problem may lie in the fact that studies have shown that there are weaknesses in training programs and in clinical supervision with regard to addressing affirmative training in clinical work with the gay and lesbian population (Murphy, Rawlings, & Howe, 2002). For example, a study by Ben-Ari (2001) measured homophobia among 235 social work and psychology faculty members and found that overall, members of the academic departments of helping professions display “low grade” homophobic attitudes.

Bias toward homosexual individuals in therapy has also been evidenced through studies which have looked at therapists and their actual beliefs about, and professional interactions with, homosexual clients. Studies, beginning in the late 1970s, have used an experimental design in order to actually measure how a client’s reported sexual orientation may affect therapists’ views of the client. In 1978, Lipinski studied counselors at 13 universities in the United States. Participants were given four case descriptions with audiotaped segments of the four clients. The four clients were a gay man, a straight man, a straight woman, and a lesbian. Results indicated that counselor participants rated the gay male and lesbian female clients as more pathological, as needing more intensive treatment, and as warranting more serious diagnoses than were the heterosexual male and heterosexual female clients. In an assessment of the presence of heterosexual bias in assessment and diagnosis of patients, Garfinkle and Morin (1978) asked 40 psychotherapists to rate a hypothetical client based on an intake case history, as well as their view of a psychologically healthy individual. The case histories included

hypothetical clients who were either a straight male, a straight female, a gay male, or a lesbian woman, and each participant received one of the histories for evaluation. Results indicated that attributions of psychological health did differ as a function of sexual orientation of the hypothetical client. Specifically, heterosexual clients were perceived as more psychologically healthy than homosexual clients.

It could be argued that considering the fact that homosexuality was only removed from the *DSM* as a psychological diagnosis in 1973, it is somewhat understandable how early studies of diagnostic bias against homosexual individuals would demonstrate that mental health professionals' diagnostic impressions were influenced negatively if the presenting patient was a gay man or lesbian woman. However, more current studies have continued to show similar bias by mental health professionals against homosexual individuals. For example, Rubinstein (1995) studied the influence of patients' sexual orientation on therapists' perception of mental health. In this study, 417 therapists were assigned case histories where the hypothetical client was either heterosexual or ego-syntonic homosexual (not experiencing any reported difficulties with his or her sexual orientation). Results illustrated that opinions of severity of mental illness were found to differ as a function of the hypothetical patient's sexual orientation. Specifically, when therapists' age and experience were held as covariates, results indicated that the homosexual patient's mental state was perceived as significantly more severe than the heterosexual patient's mental state. In a more recent study, Bartlett, King, and Phillips (2001) explored homophobia among 218 psychotherapists. Results showed that the therapists' self-reported interactions with gay and lesbian clients were indicative of both

overt and covert forms of bias, including approaching clients in ways so as to pathologize their homosexual orientation.

Biases have also been found among undergraduate students enrolled in psychology courses, which indicates that students may enter training programs with previously developed biases toward homosexual individuals. For example, Davison and Friedman (1981) explored bias toward homosexual clients among students enrolled in an undergraduate abnormal psychology course. Participants were asked to evaluate a hypothetical male client, who was presented through a case vignette as being either homosexual or heterosexual. Results indicated that when the hypothetical client was presented as homosexual, he was more likely to be diagnosed with a sexual deviation and to have his non-sexual diagnoses justified on the basis of his homosexuality. In addition, the hypothetical homosexual client was more likely to have his sexual or marital life investigated and more likely to have his sexuality perceived as important in the development of his non-sexual psychological problems. These types of biases may be expected among undergraduate students in 1981, eight years after homosexuality was removed from the *DSM* as a psychological disorder; however, results from more recent graduate training program studies indicate that such biases continue to exist, even among higher level students.

Despite the fact that psychology training programs have begun emphasizing homosexual-affirmative techniques in the last several years, recent studies show that findings similar to those noted above, found among practicing therapists and undergraduate psychology students, have also been found among therapists in training. Liddle (1995) investigated advanced graduate counseling and counseling-psychology

students' level of respect for a hypothetical female client, who was presented via a videotaped intake session as either heterosexual or homosexual. Results indicated that male participants' respect ratings were lower for the lesbian condition than for the heterosexual condition. In a similar study, Kerr, Walker, Warner, and McNeill (2003) examined graduate-level counselor trainees' conceptualizations of client problem, diagnosis, and assessment of overall psychopathology for hypothetical female clients who were identified through case vignettes as being either heterosexual or homosexual. Results indicated that participants were more likely to perceive the lesbian client's problems as being related to sexual orientation than the heterosexual client's problems.

Barrett and McWhirter (2002) explored how three factors (client sexual orientation, counselor trainee homophobia, and counselor trainee gender) affected counselor trainees' assignment of positive and negative adjectives to clients. Participants received one of four case descriptions, varied by gender and sexual orientation, which resulted in a gay male history, a heterosexual male history, a lesbian history, and a heterosexual female case history. All three factors were found to significantly predict counselor trainees' perceptions of clients. Not surprisingly, homophobia scores were found to significantly predict the assignment of unfavorable adjectives. In addition, more homophobic trainees assigned fewer favorable adjectives to lesbian and gay clients and higher amounts of favorable adjectives to heterosexual male and female clients. Finally, the study revealed a significant interaction between trainee gender and homophobia scores, with male trainees assigning increasingly more unfavorable adjectives as their homophobia scores increased when compared to female trainees.

Gender Bias in Assessment and Diagnosis

Many of the stereotypes that influence the assessment of gay men and lesbian women and prevent the unbiased diagnosis of this population are based on the gender inversion theory of homosexuality proposed by Freud. According to this theory, gay men are more similar to heterosexual females than they are to heterosexual males, and lesbians are more similar to heterosexual males than they are to heterosexual females (Blashill & Prowlishta, 2009). In order to understand the ways that these stereotypes affect the diagnosis of gay men and lesbian women, it is necessary to first understand gender role stereotypes and how gender bias has affected assessment and diagnosis of heterosexual men and women historically. Following a discussion of gender stereotypes and their influence on diagnostic decision making, the discussion turns to an exploration of how these stereotypes have often been inverted and applied when assessing and diagnosing homosexual individuals.

The major theories of psychology have evolved almost exclusively from the experiences of Caucasian, upper- to middle-class men treating clients with similar traits in a Western culture. The result has been a set of assumptions about what constitutes mental health and mental illness that is based on these white, masculine, middle class values and worldviews (Lee & Richardson, 1991). Definitions of mental health are of paramount importance because they are at the base of psychological theory, practice, and research. If these definitions are biased in favor of some groups over other groups, the result is unfair assumptions about the mental health of members of minority or “out” groups. For example, Usher (1989) demonstrated that individuals who are viewed by mental health professionals as mentally and emotionally healthy have an internal locus of

control and are independent, self-confident, competitive, self-sufficient, and assertive. These attributes are stereotypes of white, middle-class, American men, and individuals displaying traits such as cooperativeness, connection to others, stability, and who have an external locus of control, may be viewed as less emotionally and psychologically healthy. This represents a clear gender bias within the field of psychology, as these characteristics are often associated with female gender roles (Cook, 1992).

Current diagnostic systems are based on the above-noted biases and worldviews. Acceptance without question of these views of mental health can easily result in the mislabeling of groups of people who do not conform to this certain set of standards. There is a long history of complaints about the *DSM* being biased against certain cultural groups and women. For example, some researchers have asserted that women appear less psychologically healthy than men based on the fact that they are diagnosed with mental disorders more often (Ritchie, 1994). Other researchers, as opposed to blaming diagnostic criteria that are based on the worldview of a relatively small portion of the world population (i.e., white, middle-class men), assert that the problems with bias in assessment and diagnosis may be the result of the preponderance of male-based norms in society and resulting personal biases on the part of mental health professionals (Cook, Warnke, & Dupuy, 1993). Regardless of the etiology of the bias, the result is that certain groups, women and homosexual individuals included, are disproportionately labeled with certain disorders because of their propensity toward displaying certain traits, as opposed to the presence of true psychopathology (Velsquez, Johnson, & Brown-Cheatham, 1993).

There is much research regarding how males and females are diagnosed with certain psychological disorders at disproportionate rates. Some researchers have asserted that this is because there is an actual difference in the rates of certain disorders between the sexes. For example, according to Cleary (1987), men are more likely than women to display problems with suicide, antisocial behaviors, and drug and alcohol abuse. Conversely, women are more likely than men to display problems with psychotropic drug abuse, depressive disorders, anxiety disorders, and phobias. The majority of theories, however, indicate that differential rates of certain psychological disorders between the sexes are due to social norms and gender stereotypes.

Depression, specifically, has been highly studied because far more women than men are diagnosed with depressive disorders (Cook, 1990). Some researchers have theorized that this occurs because depressive symptoms are indicative of traditional gender role stereotypes. For example, Landrine (1988) described definitions of depression as caricatures of women's traditional roles, which stressed characteristics such as passivity, dependence on others, helplessness, and lack of self-confidence. Other theorists have suggested that the higher rates of depression in women are the result of differences in the ways that men and women are socialized. Kaplan (1987) stated that because women are socialized to have strength in the area of relationships, but this strength is not valued by society, their depression is often a result of difficulties in their interpersonal relationships, including frequent disappointments in relationships and a sense of responsibility for maintaining relationships at the expense of expressing their own wishes, anger, and needs. Warren (1983) suggested that the differential rates of depression between women and men may be due to social norms regarding how the sexes

feel it is appropriate to display their distress, in that men may be more prone to externalize, avoid, or deny their depression, to withdraw from others, and to allow symptoms to manifest as work problems because they fear social rejection for admitting the experience of depressive symptoms.

Another reason that women may be diagnosed with mental disorders at higher rates than men was suggested by Eriksen and Kress (2008). The authors stated that young girls' problems are more likely to evolve into mental illnesses later in life, while young boys' problems may be more likely to evolve into criminality. This may be because young girls are socialized to internalize their problems, while young boys are socialized to externalize their problems. In addition, there may be more pressure on women to maintain the gender stereotypes with which they are socialized, which may lead to higher rates of certain disorders among women. For example, Angermeyer, Matschinger, and Holzinger (1998) found that women who act in ways that are not considered feminine receive very harsh criticism, but that men who act in ways that are not considered masculine do not receive as much criticism. Feminist theorists criticize the *DSM* for including disorders that reflect a masculine bias and have higher prevalence rates in females, such as premenstrual dysphoric disorder and borderline, histrionic, dependent, and self-defeating personality disorders. Of particular concern among feminist theorists is the fact that parallel diagnoses for men have not been proposed or added to the current diagnostic system (Caplan, 1992).

Regardless of the reasons why, two facts remain clear: Women are diagnosed with mental illnesses more often than men, and there are diagnoses that are particularly masculine or feminine in their qualifying criteria and reflect societies views of extreme

masculinity and extreme femininity. In addition, traditional female roles are evaluated negatively by society, and traditional male roles are evaluated positively by society. This fact is displayed through Collins' (1998) review of Zimbardo's prison study, which was conducted in 1971. Collins observed, through watching videotapes of the experiment, that students who were designated as prisoners developed symptoms that are most commonly seen in *DSM* diagnoses that are typically ascribed to women, such as depression, anxiety, suicidality, and eating disturbances. Conversely, students who were designated as prison guards developed symptoms that are most commonly seen in *DSM* diagnoses that are typically ascribed to men, such as antisocial acts including becoming verbally and physically assaultive.

A greater problem than biased diagnostic criteria is the fact that gender stereotypes appear to create negative biases among clinicians, which then affect the assessment and diagnosis of women. Problems with gender stereotyping in the process of assessment and diagnosis seem to be reflections of broader social problems with the unequal treatment of women and other minority group members. Mental health professionals, despite their best efforts to provide unbiased and equitable care to all clients, seem to be affected by these social problems, and the biases and stereotypes are reflected in their work (Eriksen & Kress, 2008). Many researchers have explored the presence of gender biases in the assessment and diagnosis of clients with the consistent result that women are often devalued and clinically affected by negative sex role stereotypes.

According to Phillips and Gilroy (1985), the most commonly cited investigation of the relationship between sex and clinical judgment was performed by Broverman,

Broverman, Clarkson, Rosenkrantz, and Vogel in 1970. The researchers in the Broverman study administered a measure of sex role stereotypes to 79 clinically trained psychiatrists, psychologists, and social workers. They also asked participants to describe a mature, healthy, socially competent male, female, and adult (sex unspecified). Results indicated that clinical judgment of mental health varied with the sex of the individual being evaluated in a manner that reflects traditional sex role expectations. In addition, the researchers found that participants were more likely to attribute traits of a psychologically healthy individual to a male than to a female. The researchers highlighted the irony in the findings, and how it places women in a difficult position, stating that in order to be considered mentally healthy, a woman must “adjust to and accept behavioral norms for her sex, even though these behaviors are generally less socially desirable and considered to be less healthy for the generally competent, mature adult” (Broverman, et al., 1970, p. 6).

Teri (1982) investigated the effects of sex and sex role style on clinical judgment. The results indicated that client sex role style significantly affected ratings of current functioning, and client sex significantly affected ratings of expected client functioning. More specifically, the findings supported the theory of there being sex biases in clinical assessment, as the therapist-participants negatively evaluated behaviors that are stereotypically female, and they also expected females to be more amenable to treatment. Loring and Powell (1988) found that merely knowing a client’s sex influenced the diagnostic process, even amongst experienced mental health practitioners. Poole and Tapley (1988) explored whether or not clinical psychologists expected similar behavior from females and males in situations that were traditionally female or male. Specifically,

participants were asked to rate the appropriate behavior of a mature, healthy, and socially competent individual under four circumstances (a male in the home environment, a male in the work environment, a female in the home environment, and a female in the work environment). Results indicated that there was a significant effect for environment, in that ratings for the work environment were closer to traditionally masculine traits. In addition, many researchers, including Becker and Lamb (1994), have shown that even when women and men presented with identical symptomatology, they received different diagnoses.

Gender Bias in the Diagnosis of Personality Disorders

An area of diagnosis and assessment that has received a large degree of investigation regarding gender and gender role stereotypes and biases is the area of personality disorders. According to Crosby and Sprock (2004), bias in the diagnosis of personality disorders may occur because of bias on the part of mental health professionals, as research has shown that clinicians assign different personality disorder diagnoses based on client sex. The primary method of assessing bias in diagnosis has been to manipulate patient sex in hypothetical case studies, while holding all other factors identical. Results of differential rates of diagnoses between men and women in these types of studies have consistently shown evidence of bias on the part of diagnosticians. For example, Becker and Lamb (1994) found that men are overdiagnosed with Antisocial Personality Disorder, and women are overdiagnosed with Histrionic and Borderline Personality Disorders. An explanation for these findings that has been proposed by many researchers is that personality disorders, particularly, are associated with masculine and, to a larger extent, feminine sex role stereotypes (Rienzi, Forquera, & Hitchcock, 1995).

Since 1980, when diagnostic criteria for personality disorders were first standardized for the *DSM*, all versions of the manual have stated that Borderline Personality Disorder has a higher prevalence in women than in men. In fact, according to the most recent edition, *DSM-IV-TR*, there is a 3:1 female-to-male ratio for prevalence of the disorder (Sansone & Sansone, 2011). However, more current research indicates that there is no difference in prevalence rates of personality disorders by gender. For example, in a recent epidemiological study, Grant, Chon, and Goldstein (2008) found that Borderline Personality Disorder is equally common among women and men. In addition, studies on gender bias in the diagnosis of personality disorders, dating as far back as 25 years, have indicated that clinicians do display negative female gender biases in the diagnosis of Borderline Personality Disorder (Henry & Cohen, 1983).

Some researchers have suggested that although men and women may display equal rates of Borderline Personality Disorder, they may display symptoms and behaviors indicative of the disorder in different ways. For example, men with the disorder may display higher rates of explosive behaviors while women with the disorder may display higher rates of neurotic symptoms (Sansone & Sansone, 2011). These differences in symptom presentation could affect the rates at which men and women are diagnosed with the disorder, as women with the disorder may be more likely to present for assessment and treatment, and men with the disorder may be more likely to be incarcerated because of their behavioral manifestations of the disorder. In addition, men with the disorder may display their impulsivity in explosive ways, which may lead to diagnoses of Antisocial Personality Disorder. Women, on the other hand, may display their impulsivity in more

internal ways, which may lead to diagnoses of Borderline Personality Disorder (Johnson, et al., 2003).

Zlotnick, Rothschild, and Zimmerman (2002) provided evidence for this theory. In their study, 130 outpatients with diagnoses of Borderline Personality Disorder were assessed for lifetime impulse-related disorders. The results indicated that men with Borderline Personality Disorder reported more symptoms of substance abuse disorders, antisocial traits, and symptoms of intermittent explosive disorder than women with the disorder. Women in the study were significantly more likely than men to report symptoms of an eating disorder. However, no gender differences were found in the rates of overall impairment of participants. These differences in symptom manifestation could easily explain the differences in reported prevalence rates of the disorder between the genders (Eriksen & Kress, 2008).

Borderline Personality Disorder is more frequently diagnosed in women, with two thirds to three quarters of those diagnosed with the disorder being female. As a result, the majority of the literature on the disorder focuses on occurrence and manifestation in women, and it does not incorporate gender as a variable or address the differences in clinical presentation between the sexes (Johnson et al., 2003). This fact leads to the continuance of the gender bias that exists with regard to Borderline Personality Disorder and it often being considered, both by mental health professionals and by lay persons, as a female disorder. Some researchers have suggested that the differential prevalence rates in Borderline Personality Disorder are a result of sampling bias. In other words, because women are more likely to present for treatment, whereas men may be more likely to become involved with the legal system as a result of the ways they display symptoms of

the disorder, women are overrepresented in research that investigates the disorder. In addition, the reverse is true as well, with three times more men being diagnosed with Antisocial Personality Disorder (Skodol & Bender, 2003). Some researchers have suggested that the two disorders are actually manifestations of the same symptomatology, but that when it is observed in men, it is seen as antisocial behavior, and when it is displayed in women, it is seen as borderline behavior. This may be due not only to gender stereotypes about what is considered acceptable masculine and feminine behavior, but also because the disorders seem to have become separated into gender categories over time.

Widiger (1998) suggested six ways that differential prevalence rates of personality disorders between the sexes may reflect sex bias in assessment and diagnosis. First of all, there is sampling bias, which means that higher rates of women in clinical settings may reflect the fact that women are more likely than men to seek assistance with psychological problems. Another form of bias may be biased diagnostic constructs, which is the sexist stereotyping of female behaviors as pathological. Similarly, there may be biased diagnostic criteria, which means that behaviors that are consistent with a person's gender role may be viewed as less pathological (this issue will be re-addressed when discussing inversion stereotypes of homosexuality and how gay men and lesbian women may experience bias in diagnosis). A fourth source of bias may be biased thresholds for diagnosis, which indicates that different levels of impairment are considered pathological or not pathological in women and men. Another form of bias may be the fact that mental health professionals have a tendency to misdiagnose certain personality disorders more often in women than in men. Finally, Widiger suggested that

a sixth form of gender bias in diagnosis and assessment may be the fact that items in self-report inventories and interviews may be more applicable to one sex than to the other, or they may not reflect dysfunction in one sex, but they do so in the other sex.

There is support in the research of biased sampling. Since a difference in the reported prevalence rates of Borderline Personality Disorder may be higher in women because more women are in treatment settings, in order to determine true prevalence rates, studies of the general population are needed (Skodol & Bender, 2003). There have been few such studies; however, there was a representative population-based study performed by Torgersen, Kringlen, and Cramer (2001), in which no difference in prevalence rates was found between the sexes. There is also empirical evidence for the presence of biased diagnostic constructs and criteria. Sprock, Blashfield, and Smith (1990) explored whether *DSM* diagnostic criteria for Borderline Personality Disorder varied along a female-male dimension and found that almost all criteria for the disorder were rated as more characteristic of women, with the exception of inappropriate and intense anger, which was rated as strongly masculine. Furthermore, Klonsky, Jane, and Turkheimer (2002) found that individuals who behave contrary to socially-sanctioned gender roles were perceived as having more pathology consistent with Borderline Personality Disorder. Evidence of biased diagnostic thresholds has been shown through research by Sprock (1996), as the researcher showed that inappropriate and intense anger was rated as more abnormal for women than it was for men.

Other researchers have focused on cultural factors and socially sanctioned constraints on both male and female behaviors as the reason why women seem to be over-pathologized in general, as well as overly diagnosed with certain forms of

pathology, specifically Borderline, Dependent, and Histrionic Personality Disorders (Bjorklund, 2006). For example, Akhtar (1995) suggested that social factors may be related to the reported prevalence rates in personality disorders, hypothesizing that the lower rates of Antisocial Personality Disorder in women may be the result of more intense social control over female behavior. As evidence of this, the author stated that as society has changed and women have been allowed greater freedom to engage in various means of self-expression, the rates of Antisocial Personality Disorder diagnoses among women have increased.

Sargent (2003) similarly suggested that Borderline Personality Disorder, as well as the self-injurious behaviors that often times are associated with it, is part of the gender ideologies of industrialized, class-based societies in which the female body is seen as a commodity. This may explain why researchers such as Pinto, et al. (2000) have found that Borderline Personality Disorder is most often diagnosed in Westernized countries, with significantly fewer reports of the disorder in developing countries. Another social explanation for the gender differences in reported prevalence rates of Borderline Personality Disorder has been suggested by Wright and Owen (2001). The authors stated that women are considered by society to be more emotional, dependent on relationships, and relationally defined than men, and that these gender stereotypes affect women and the ways that they express psychological distress. As a result, gender stereotypes are embedded in diagnostic nosology, which makes the *DSM* a social construction (Horsfall, 2001).

Regardless of where the bias occurs in the diagnostic process or what the causes of gender bias are, bias in the diagnosis of personality disorders consistently has been

found to exist. Traits that are socially sanctioned as being more feminine than masculine have been found to be rated as more pathological among mental health professionals. For example, Simmons (1992) found that when stereotypically female behaviors are displayed by adult women, they are more likely to be diagnosed with a psychiatric disorder. There is also evidence that certain traits are seen as indicative of psychopathology in one sex; however, the same symptoms are overlooked in the other sex. For example, Gunderson and Zanarini (1987) found that demanding and dependent behavior in women were diagnosed as symptoms of Borderline Personality Disorder; however, they were not addressed when displayed by men. Finally, the presence of behaviors that are seen as stereotypically “male” are assessed differently in men and women. For example, Simmons (1992) found that women who were viewed as being angry and promiscuous were diagnosed as having Borderline Personality Disorder; however, men who were viewed as angry and promiscuous were diagnosed as having Antisocial Personality Disorder.

Hamilton, Rothbart, and Dawes (1986) performed a study in which 65 licensed clinical psychologists independently assessed and diagnosed 18 case histories on the basis of *DSM-III* categories. The results indicated that there was bias present in the diagnosis of personality disorders. Of the 18 case histories provided to participants, 10 were target cases. The target cases consisted of a male version and a female version in which the individual displayed one of five symptom clusters: all antisocial behavior, all histrionic behavior, predominantly antisocial behaviors with some histrionic behaviors, all histrionic behaviors with some antisocial behaviors, and an equal amount of antisocial and histrionic behaviors. Participants were then asked to provide an applicability rating

from 1 to 11 for each vignette for 10 diagnostic categories provided. Results showed sex bias. Specifically, there was a main effect for sex and the category of Histrionic Personality Disorder, with females being rated as more histrionic than males. The authors concluded that women are far more likely to be diagnosed as histrionic than men, even when presenting symptoms are identical.

In a similar study, Ford and Widiger (1989) also explored gender bias in the diagnosis of Histrionic and Antisocial Personality Disorders. Three hundred fifty-four psychologists read 9 case studies and provided specific personality disorder diagnoses and also rated the degree to which specific features of the cases met 10 histrionic and antisocial criteria. The researchers used the second method of assessment listed above in order to attempt to control for the actual names of the disorders, as they are often automatically conceptualized as predominantly male or female disorders. Results indicated the presence of sex bias in the diagnosis of personality disorders. Specifically, for the histrionic case study, participants were significantly more likely to diagnose women with Histrionic Personality Disorder than they were men. For the antisocial case study, participants were significantly more likely to diagnose males with Antisocial Personality Disorder than they were females. Finally, results also indicated that the female antisocial vignette was significantly more likely to be diagnosed as histrionic than as antisocial. Despite the presence of sex bias in the diagnosis of disorders, there were no significant differences between the sexes on ratings of individual disorder criteria. Regarding this outcome, the researchers stated, "Individual items may not be sex-biased, but the absence of such bias at the item or criterion level does not prevent or even inhibit bias in the final diagnosis" (Ford & Widiger, 1989, p. 304).

Belitsky et al. (1996) also studied the presence of sex bias in the diagnosis of personality disorders; however, in addition, the researchers had participants complete the *Sex-Role Egalitarianism Scale*. In the study, 96 psychiatry residents evaluated one of four possible case histories, which included male and female versions of an individual with either Histrionic Personality Disorder or Antisocial Personality Disorder. Results indicated that female participants held more egalitarian views of sex roles than did male participants. In addition, although significantly more men than women received a diagnosis of Antisocial Personality Disorder, there were no significant differences between men and women for the diagnosis of Histrionic Personality Disorder. This was a surprising finding, as the majority of studies completed have shown that women are far more likely than men to receive a diagnosis of Histrionic Personality Disorder. The researchers attempted to explain this inconsistent finding by stating that participants may have been aware of the purpose of the study by being primed by questionnaire packets that were high in face validity and by the fact that the researchers were known to the participants as being interested in women's mental health issues.

In another study in which the relationship between patient sex and bias in personality disorder diagnosis was explored, Crosby and Sprock (2004) found that bias occurred when the patient's sex (female) was inconsistent with the symptoms displayed (masculine). Participants were asked to read two case studies, the target study and a study that was used to divert attention from the target case. The target case was a case that met criteria for Antisocial Personality Disorder; however, the case was also somewhat ambiguous in order to allow for variability in diagnosis. The non-target case was a case of mixed personality symptoms meeting criteria for a diagnosis of Personality

Disorder Not Otherwise Specified. Three versions of both cases were constructed: a male version, a female version, and a gender-unspecified version. Participants were also asked to complete a sex role inventory in order to determine if participants held traditional or nontraditional sex role beliefs. Results indicated sex bias in the diagnosis of personality disorders. Specifically, results showed that the male version of the vignette received more diagnoses of Antisocial Personality Disorder, and that the female version of the vignette received more diagnoses of Borderline Personality Disorder. In fact, almost all diagnoses of Borderline Personality Disorder were assigned to the female vignette. In addition, the female version of the target vignette was rated as more histrionic than the male version. Finally, when the female version of the target vignette did receive traditionally masculine diagnoses, such as antisocial and narcissistic symptoms, they were also rated as having higher symptom severity, indicating that women who displayed behaviors that are not seen as consistent with traditional sex roles were seen as more pathological.

Gender Role Bias in Assessment and Diagnosis

The results of the majority of research available suggest that gender bias exists in assessment and diagnosis. Women are more likely to be diagnosed with mental illnesses in general, they are more likely to be rated as more severely impaired, and they are more likely to be diagnosed with certain disorders, especially Histrionic, Dependent, and Borderline Personality Disorders. However, there is another form of gender bias in assessment and diagnosis that seems to affect both men and women, heterosexual and homosexual. This is sex role bias, and it is bias based on deviation from socially-sanctioned sex role stereotypes.

Sex role stereotypes, according to Belitsky et al. (1996), are societal expectations about what the appropriate attributes, behaviors, goals, and activities of males and females are. According to gender schema theory, individuals develop ways of organizing information regarding gender roles early in life. This organization is referred to as schemas, and these schemas are based on behaviors that are expected of men and of women, as well as on prototypes of what society considers masculine and feminine. This theory further asserts that individuals with strong sex role beliefs of a traditional nature are more influenced by others' sex and sex roles and are more likely to display sex bias (Crosby & Sprock, 2004). Research has consistently shown that society has agreed upon what are considered appropriate personality traits for men and for women. In addition, society has traditionally had higher regard for personality traits that are considered masculine. Furthermore, research has shown that sex role stereotyping occurs for both men and women, resulting in bias in the diagnosis of both sexes (Basow, 1992).

Past studies have shown that individuals who behave contrary to gender role stereotypes are perceived to be more pathological in general, as well as to show higher levels of Borderline Personality Disorder (Klonsky et al., 2002). Research has also shown that judgments of mental health are strongly correlated with a person's conformity to socially-prescribed gender roles (Waisberg & Page, 1988), and that women and men are judged and treated as more seriously mentally ill when their behaviors are inconsistent with these socially-constructed gender roles (Belitsky et al., 1996). Women are believed to have higher rates of neurotic psychopathology than men, and the symptoms represented by such disorders are consistent with expectations of the feminine role within society. Also, men are believed to have higher rates of antisocial

psychopathology than women, and the symptoms represented by such disorders are consistent with expectations of the masculine role within society. Rosenfield (1982) referred to this as deviant deviance, which she described as individuals presenting with psychiatric disorders that are more consistent with expectations of individuals of the opposite sex. When men and women stray from what would be considered expected psychopathology based on their sex, they are frequently judged as being more pathological.

According to Rosenfield (1982), when men exhibit deviant behavior that is more consistent with a feminine sex role, the reaction to them is stronger than it is to women who display the same behavior. In addition, when women exhibit deviant behavior that is more consistent with a masculine sex role, the reaction to them is stronger than it is to men who display the same behavior. There is evidence for the pathologizing of divergence from gender role stereotypes in the literature. For example, Spitz (1976) showed that men who displayed passive and clinging behaviors drew out hostility and rejection from therapists working with them. Bernstein, Kick, Leung, and Shultz (1977) explored this gender role bias in the area of criminal behavior. The researchers found that women who committed crimes which were more stereotypically typical of men (i.e., assault) were punished more severely, as evidenced by them being convicted of more serious charges than men who committed the same crime. Rushing (1979) explored the numbers of males and females in mental institutions, specifically looking at their lengths of hospitalization. Results caused the author to conclude that a double standard of mental health is applied to both men and women, with both sexes being deemed more

pathological if their presenting symptoms are not consistent with expected sex role behaviors.

Rosenfield (1982) examined the effect of patient sex role status on decisions about psychiatric hospitalization. The researcher made three specific hypotheses, and the overall prediction of the study was that individuals would be seen as more pathological if their symptoms deviated from societal expectations of appropriate gender role behavior. It was first hypothesized that men would be responded to more harshly (i.e., would be more likely to be hospitalized) if they displayed the stereotypically feminine symptoms of neurosis and depression. The second hypothesis was that women would be responded to more harshly (i.e., would be more likely to be hospitalized) if they displayed the stereotypically masculine symptoms of substance abuse and certain personality disorder pathology. The final hypothesis was that there would be no differences in the rates of hospitalization for individuals with schizophrenia, a disorder that is not typically associated with either masculine or feminine sex role stereotypes. Results of the study indicated that all hypotheses were supported, as both males and females were more likely to be hospitalized if they displayed symptoms that deviated from expected symptoms based on gender role. In addition, there was no difference in the rates of hospitalization of individuals displaying symptoms of schizophrenia. The researcher concluded that “the same level or form of behavior in males and females seems more visible or striking if it contradicts sex role expectations and thus appears to the observer as a more problematic form of the behavior” (Rosenfield, 1982, p. 23).

This gender role bias has obvious implications for homosexual individuals, who, based on inversion theory, are assumed to display symptoms of opposite-gender

individuals. According to Kite and Deaux (1987), stereotypes about homosexual individuals are based on dominant stereotypes of heterosexual men and women, which when applied to homosexual individuals, are based on the inversion theory of homosexuality that derived from classic theories of sexuality as proposed by Freud (1905) and Ellis (1915). This inversion theory states that some young men and women begin to identify so strongly with the opposite-sex parent that they take on his or her characteristics, including his or her sexual interests. Therefore, it appears as if homosexual individuals are particularly susceptible to bias based on sex role stereotypes since they are typically seen as violating traditional expectations of masculinity and femininity. In fact, research has indicated that gay men and lesbian women are the victims of diagnostic decisions that are based, at least partially, upon an inversion of gender stereotypes, which means that homosexual individuals are seen as more closely resembling the opposite sex.

According to Drescher (2010), many cultures have historically confused having a homosexual identity with having the personal identity of opposite-gender individuals. This may happen because traditional heterosexuality is used as the frame of reference, so any behavior differing from heterosexuality is viewed as opposite and inappropriate. It is only recently that homosexuality and trans-gender identity have been clearly distinguished as two separate categories. Homosexuality is now understood as “an individual’s erotic response tendency or sexual attractions,” while gender identity is understood as “one’s sense of oneself as being either male or female” (Drescher, 2010, p. 430).

Despite this clarification, many individuals, both lay people and mental health professionals, continue to hold inversion stereotypes of homosexual individuals, which frequently results in bias, discrimination, and unfair treatment. This occurs in the realm of psychological assessment and diagnosis, which is expected to be a scientific and unbiased endeavor for mental health professionals. For example, Millham, San Miguel, and Kellogg (1976) found that participants endorsed statements about homosexuality that indicate implicit inversion theory, or that homosexual individuals exhibit characteristics of the opposite sex. Also, Deaux and Lewis (1984) found that in both males and females, gender-inconsistent role behavior resulted in participants assuming that the individual was homosexual. Furthermore, according to Herek (1989), people appear to be more tolerant of homosexual individuals who fit gender stereotypes than those who do not, which seems to support the claim that stereotypes of homosexual individuals are based on the inversion of gender stereotypes of heterosexual men and women.

Bias based on these gender inversion stereotypes of homosexual individuals has important implications for the provision of mental health services because, according to Zucker (1994), individuals who are perceived as being gender nonconforming are at a greater risk of stigmatization. In addition, these individuals may be ostracized for violating gender norms, in addition to being ostracized because of the assumption that they are homosexual (Herek, 1991).

Inversion Stereotype Bias in Assessment and Diagnosis

As explained by Kite & Deaux (1987), the idea that homosexual individuals violate traditional gender roles originated with Freud and his gender inversion theory. According to the theory, gay men are more similar to heterosexual females than they are

to heterosexual males, and lesbians are more similar to heterosexual males than they are to heterosexual females. Gays and lesbians are said to be inverted because they do not conform to the expectation of opposite-sex attraction (Rees, Doyle, Holland, & Roots, 2005). Like much of early psychoanalytic theory, despite its lack of basis in empirical research, the inversion theory of homosexuality has taken its place within the consciousness of lay people and mental health professionals. The result is that gay men and lesbian women are often responded to in ways that are influenced by these inversion stereotypes.

According to Blashill & Prowlishta (2009), another reason that the gender inversion theory of homosexuality is retained by people is the fact that stereotypes provide a way for individuals to categorize, conceptualize, and make sense of their world. This theory asserts that objects (or people) who are alike in some way are assumed to be alike in other ways as well. Therefore, if a lesbian woman and heterosexual man have the common characteristic of being sexually attracted to women, they may be (even if incorrectly) assumed to be alike in other ways as well. This type of thinking allows people to focus on relevant distinctions and ignore irrelevant distinctions when learning a new category of information and applying this information to new situations. This tendency does help people simplify their world; however, it also causes them to exaggerate the differences between groups of people, as well as the similarities within groups of people. According to Yarhouse (1999), this is how stereotypes lead to overgeneralizations about groups of people.

According to Blashill and Prowlishta (2009), there are a number of ways to examine whether or not the inversion stereotypes of homosexual individuals affect the

ways that they are perceived by others. The first approach is to present male and female targets with unspecified sexual orientations, but who vary in terms of gender role behaviors, and then to determine participants' ideas about the targets' sexual orientations. The results of such studies have revealed that targets who do not conform to gender norms are seen as more likely to be homosexual (Deaux & Lewis, 1984; McCreary, 1994). Another means of exploring inversion stereotypes is to present targets that vary in their sexual orientation and then assess participants' views of the targets' masculinity and femininity. The results of these studies have revealed that gay male targets are seen as more feminine and less masculine than heterosexual male targets and that lesbian targets are seen as more masculine and less feminine than heterosexual female targets (Lehavot & Lambert, 2007). A third method of exploring gender inversion stereotypes is to assess participants' views of the characteristics that targets are assumed to possess. Results of these studies have shown that gay males are seen as more feminine and less masculine than lesbians or heterosexual men, and lesbians are seen as more masculine and less feminine than gay men and heterosexual women (Taylor, 1983).

In a study assessing masculine and feminine traits believed to be possessed by men and women of both heterosexual and homosexual orientation, Kite and Deaux (1987) found that participants viewed gay males as less masculine and more feminine than heterosexual males and that they viewed lesbian women as less feminine and more masculine than heterosexual females. The researchers concluded, "Results showed that people do subscribe to an implicit inversion theory wherein male homosexuals are believed to be similar to female heterosexuals, and female homosexuals are believed to be similar to male heterosexuals" (p. 83). In a 1992 study, Eliason, Donelan, and Randall

asked 189 nursing students to state how they would know if a co-worker was a lesbian. Thirty-one percent of participants stated that they would assume a co-worker to be a lesbian if she displayed an aura of masculinity. Participants also reported several physical characteristics that would lead them to conclude that a co-worker was a lesbian, such as wearing masculine clothes and having a masculine hairstyle. In a study assessing inversion stereotypes of gay males, Madon (1997) found that people have a tendency to divide gay males into two distinct groups, one that is indicative of feminine traits and personality variables, and another that is indicative of feminine behaviors and physical appearance.

In her study, Madson (2000) showed that when shown male, female, and physically androgynous target pictures, participants rated the physically androgynous targets as more likely to be homosexual than heterosexual. In a more current study, Blashill and Prowlishta (2009) investigated whether or not gay men and lesbian women are assumed to possess attributes that are most commonly attributed to opposite-gender individuals. Participants were asked to rate a target individual (gay male, lesbian female, heterosexual male, or heterosexual female) on his or her adherence to traditionally masculine and feminine traits, activities, and occupational interests. Results indicated that gay males were viewed by participants as less masculine and more feminine than heterosexual males, and that lesbian women were viewed by participants as being more masculine and less feminine than heterosexual females. Wright and Canetto (2009) studied stereotypes held about older gay men and lesbian women and found that older lesbians were viewed as similar to heterosexual men and that older gay men were viewed as similar to heterosexual women. The authors concluded, "Sexual minorities were

targets of unique stereotypes. Consistent with the implicit inversion theory . . . these findings suggest the persistence into late adulthood of the belief that lesbians and gay men are inverted females and males” (p. 424).

The majority of the above-described studies used undergraduate college students as participants in order to gauge the degree that gender inversion stereotypes of homosexual individuals exist within society. However, there is empirical evidence that gender inversion stereotype bias toward homosexual individuals also occurs within the diagnostic work of mental health professionals. According to Yarhouse (1999), “Therapists may accept or reject certain perceptions about in-group and out-group members on the basis of a priori assumptions, beliefs, and associations. Clearly, the effect can be negative because it denies the idiosyncratic characteristics of the individual” (p. 156). A study by Casas, Brady, and Ponterotto (1983) showed that clinicians did not accurately process information that opposed commonly held stereotypes of homosexual individuals, as the authors discovered that therapists made more errors when processing information about gay men and lesbians than they did when processing information about heterosexual men and women. In a similar study, Dillon (1986) found that therapists failed to ask detailed, routine questions of homosexual clients, were more likely to rely on stereotypes, and viewed the etiology of the client’s presenting problem as related to his or her sexual orientation, as opposed to reported concerns. The study also showed that when therapists failed to ask the questions that would have resulted in data that was unique to the client, they were more likely to rely on stereotypes.

A more current study by Eubanks-Carter & Goldfried (2006), which focused on the effects of sexual orientation on the diagnosis of Borderline Personality Disorder,

showed the presence of gender inversion stereotype bias in the diagnostic process. In the study, 141 psychologists evaluated case vignettes that were varied by sexual orientation and gender and in which the depicted individual displayed symptoms that were partially consistent with Borderline Personality Disorder. Results indicated that when the individual was depicted as a male and assumed by participants to be homosexual, the vignette was more likely to receive a diagnosis of Borderline Personality Disorder. This is interesting because, as stated previously, bias in the diagnosis of Borderline Personality Disorder has traditionally been displayed as overdiagnosis in females and underdiagnosis in males. The results in this study, however, displayed opposite results, which may be indicative of the application of inversion stereotypes of homosexuality in the diagnostic decision-making process.

Despite the depth of research in the areas of psychologists' bias in diagnosis, homosexual bias, gender bias, and gender role bias, few studies have attempted to study the effects of sexual orientation and gender inversion stereotypes on the assessment and diagnosis of homosexual individuals, specifically. Boysen et al. (2006) asked participants (college students and counselor trainees) to rate a list of psychological symptoms based on their perceived applicability to gay men. Results indicated that participants (both college students and counselor trainees) listed symptoms as being applicable to the mental health of gay men that were traditionally seen as being applicable to the mental health of women, including symptoms of anxiety, eating, mood, and personality disorders. In a follow-up study, Boysen, Fisher, and DeJesus (2011) studied college students' mental health stereotypes about various groups and found that among stereotypes about gay men, heterosexual women, and lesbian women, stereotypes

about the mental health of gay men partially overlapped with stereotypes of the mental health of women.

In a study that attempted to explore the effect of client sexual orientation and gender role on psychologists' clinical judgment, Gordon (2010) examined 135 psychologists' clinical judgments (measured through diagnostic impression ratings, global and relational functioning ratings, and views of client attractiveness) of gay men, lesbians, individuals displaying cross-gendered roles, heterosexual females, heterosexual males, and individuals displaying gender-congruent roles. The researcher also examined participants' levels of heterosexual identity development. Results of the study indicated that the psychologist-participants significantly differed on the ratings they assigned to homosexual versus heterosexual individuals. More specifically, the results indicated that, although sexual orientation of the target client and participants' level of heterosexual identity development both predicted the differences in participant ratings between homosexual and heterosexual individuals, the two factors together were a better predictor of the difference than either of the two factors alone.

Finally, although some research has focused on the presence and results of gender inversion stereotypes of homosexual individuals among mental health professionals, there is relatively little research that has focused specifically on the presence and results of mental health stereotypes about lesbian women. Several studies have focused on stereotypes of gay males, and when lesbian women are discussed in the literature, it is typical for them to be included in the larger group of all homosexual individuals. In fact, according to Phillips et al. (2003), lesbians represent an understudied group in the

psychological literature, and future researchers need to examine stereotypes that are specific to this group.

Assessment of Personality Disorders in DSM-5

In the fifth edition of the *DSM*, which was released in May of 2013, the manner in which personality is assessed and personality disorders are diagnosed underwent a significant change from the methods used in *DSM-IV-TR*. As explained on the *DSM-5* website (www.DSM5.org), the Personality and Personality Disorders Work Group worked to move the diagnosis of personality disorders from a system in which individuals are placed into discrete categories of specific diagnoses to a system in which individuals are rated on a series of personality traits along continua (APA, 2010). This hybrid categorical/dimensional model was adopted in *DSM-5* as an alternative model for personality disorders. In this alternative model, all individuals are evaluated on certain personality traits along continua, as opposed to only being placed into dichotomous categories of disorder when personality pathology exists (APA, 2013).

The result of the work group was an alternative model of personality assessment that incorporates a combination of the discrete and continuous methods of personality assessment and personality disorder diagnosis, and this model has three primary changes from the current system. First, in the alternative model, specific categories of six personality disorders have been maintained for individuals displaying severe personality pathology that meet criteria for the disorders. In addition, all individuals will be rated on five broad personality domains and 25 more specific personality facets. Therefore, the specific personality traits of all individuals will be placed on continua, so for individuals meeting criteria for specific personality disorders, the traits displayed will be better

specified, and for individuals not meeting criteria for a specific personality disorder, personality traits will continue to be assessed from a dimensional model. Finally, individuals who display significant difficulty in either self-identity or interpersonal functioning, but who do not meet criteria for a specific personality disorder, will receive a diagnosis of Personality Disorder, Trait Specified, and specific traits will be assessed using the dimensional model.

Specific reasons have been given for this shift in the assessment of personality and diagnosis of personality disorders. One argument is that the criteria for personality disorders as outlined in *DSM-IV-TR* are too specific. This results in limited utility of the personality criteria because even individuals displaying obvious personality pathology may not meet the specific criteria for a particular disorder, which results in the overuse of the diagnostic category of Personality Disorder Not Otherwise Specified (Verheul & Widiger, 2004) and in many individuals being diagnosed with more than one personality disorder (Zimmerman, Rothschild, & Chelminski, 2005). Another reason is that although personality traits are understood as being stable over time, studies have shown that discrete personality disorder categories may be more fluid and changing in nature (Durbin & Klein, 2006). Finally, it is now understood that the range between healthy and disordered personality is continuous, as opposed to dichotomous (Widiger, Simonsen, Krueger, Livesley, & Verheyl, 2005). As a result, the current discrete categories of specific personality disorders do not account for differences between individuals who meet criteria for the same personality disorder, and they cannot be applied to individuals who display personality problems but who do not meet criteria for a specific personality disorder (APA, 2010).

At the time of the development of this study, proposed diagnostic changes in personality assessment for *DSM-5* (which, as noted above, have since been added to *DSM-5* as an alternative model) had undergone two major rounds of revisions. As a result of the initial changes in 2010, in the alternative model, personality was to be assessed on multiple levels. First, clinicians would be required to rate an individual's overall level of personal and interpersonal functioning on a 5-point scale. In addition, clinicians would assess the person on six broad personality domains on a 4-point scale and on 37 more specific personality facets on a 4-point scale. The rating of individuals on the domains and facets was to occur regardless of whether an individual was thought to have a personality disorder, which is consistent with the fact that personality traits fall along continua of normal to dysfunctional for all people. In addition, it was initially proposed that some degree of discrete diagnosis would remain as evidenced through the decision that five personality types (borderline, antisocial, schizotypal, avoidant, and obsessive-compulsive) would be retained as well, with each disorder having a specific constellation of trait facets. Finally, the general definition of personality disorder was changed to focus on adaptive failure, as evidenced by failure to develop a sense of identity of self and/or failure to develop or maintain appropriate interpersonal functioning (APA, 2010). The reason for this general definition, according to Hopwood et al. (in press), is that the general severity of personality pathology is the most important single predictor of concurrent and prospective dysfunction.

The second revised version of personality assessment proposed for *DSM-5* was announced in 2011 and included a few, relatively minor, changes. The total number of personality trait domains was reduced from six to five, and the total number of

personality trait facets was reduced from 37 to 25. The trait domain of compulsivity was removed from the revised proposal; however, it has been suggested that an opposite trait, disinhibition (which is defined as lack of rigid perfectionism), could be used to measure the construct. In addition, trait facets were included in multiple trait domains, resulting in an overall consolidation of trait domains and facets (Mayer, 2012). This resulted in the following domains: Antagonism, Detachment, Disinhibition, Negative Affectivity, and Psychoticism, each of which is comprised of a specific cluster of the 25 personality trait facets. It has been proposed that mental health professionals use the domains and facets in the following ways: Depending on how relevant an assessment of personality traits is to the individual being assessed, only the five domains could be assessed, all of the facets could be assessed, or the five domains and then the facets of those domains rated as significantly elevated could be assessed.

In addition, in the alternative diagnostic system for personality disorders added to *DSM-5*, Narcissistic Personality Disorder was added to the list of retained specific personality types, and specific diagnostic criteria were included for each of the six personality types. Finally, diagnostic criteria were given for a Personality Disorder, Trait Specified label, which replaces the current Personality Disorder Not Otherwise Specified category and is to be used when an individual has impairments in personal functioning and interpersonal functioning, but who does not meet criteria for one of the six retained personality types (APA, 2013). The hybrid of dimensional and categorical methods that has been added as an alternative model in *DSM-5* presents the opportunity to assess the use of this new method in the assessment of personality and diagnosis of personality disorders in heterosexual and homosexual men and women in order to determine if

differences exist for these groups based on the presence of gender role and inversion stereotypes.

The Current Study

The study was approved by the Human Use Committee of Louisiana Tech University (see Appendix A). The purpose of the study was to explore the effects of gender role biases, as well as gender inversion stereotypes, on diagnostic impressions of persons presenting for treatment who display difficulties in personality functioning. It has been well established that there are negative effects of gender bias in the diagnosis and assessment of heterosexual men and women, including the pathologizing of behaviors that may be normative within particular gender-related contexts and the under diagnosis of gender non-congruent behaviors (Eriksen & Kress, 2008). In addition, research has shown the negative effects of inversion stereotypes in the diagnosis and assessment of both gay men and lesbian women; however, this research has focused primarily on Axis I disorders and the presence of psychopathology in general (Gordon, 2010). There has been some research that has investigated the effects of inversion stereotypes on personality assessment and suggested that inversion stereotypes may influence mental health professionals' clinical judgment of personality functioning (Boysen, Fisher, & DeJesus, 2011); however, research in this area is lacking. In addition, in an extensive review of the related literature, no studies were found that have assessed both heterosexual gender role biases and homosexual inversion stereotypes simultaneously.

This is an area of great importance, as bias in assessment and diagnosis has been shown to be related to a host of negative treatment factors. This includes inaccurate case

conceptualization (specifically focusing on gender roles and/or sexual orientation, even when those are not part of the presenting problem); clients feeling misunderstood and at times like victims of discrimination within the therapeutic relationship; premature ending of treatment; exacerbation of symptoms; and underdiagnosis of some disorders and overdiagnosis of other disorders across genders and sexual orientations (Greene, 2005). Greater understanding of the manifestations of bias in assessment and diagnosis has the potential to lead to more effective and ethical practices by highlighting areas of weakness, which may merit a greater focus in training programs. Personality disorders are an area that have proven to be particularly susceptible to the effects of biased diagnostic practices, particularly when gender roles and gender stereotypes are considered; however, no known study, to date, has assessed both gender and inversion stereotype bias in the assessment of personality traits and in the diagnosis of personality disorders.

As previously noted, past research has shown that Borderline and Antisocial Personality Disorders are particularly susceptible to the effects of gender biases. This is because antisocial behaviors are seen as more appropriate when displayed by men than by women. In addition, research has shown that behaviors consistent with Borderline Personality Disorder are seen as more acceptable when displayed by women than by men. This is likely because the emotional symptoms of Borderline Personality Disorder have been determined by society to be feminine traits, and the acting-out behaviors of Antisocial Personality Disorder have been determined by society to be more masculine traits. For this reason, the current study focused on the diagnoses of Borderline and

Antisocial Personality Disorder, as well as on the trait domains and facets associated with these disorders.

The influence of gender and inversion biases on the diagnostic process in graduate-level counseling and clinical psychology trainees was assessed for two important reasons. First, it is assumed that graduate training programs strongly emphasize acceptance and appreciation of diversity, as well as the ethical implications of biased practice. However, a great deal of research has shown that training programs are lacking in the amount of time spent on training in the areas of multiculturalism and diversity and that graduate student trainees may still continue to hold biased opinions of sexual minorities, despite the fact that the field as a whole is moving toward acceptance and unbiased, ethical treatment. In addition, there have been many older studies conducted in which gender and inversion biases in practicing professionals have been assessed; however, in order to ascertain the degree to which problems in this area have or have not improved in the last few decades, it seemed appropriate to assess the practices of newer participants in the profession.

Finally, an additional purpose of the current study was to explore the effects of heterosexual gender biases and homosexual inversion stereotypes on the assessment and diagnosis of personality disorders from both discrete and dimensional models. Although many studies have assessed gender bias in the diagnosis of personality pathology, an extensive literature review revealed no research that has studied the effects of stereotypic thinking on the diagnosis of personality disorders using both discrete and dimensional scales of measurement. Both the discrete and dimensional methods of diagnosis were utilized by asking participants to choose a specific *DSM-IV-TR* diagnosis, as well as by

asking them to rate subjects along continua of applicable personality traits. This method was quite timely, as an alternative model for the assessment of personality disorders has since been added to *DSM-5* nosology, and this model is a hybrid system, such as the one used in current study.

The study provides the opportunity for the assessment of personality using *DSM-5* dual scales by assessing the presence of these biases when methodology consistent with the alternative model for personality assessment in *DSM-5* was employed. Additionally, as stated previously, the presence of gender and inversion biases in assessment and diagnosis has implications for the quality of treatment for a large portion of the population. Furthermore, the findings of this study are useful in assessing the presence of gender and inversion biases in the newest generation of psychologists, which may have implications for areas of needed change and/or improvement in current training programs.

Hypotheses

The following set of hypotheses reflects expectations about participants' gender and inversion stereotype biases in the diagnosis of discrete categories of personality disorders.

Hypothesis 1

Individuals seen as displaying more traditionally feminine attributes (heterosexual women and gay men) will receive more frequent diagnoses of Borderline Personality Disorder; whereas, individuals seen as displaying more traditionally masculine attributes (heterosexual men and lesbians) will receive more frequent diagnoses of Antisocial Personality Disorder. More specifically:

H1a. Participants who receive the heterosexual female vignette will assign a diagnosis of Borderline Personality Disorder at a significantly higher rate than participants who receive the lesbian vignette, as measured by both a free-response diagnosis and a forced-choice diagnosis.

H1b. Participants who receive the gay male vignette will assign a diagnosis of Borderline Personality Disorder at a significantly higher rate than participants who receive the heterosexual male vignette, as measured by both a free-response diagnosis and a forced-choice diagnosis.

H1c. Participants who receive the heterosexual male vignette will assign a diagnosis of Antisocial Personality Disorder at a significantly higher rate than participants who receive the gay male vignette, as measured by both a free-response diagnosis and a forced-choice diagnosis.

H1d. Participants who receive the lesbian vignette will assign a diagnosis of Antisocial Personality Disorder at a significantly higher rate than participants who receive the heterosexual female vignette, as measured by both a free-response diagnosis and a forced-choice diagnosis.

H1e. Participants who receive a female vignette (heterosexual or homosexual) will assign a diagnosis of Borderline Personality Disorder at a significantly higher rate than participants who receive a male vignette (heterosexual or homosexual), as measured by both a free-response diagnosis and a forced-choice diagnosis.

H1f. Participants who receive a male vignette (heterosexual or homosexual) will assign a diagnosis of Antisocial Personality Disorder at a significantly higher rate than

participants who receive a female vignette (heterosexual or homosexual), as measured by both a free-response diagnosis and a forced-choice diagnosis.

The next set of hypotheses reflects expectations about participants' gender and inversion stereotype biases in the assessment of continuous personality traits.

Hypothesis 2

Individuals seen as displaying more traditionally feminine attributes (heterosexual women and gay men) will be rated higher on traits of negative affectivity; whereas, individuals seen as displaying more traditionally masculine attributes (heterosexual men and lesbians) will be rated higher on traits of antagonism and disinhibition. More specifically:

H2a. Participants who receive the heterosexual female vignette will assign significantly higher ratings on traits of negative affectivity than participants who receive the lesbian vignette, as measured by ratings on the Brief Assessment of Traits - 37 (BAT-37).

H2b. Participants who receive the gay male vignette will assign significantly higher ratings on traits of negative affectivity than participants who receive the heterosexual male vignette, as measured by ratings on the BAT-37.

H2c. Participants who receive the heterosexual male vignette will assign significantly higher ratings on traits of antagonism and disinhibition than participants who receive the gay male vignette, as measured by ratings on the BAT-37.

H2d. Participants who receive the lesbian vignette will assign significantly higher ratings on traits of antagonism and disinhibition than participants who receive the heterosexual female vignette, as measured by ratings on the BAT-37.

H2e. Participants who receive a female vignette (heterosexual or homosexual) will assign significantly higher ratings on traits of negative affectivity than participants who receive a male vignette (heterosexual or homosexual), as measured by ratings on the BAT-37.

H2f. Participants who receive a male vignette (heterosexual or homosexual) will assign significantly higher ratings on traits of antagonism and disinhibition than participants who receive a female vignette (heterosexual or homosexual), as measured by ratings on the BAT-37.

The next set of hypotheses reflects expectations about the interaction between participants' gender role values and their gender and inversion stereotype biases, as displayed in both the diagnosis of discrete categories of personality disorder and the assessment of continuous personality traits.

Hypothesis 3

Participants scoring higher in conservatism on the Attitudes toward Women Scale-Short Version will display higher rates of gender bias and inversion stereotype bias in their diagnosis of personality disorders and rating of personality traits than individuals scoring higher in egalitarianism on the Attitudes toward Women Scale-Short Version.

More specifically:

H3a. Participants scoring higher in conservatism will assign diagnoses of Borderline Personality Disorder to heterosexual women and gay men at a significantly higher rate than participants scoring higher in egalitarianism.

H3b. Participants scoring higher in conservatism will assign significantly higher ratings on traits of negative affectivity to heterosexual women and gay men than participants scoring higher in egalitarianism.

H3c. Participants scoring higher in conservatism will assign diagnoses of Antisocial Personality Disorder to heterosexual men and lesbians at a significantly higher rate than participants scoring higher in egalitarianism.

H3d. Participants scoring higher in conservatism will assign significantly higher ratings on traits of antagonism and disinhibition to heterosexual men and lesbians than participants scoring higher in egalitarianism.

The next set of hypotheses reflects expectations about the interaction between participants' positive or negative attitudes toward homosexual individuals and their gender and inversion stereotype biases, as displayed in both the diagnosis of discrete categories of personality disorder and the assessment of continuous personality traits.

Hypothesis 4

Participants scoring higher in negative attitudes toward homosexual individuals, as measured by performance on the Attitudes Toward Lesbians and Gay Men Scale-Revised, will display higher rates of gender bias and inversion stereotype bias in their diagnosis of personality disorders and ratings of personality traits than individuals scoring higher in positive attitudes toward homosexual individuals on the Attitudes toward Lesbians and Gay Men Scale-Revised. More specifically:

H4a. Participants scoring higher in negative attitudes toward homosexual individuals will assign diagnoses of Borderline Personality Disorder to heterosexual

women and gay men at a significantly higher rate than participants scoring higher in positive attitudes toward homosexual individuals.

H4b. Participants scoring higher in negative attitudes toward homosexual individuals will assign significantly higher ratings on traits of negative affectivity to heterosexual women and gay men than participants scoring higher in positive attitudes toward homosexual individuals.

H4c. Participants scoring higher in negative attitudes toward homosexual individuals will assign diagnoses of Antisocial Personality Disorder to heterosexual men and lesbians at a significantly higher rate than participants scoring higher in positive attitudes toward homosexual individuals.

H4d. Participants scoring higher in negative attitudes toward homosexual individuals will assign significantly higher ratings on traits of antagonism and disinhibition to heterosexual men and lesbians than participants scoring higher in positive attitudes toward homosexual individuals.

Justification for Hypotheses

Past research has been consistent regarding the existence of gender bias in the diagnosis of personality disorders (Becker and Lamb, 1994; Belitsky et al., 1996; Crosby & Sprock, 2004; Ford & Widiger, 1989; Simmons, 1992; Zanarini, 1987); however, there has been much less research in the area of the effects of gender stereotypes on the dimensional assessment of personality traits. In addition, past research has been consistent regarding the existence of inversion stereotype biases held among the general population and among mental health professionals (Boysen et al., 2011; Eliason et al., 1992; Gordon, 2010; Kite & Deaux, 1987; Madon, 1997; Madson, 2000); however, very

little research (Eubanks-Carter & Goldfried, 2006) has explored the effects of inversion stereotype bias in the diagnosis of personality disorders specifically.

It was expected that gender biases would be found to affect the dimensional assessment of personality traits in much the same way that they have been shown to affect the diagnosis of discrete categories of personality disorders. It was also expected that inversion stereotype biases would be found to affect the assessment of personality traits and diagnosis of personality disorders in gay men and lesbian women in much the same way that gender biases have been shown to affect the diagnosis of personality disorders in heterosexual individuals. It was further anticipated that both gender and inversion stereotype biases would be affected by interactions with egalitarian vs. conservative gender role views and with positive vs. negative views of homosexual individuals. Finally, it was expected that participants, who were clinicians in training, would exhibit the same biases that have been shown in practicing mental health professionals.

CHAPTER TWO

METHOD

Pilot Study

Prior to presenting the clinical vignettes to participants in the current study, a preliminary study was conducted to examine the construct validity for the diagnoses of interest. Specifically, the investigator sought to ensure that the clinical vignettes described symptomology consistent with diagnoses of Borderline Personality Disorder and Antisocial Personality Disorder as outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*.

The control vignette, in which gender and sexual orientation were not identified, was distributed to clinical faculty, fourth-year counseling psychology doctoral students, and practicing clinical psychologists associated with the Department of Psychology and Behavioral Sciences at a public southern university. Fifteen vignettes were distributed, with a response rate of 12 individuals (80%). Participants included five faculty members, four practicing psychologists, and three fourth-year counseling psychology doctoral students. Once the 12 pilot study participants signed an informed consent form and read the vignette, they were asked to provide their initial diagnostic impression of the individual described in the vignette. Anonymity was ensured by requiring pilot study participants to place diagnostic impression forms and informed consent forms in separate envelopes in a secured location.

Validity of the vignette was to be considered established if 80% of individuals diagnosed the individual portrayed in the vignette with Borderline Personality Disorder, Antisocial Personality Disorder, or Personality Disorder Not Otherwise Specified with Borderline and/or Antisocial traits/features. This method of ensuring that the vignette portrays the symptoms of interest is consistent with past studies that have used clinical vignettes in order to assess diagnostic decision making (e.g., Becker & Lamb (1994); Crosby & Sprock (2004); Ford & Widiger (1989)).

Pilot study results (Table 1) revealed that 11 individuals (92%) diagnosed the individual portrayed in the vignette with Borderline Personality Disorder, Antisocial Personality Disorder, or as possessing traits/features of Borderline Personality Disorder and/or Antisocial Personality Disorder. One participant (8%) did not give one of the above-listed diagnoses.

Pilot study data indicated that the majority of participants perceived the individual portrayed in the vignette as displaying symptoms consistent with a diagnosis of Antisocial Personality Disorder and/or Borderline Personality Disorder. Pilot study results further indicated that the diagnoses of either Borderline Personality Disorder/traits/features or Antisocial Personality Disorder/traits/features were fairly evenly distributed among participants, with six participants (50%) assigning a diagnosis of Borderline Personality Disorder, five participants (42%) assigning a diagnosis of Antisocial Personality Disorder, four participants (33%) assigning a diagnosis of traits or features of Borderline Personality Disorder, and three participants (25%) assigning a diagnosis of traits or features of Antisocial Personality Disorder. Given the satisfactory

findings of this preliminary study, it was decided to retain the clinical vignettes for inclusion in the study.

Table 1

Pilot Study Results

Participant	Diagnostic Impression(s)
1	Borderline Personality Disorder; Poly Substance Dependence (Provisional)
2	Antisocial Personality Disorder with Borderline Traits
3	Comorbid Borderline and Antisocial Personality Disorder
4	Personality Disorder NOS with Borderline and Antisocial Features
5	Antisocial Personality Disorder with Borderline Features
6	Antisocial Personality Disorder
7	Borderline Personality Disorder
8	Borderline Personality Disorder with Antisocial Features
9	Bipolar Disorder; Avoidant Personality Disorder
10	Antisocial Personality Disorder with Borderline Traits
11	Borderline Personality Disorder; Rule Out Antisocial Personality Disorder
12	Borderline Personality Disorder; Rule Out Bipolar Disorder

Participants

Participants were recruited from Clinical and Counseling Psychology doctoral training programs throughout the United States. Programs were selected for inclusion based on membership in one of the following two organizations: Council of Counseling Psychology Training Programs (CCPTP) or Council of University Directors of Clinical Psychology (CUDCP). Participants were recruited through emails sent to the training directors of their respective programs. Upon agreeing to participate, participants were provided with an internet link to the online study. Randomization to one of the four experimental groups, or to the control group, was accomplished through the survey website.

Measures

When accessing the study, participants were presented with a series of forms, and they were informed that they must complete each section prior to advancing to the next. They were informed that they would not be able to return to previous sections once completed. The series of forms were presented in the following order: Consent Form; Pre-Vignette Demographic Questionnaire (Appendix B); Clinical Vignette (Appendix C); *DSM-IV-TR* Diagnostic Impression Form (Appendix D); Brief Assessment of Traits – 37 (BAT-37) (Appendix E); Attitudes Toward Women Scale-Short Version (AWS) (Appendix F); Attitudes Toward Lesbians and Gay Men Scale-Revised (ATLG-R) (Appendix G); Post-Vignette Demographic Questionnaire (Appendix H); and a Research Information and Follow-up Form.

Demographic Questionnaires

Upon accessing the study online, participants were asked to complete a pre-vignette demographic questionnaire. This questionnaire included information regarding gender, age, race, sexual orientation, political orientation, religious orientation, type of training program, highest degree awarded and area of degree, year in training program, an estimation of the number of hours of direct clinical experience they have had, number and type of practicum placements, theoretical orientation, and specific courses taken as part of training. After being presented with the clinical vignette, providing categorical and trait diagnostic impressions, and completing the Attitudes Toward Women and Attitudes Toward Lesbians and Gay Men scales, participants were then asked to complete a post-vignette demographic questionnaire. This questionnaire included information regarding classes, trainings, and workshops taken related to multiculturalism and psychopathology/diagnosis; diversity of training program and university campus; comfort interacting with individuals displaying sexual orientation and gender identity diversity both in personal and professional situations; experience with addressing diversity issues in supervision; and specific areas in which diversity training has been received. This questionnaire was presented at the end of the study in order to prevent participants from being prompted regarding the purpose of the study, in order to attempt to control for socially desirable responding.

Clinical Vignette

Participants were then provided with one of five clinical vignettes to read. The vignettes were all identical, with the exception of the sample client's characteristics being varied by gender and sexual orientation, resulting in a heterosexual male, a heterosexual

female, a homosexual male, and a homosexual female vignette. There was also a control vignette, in which the gender and sexual orientation of the presented individual was unspecified. The vignettes presented the case history of an individual displaying symptoms of both Borderline and Antisocial Personality Disorder, a method which past researchers (Hamilton, Rothbart, & Dawes, 1986) have used to assess the effects of gender biases on the assessment of personality disorders. The vignettes were constructed using the borderline and antisocial vignettes from a *DSM-IV-TR* case studies book (Frances & Ross, 2001).

DSM-IV-TR Diagnostic Impression Form

After indicating that they had completely read the vignette, participants were presented with a diagnostic impression form. The *DSM-IV-TR* Diagnostic Impression Form was created for this study in order to assess trainees' views of where the individual described in the vignette should be placed with regard discrete diagnostic categories based on *DSM-IV-TR* nosology, as well as to collect diagnostic impressions that are unbiased by the subsequent forced-choice diagnoses of interest. The form first asked for a discrete diagnostic impression of the vignette based on *DSM-IV-TR* nosology. Participants were asked to provide their initial diagnostic impression in a free response blank. For the initial diagnostic impression, participants were not limited to Axis I or II, and they were not limited to a certain number of permissible diagnoses. After submitting their initial diagnosis, participants were then presented with a forced-choice diagnostic question, in which they were asked to choose the one diagnosis that they felt best fit the individual presented in the case vignette from a list of various mood and Axis II personality disorders. Diagnoses included the diagnoses of interest in the current study

(Borderline Personality Disorder and Antisocial Personality Disorder). However, other options were also provided and were intended to serve as distractors of the purpose of the study. These disorders included other Axis II personality disorders (Narcissistic Personality Disorder and Histrionic Personality Disorder), which past research has shown are diagnosed at different rates for women and men (Becker & Lamb, 1994), and which therefore served the dual purpose of being distractors from the diagnoses of interest and also of potentially providing additional gender and inversion stereotype bias data. Further, the Axis I mood disorder diagnoses of Major Depressive Disorder and Bipolar I Disorder were also listed as options in order to distract from the purpose of specifically assessing the diagnosis of personality disorder.

Brief Assessment of Traits – 37

After choosing a specific diagnosis, participants were asked to form a continuous diagnostic impression using the Brief Assessment of Traits – 37 (Mayer, 2012).

Participants rated the applicability of personality trait domains and facets initially proposed for *DSM-5* to the individual portrayed in the vignette, with an emphasis on the three domains and 11 facets that overlap in the diagnoses of Borderline and Antisocial Personality Disorders. The three domains of interest included Negative Affectivity, Antagonism, and Disinhibition, and the 11 facets of those domains included Emotional Lability, Anxiousness, Separation Insecurity, Depressivity, Impulsivity, Risk Taking, Hostility, Manipulativeness, Deceitfulness, Callousness, and Irresponsibility.

The Brief Assessment of Traits – 37 was developed by Mayer in 2012 to assess personality domains and traits along spectrums, which is consistent with the assessment of personality traits that has been added as an alternative model in *DSM-5*. The BAT-37

measures the 37 facets initially proposed for *DSM-5* through 37 3-question clusters, which were derived from the 111 descriptions of traits provided by the American Psychiatric Association (2010). The ratings of the 37 clusters are provided on a 4-point Likert-type scale, where 0 indicates *does not describe the individual at all*, 1 indicates *mildly describes the individual*, 2 indicates *moderately describes the individual*, and 3 indicates *describes the individual very well*.

A preliminary study by Mayer (2012) provides empirical justification for assessing the initially-proposed *DSM-5* personality traits using the 37 3-question clusters included in the BAT-37. Moderate to strong correlations were obtained between the cluster scores and the averages of the combined corresponding item scores on each trait facet ($r = .454$ to $r = .861$). In addition, moderate to strong correlations were obtained between individual items and the corresponding cluster scores ($r = .338$ to $r = .830$). Finally, correlations between overall cluster and item means were also strong ($r = .878$). Overall, few psychometric differences were found between the 37 clusters on the BAT-37 and the original 111 items proposed for *DSM-5* (Mayer, 2012).

Comparison of the BAT-37 to theoretically-related scales such as the Dimensional Assessment of Personality Pathology – Basic Questionnaire (DAPP-BQ; Livesley & Jackson, 2009), the HEXACO Personality Inventory – Revised (HEXACO-PI-R; Ashton & Lee, 2009; Lee & Ashton, 2004), and the Personality Assessment Inventory (PAI; Morey, 1991, 1996, 2007) indicated support for the construct validity of the BAT-37. Correlations were in the hypothesized directions and ranged from moderate to high. In addition, exploratory factor analysis of the BAT-37 traits produced a factor structure that has similarity to the trait factors proposed by the Five Factor Model of personality, which

has been stated to be influential in the development of the portion of personality assessment in *DSM-5* that incorporates dimensional measurement of traits (Mayer, 2012).

Attitudes Toward Women Scale-Short Version

The AWS was originally developed in 1972 by Spence and Helmreich at the University of Texas. The instrument was designed to measure beliefs about the rights and roles of women in comparison to men. The AWS is a 55-item questionnaire made up of statements that describe roles and behaviors across all major areas of life. Sample items include, “Intoxication among women is worse than intoxication among men,” and “Swearing and obscenity are more repulsive in the speech of a woman than of a man.” A shorter version of the questionnaire, the Attitudes toward Women Scale-Short Version (Spence, Helmreich, & Stapp, 1973), was later developed. This version was used in the proposed study. The scale consists of 25 statements that are rated on a 4-point Likert scale, with 0 indicating *agree strongly*, 1 indicating *agree mildly*, 2 indicating *disagree mildly*, and 3 indicating *disagree strongly*. Higher scores indicate more egalitarian attitudes, and lower scores indicate more traditional, conservative gender attitudes. Twelve of the items are reverse scored. Obtained alpha and split-half reliabilities for the 55-item scale are .92 and .93, respectively, and for the 25-item scale, they are .89 and .86, respectively (Daugherty & Dambrot, 1986).

Attitudes Toward Lesbians and Gay Men Scale-Revised

The ATLG-R (Herek, 1984) is a brief scale that measures individuals’ attitudes toward gay men and lesbian women. Specifically, the scale gauges respondents’ affective responses to homosexuality, in general, and to gay men and lesbians, specifically. The scale consists of 20 items – 10 about gay men and 10 about lesbians –

and respondents are asked to provide their level of agreement or disagreement with each statement. Responses are coded on a 2-point scale, with 1 indicating *agree* and 2 indicating *disagree*. High scores indicate positive attitudes toward homosexuals, and low scores indicate negative attitudes toward homosexuals. Three of the lesbian items are reverse scored, and four of the gay male items are reverse scored. Alpha levels have consistently been found to be greater than .85 for each of the two subscales and .90 for the full scale. Test-retest reliability correlations have been found to be .83 for the gay male subscale, .84 for the lesbian subscale, and .90 for the entire scale (Herek, 1994). With regard to validity, high scores (which are indicative of negative attitudes toward homosexuals) have been found to be significantly correlated with high religiosity, little contact with homosexual individuals, traditional sex role attitudes, and high levels of dogmatism. Furthermore, individuals in gay and lesbian activism and advocacy groups have been found to consistently receive low scores, which indicate positive attitudes towards homosexual individuals (Herek, 1994).

Procedure

Participants were informed about the study and given information about how to access the study online from the training director of their Clinical or Counseling Psychology programs. They were also informed that participation would result in the option to enter their email address in a drawing to receive a \$100 gift card. Once participants accessed the study via *Qualtrics*, they were presented with an informed consent form and informed that they should click an “accept” button in order to continue with the study. Participants were informed about confidentiality, anonymity, and their right to withdraw from participation in the study at any time. In order to control for

social desirability effects, the purpose of the study was listed by the more general title of “An exploration of decision making in differential diagnosis.” Participants who continued with the study clicked a button stating that they agreed to the terms and conditions. Participants then completed the demographic questionnaire. Once this form was completed, they clicked to continue to the presentation of the clinical vignette. Each participant was randomly assigned to read either one of the four experimental vignettes or the control vignette. Randomization was achieved through *Qualtrics* set up options, which allowed for the randomization of variables within a single study.

After participants clicked to indicate that they had read the vignette, they were presented with the diagnostic impression portion, on which they first typed their initial diagnostic impression. Participants were then asked to select a discrete diagnosis based on *DSM-IV-TR* nosology and then to rate the applicability of a series of personality domains and facets based on proposed *DSM-5* nosology through the BAT-37 questionnaire. Upon completion of the diagnostic impression form, participants were presented with the AWS-Short Form and then the ATLG-Revised. Participants were only informed of the general purpose of the study, which was to explore differential diagnostic decision-making. Therefore, the AWS and ATLG were presented after the clinical vignettes and diagnostic impression form so that participants would not be influenced by the specific purpose of the study. This was an attempt to control for the effects of social desirability. In addition, participants were not able to return to previous pages of the study once they had progressed.

Upon completion of the study, participants were informed of the full purpose of the study, provided with contact information for obtaining a summary of the results of the

study, and provided with referral information for seeking help or counseling if needed. In addition, participants were given the option of entering an email drawing for a \$100 gift card. Anonymity was ensured by having the gift card emailing process completely separated from the process of participating in the actual study. The data was then analyzed to determine differences between diagnostic impressions among the five vignette groups.

CHAPTER THREE

RESULTS

Participants

A total of 340 participants initiated the survey in the present study. Of this group, 204 participants (60%) completed the survey. Of the 204 participants who completed the study, 168 (82.4%) were female, 35 (17.2%) were male, and 1 (0.5%) was transgendered (female-to-male). The majority ($n = 167$, 81.9%) were Caucasian, 12 (5.9%) were Asian, 9 (4.4%) were Bi/Multiracial, 7 (3.4%) were Hispanic/Latino(a), 5 (2.5%) were African American, 3 (1.5%) were Middle Eastern, and 1 (0.5%) was Native American/Alaska Native. Participants' ages ranged primarily ($n = 136$, 66.7%) from 18 to 28 years, 58 (28.4%) ranged from 29 to 39 years, 8 (3.9%) ranged from 40 to 50 years, 1 (0.5%) ranged from 51 to 61 years, and 1 (0.5%) ranged from 62 to 72 years. The majority of participants ($n = 176$, 86.3%) identified their sexual orientation as heterosexual, 16 (7.8%) identified as bisexual, 11 (5.4%) identified as homosexual, and 1 (0.5%) identified as asexual.

Regarding political orientation, 136 of the 204 of participants (66.7%) identified as Democrat, 39 (19.1%) identified as Independent, 17 (8.3%) identified as Republican, 5 (2.5%) identified as Libertarian, and 7 (3.4%) identified no specific political preference. With regard to religion, 52 participants (25.5%) were Agnostic, 33 (16.2%) were Atheist,

26 (12.7%) were Catholic, 24 (11.8%) were non-denominational Christian, 21 (10.3%) were Protestant, 18 (8.8%) were Jewish, 7 (3.4%) were spiritual/non-affiliated, 6 (2.9%) were unspecified Christian, 6 (2.9%) were Buddhist, 3 (1.5%) chose no religion, 2 (1.0%) were Islamic, and 6 (2.9%) were unspecified.

The 204 participants represented a wide range of different types of training programs. 84 (41.2%) were from Clinical Psychology Psy.D. programs, 63 (30.9%) were from Clinical Psychology Ph.D. programs, 33 (16.2%) were from Counseling Psychology Ph.D. programs, 12 (5.9%) were from Counseling Psychology Psy.D. programs, 2 (1.0%) were from combined Clinical/Counseling/School Psychology Ph.D. programs, 2 (1.0%) were from Clinical-Community Psychology Ph.D. programs, and 8 (4%) were from unspecified doctoral-level mental health training programs. At the time of the study, the majority of participants ($n = 126$, 61.8%) had earned a Master's degree, 73 (35.8%) had earned a Bachelor's degree, 3 (1.5%) had earned a Doctorate degree, and 2 (1.0%) had earned an unspecified degree. Of these highest degrees earned, 74 (36.3%) were in the area of General Psychology; 64 (31.4%) were in Clinical Psychology; 20 (9.8%) were in Counseling; 17 (8.3%) were in Counseling Psychology; 4 (2.0%) were in Forensic Psychology; 2 (1.0%) each were in the fields of Industrial and Organizational Psychology, Social Work, Educational Psychology, and Cognitive and Brain Science; and 1 (0.5%) each was in the field of School Psychology, Gerontology, International Disaster Psychology, Behavioral Research, Neuroscience, Human Services, Classics, Health Psychology, Post-Secondary Education, Education, Studio Art, Human Development, Music, Neurobiology, Public Health, other mental health-related field, and other non-mental health-related field.

Regarding level of training, of the 204 participants, 68 (33.3%) were in the second year of their doctoral training program, 38 (18.6%) were in their third year, 30 (14.7%) were in their first year, 26 (12.7%) were in their fourth year, 25 (12.3%) were completing their pre-doctoral internship at the time of the study, 8 (3.9%) were in their fifth year of training, 7 (3.4%) had completed all doctoral training except for their dissertation, and 2 (1.0%) were in their sixth year of training or beyond but had not yet attended a pre-doctoral internship. Courses taken applicable to the current research included Adult Psychopathology ($n = 181$, 88.7%), Multiculturalism/Diversity ($n = 161$, 78.9%), Objective Personality Assessment ($n = 150$, 73.5%), Theories of Personality ($n = 110$, 53.9%), Projective Personality Assessment ($n = 103$, 50.5%), and Child Psychopathology ($n = 93$, 45.6%). With respect to theoretical orientation, 65 participants (31.9%) chose Cognitive/Cognitive-Behavioral; 35 (17.2%) chose Integrative; 29 (14.2%) chose Undecided/Not yet Developed; 20 (9.8%) chose Psychoanalytic/Psychodynamic; 12 (5.9%) chose Behavioral; 11 (5.4%) chose Interpersonal; 10 (4.9%) each chose Humanistic (including Client/Person-Centered, Existential, and Gestalt) and Eclectic; 3 (1.5%) chose Feminist; and 1 (0.5%) each chose Emotion-Focused, Third Wave Behaviorism, Integral, Relational Constructivism, Adlerian, Constructivist/Feminist, Systems, MCT, and Evidence-Based.

Forty-nine participants (24%) had completed one practicum placement, 46 (22.5%) had completed four or more practicum placements, 44 (21.6%) had completed no practicum placements, 37 (18.1%) had completed two practicum placements, and 28 (13.7%) had completed three practicum placements. These practicum placements included department-run clinics ($n = 90$, 44.1%); community mental health centers

($n = 71$, 34.8%); psychiatric hospitals ($n = 52$, 25.5%); university counseling centers ($n = 49$, 24%); medical hospitals ($n = 36$, 17.6%); private practices ($n = 27$, 13.2%); adult prisons/corrections ($n = 21$, 10.3%); primary/secondary schools ($n = 20$, 9.8%); Veterans Administration hospitals ($n = 17$, 8.3%); substance abuse centers ($n = 14$, 6.9%); child guidance centers ($n = 13$, 6.4%); child/adolescent prisons/corrections ($n = 11$, 5.4%); shelters ($n = 4$, 2%); community services and residential treatment facilities ($n = 3$, 1.5%); assessment facilities and chronic pain programs ($n = 2$, 1%); and hotlines, probations settings, senior adult centers, and traumatic brain injury centers ($n = 1$, 0.5%).

With regard to face-to-face client contact hours, 79 participants (38.7%) had 401 or more hours, 45 (22.1%) had 51 to 100 hours, 17 (8.3%) had 101 to 150 hours, 13 (6.4%) had 351 to 400 hours, 12 (5.9%) had 0 to 50 hours, 11 (5.4%) had 151 to 200 hours, 10 (4.9%) had 201 to 250 hours, 9 (4.4%) had 301 to 350 hours, and 8 (3.9%) had 251 to 300 hours.

Of the 204 participants who completed the survey, 48 (23.5%) were randomly assigned to the Heterosexual Female vignette, 43 (21.1%) to the Heterosexual Male vignette, 41 (20.1%) to the Homosexual Male vignette, 40 (19.6%) to the Control vignette, and 32 (15.7%) to the Homosexual Female vignette. Of the 48 participants who were assigned to the Heterosexual Female vignette, 39 (81.3%) were female, 8 (16.7%) were male, and 1 (2.1%) was transgendered (female-to-male). Of the 43 participants who were assigned to the Heterosexual Male vignette, 36 (83.7%) were female, and 7 (16.3%) were male. Of the 41 participants who were assigned to the Homosexual Male vignette, 31 (75.6%) were female, and 10 (24.4%) were male. Of the 40 participants who were assigned to the Control vignette, 35 (87.5%) were female, and 5 (12.5%) were male.

Finally, of the 32 participants who were assigned to the Homosexual Female vignette, 27 (84.4%) were female, and 5 (15.6%) were male.

Distribution

Prior to analysis, all variables were examined for accuracy of data entry, missing values, and the assumptions underlying multivariate analysis. The data were checked for multivariate outliers using a Mahalanobis Distance test, and ten multivariate outliers were found. It was decided to retain the outliers for data analysis in order to preserve the views of this subset of participants. Data analyses were performed with and without the above-noted outliers in order to ensure that there was not a discrepancy between the two data sets.

Scores from the Antisocial and Borderline subscales of the Brief Assessment of Traits - 37 Scale were severely negatively skewed, indicating that both antisocial and borderline traits were highly endorsed by participants, regardless of the vignette assigned. A cubed power transformation adequately corrected the skew of the Borderline subscale, and a square root transformation adequately corrected the skew of the Antisocial subscale. Scores from the Attitudes Toward Women Scale were severely negatively skewed. Multiple transformations were attempted on this scale, and the log transformation was chosen. Scores from the Attitudes Toward Lesbians and Gay Men Scale-Revised were severely negatively skewed. Multiple transformations were attempted on this scale, and the reciprocal transformation was chosen.

The assumptions for homogeneity of variances for all dependent measures were met with the exception of the Attitudes Toward Lesbians and Gay Men Scale-Revised scores. Box's test for equality of variance-covariance matrices, a test of the

homoscedasticity used in the MANOVA, was significant. Therefore, as suggested by Tabachnick and Fidell (2007), the Pillai's criterion was used because of its robustness to violations of assumptions. This is further supported by Mertler and Vannatta (2010) who stated, "... if homogeneity of variance-covariance is violated, a more robust multivariate test statistic, Pillai's Trace, can be selected when interpreting multivariate results" (p. 122).

Brief Assessment of Traits - 37

The 37 survey items and 4-point Likert response format of the Brief Assessment of Traits Scale - 37 (BAT-37) allow for a possible range of 0 – 111 for a participant's score, with high scores indicating that the traits were endorsed, and low scores indicating that the traits were not endorsed. Two subscales (Antisocial and Borderline) were created to assess for variables of interest. Both subscales were created using seven items of the BAT-37. The seven items were chosen because they were conceptually consistent with diagnostic criteria of the two disorders of interest. Both created subscales allowed for a possible range of 0 – 21 for a participant's score. BAT-37 subscale scores for all participants, as well as for each vignette, can be found in Table 2. The two created subscales were checked for reliability. Both subscales were found to have acceptable internal reliability: Antisocial, $\alpha = 0.77$; Borderline, $\alpha = 0.62$.

Table 2

Scale Scores for the Brief Assessment of Traits – 37

Vignette	Min – Max	<i>M</i>	<i>SD</i>
Borderline Domain			
All Participants	14 – 28	24.60	2.62
Control	19 – 28	24.55	2.25
Heterosexual Male	17 – 28	24.88	2.24
Homosexual Male	17 – 28	24.22	3.07
Heterosexual Female	16 – 28	24.52	2.73
Homosexual Female	14 – 28	24.88	2.81
Antisocial Domain			
All Participants	11 – 28	21.92	3.65
Control	15 – 28	22.18	3.41
Heterosexual Male	16 – 28	22.47	2.94
Homosexual Male	14 – 28	21.20	3.85
Heterosexual Female	13 – 28	22.31	4.05
Homosexual Female	11 – 27	21.19	3.86

Attitudes Toward Women Scale

The 25 survey statements and 4-point Likert response format of the Attitudes Toward Women Scale (ATW) allow for a possible range of 0 – 75 for a participant's score, with high scores indicating an egalitarian attitude, and low scores indicating a

traditional, conservative attitude. ATW scores for all participants, as well as for each vignette, can be found in Table 3.

Table 3

Scale Scores for the Attitudes Toward Women Scale (ATW)

Vignette	Min – Max	<i>M</i>	<i>SD</i>
All Participants	40 – 75	67.41	5.78
Control	53 – 75	67.95	3.41
Heterosexual Male	40 – 75	66.35	6.88
Homosexual Male	42 – 75	67.90	6.86
Heterosexual Female	55 – 75	67.23	4.81
Homosexual Female	52 – 75	67.78	5.11

Attitudes Toward Lesbians and Gay Men Scale-Revised

The 20 questions and Agree/Disagree response format of the Attitudes Toward Lesbians and Gay Men Scale-Revised (ATLG) allow for a possible range of 20 – 40 for a participant's score, with high scores indicating more positive views of homosexual individuals. The two ATLG subscales and their possible range of scores are as follows: Attitudes Toward Lesbians ($R = 10 - 20$); Attitudes Toward Gay Men ($R = 10 - 20$). ATLG total and subscale scores for all participants, as well as for each vignette, can be found in Table 4.

Table 4

Scale Scores for the Attitudes Toward Lesbians and Gay Men Scale (ATLG)

Vignette	Min – Max	<i>M</i>	<i>SD</i>
ATLG	25 – 40	38.97	2.21
Control	30 – 40	38.68	2.54
Heterosexual Male	25 – 40	38.72	2.64
Homosexual Male	27 – 40	38.85	2.73
Heterosexual Female	32 – 40	39.08	1.53
Homosexual Female	36 – 40	39.63	0.83
Attitudes Toward Lesbians	13 – 20	19.57	0.96
Control	17 – 20	19.53	0.85
Heterosexual Male	14 – 20	19.35	1.19
Homosexual Male	13 – 20	19.61	1.26
Heterosexual Female	17 – 20	19.60	0.71
Homosexual Female	18 – 20	19.81	0.47
Attitudes Toward Gay Men	11 – 20	19.40	1.44
Control	13 – 20	19.15	1.85
Heterosexual Male	11 – 20	19.37	1.56
Homosexual Male	13 – 20	19.24	1.67
Heterosexual Female	14 – 20	19.48	1.09
Homosexual Female	18 – 20	19.81	0.47

Diagnostic Impressions

Following presentation of the vignette, all participants were asked to provide free-response initial diagnostic impression(s), based on DSM-IV-TR nosology. Participants were able to give an unlimited number of diagnoses: 41.2% of participants gave a single diagnosis, 25.5% gave two diagnoses, 21.5% gave three diagnoses, 9.3% gave four diagnoses, 1% gave five diagnoses, 1% gave seven diagnoses, and 0.5% gave ten diagnoses. Of the 204 participants, 190 (93%) provided a correct diagnosis of either Borderline Personality Disorder, Antisocial Personality Disorder, features of Borderline Personality Disorder, and/or features of Antisocial Personality Disorder. These diagnostic impressions fell into one or more of the following 26 diagnostic categories: Borderline Personality Disorder ($n = 118$, 57.8%); Antisocial Personality Disorder ($n = 83$, 40.7%); Substance Use Disorder ($n = 40$, 19.6%); Antisocial Personality Disorder Features ($n = 30$, 14.7%); Posttraumatic Stress Disorder ($n = 26$, 12.7%); Borderline Personality Disorder Features ($n = 24$, 11.8%); Bipolar Disorders ($n = 19$, 9.3%); Conduct Disorder/Oppositional-Defiant Disorder ($n = 17$, 8.3%); Depressive Disorders ($n = 16$, 7.8%); Impulse Control Disorder ($n = 12$, 5.9%); V Codes ($n = 8$, 3.9%); Mood Disorder Not Otherwise Specified ($n = 6$, 2.9%); Attachment Disorders ($n = 5$, 2.5%); Narcissistic Personality Disorder, Personality Disorder Not Otherwise Specified, and Narcissistic Personality Disorder Features ($n = 4$, 2.0%); Histrionic Personality Disorder Features ($n = 3$, 1.5%); Anxiety Disorders and Cluster B Personality Disorder Features ($n = 2$, 1.0%); and Adjustment Disorder, Attention-Deficit Hyperactivity Disorder, Psychotic Features, Mental Retardation, Histrionic Personality

Disorder, Dependent Personality Disorder Features, and Unknown Diagnosis ($n = 1$, 0.5%).

After being asked to provide their initial diagnostic impression, participants were then asked to choose the “most appropriate diagnosis” from a provided list of eight DSM-IV-TR diagnoses, which included Antisocial Personality Disorder, Bipolar I Disorder, Bipolar II Disorder, Borderline Personality Disorder, Dysthymic Disorder, Histrionic Personality Disorder, Major Depressive Disorder, and Narcissistic Personality Disorder. In response to this forced-choice diagnostic question, 118 participants (57.8%) chose Borderline Personality Disorder, 69 participants (33.8%) chose Antisocial Personality Disorder, 5 participants (2.5%) chose Bipolar I Disorder, 5 participants (2.5%) chose Major Depressive Disorder, 2 participants (1.0%) chose Dysthymic Disorder, 1 participant (0.5%) chose Bipolar II Disorder, and 1 participant (0.5%) chose Histrionic Personality Disorder.

Tests of Hypotheses

A MANOVA was used to test the prediction in Hypothesis 1 that individuals seen as displaying more traditionally feminine attributes (heterosexual women and gay men) would receive more frequent diagnoses of Borderline Personality Disorder; whereas, individuals seen as displaying more traditionally masculine attributes (heterosexual men and lesbians) would receive more frequent diagnoses of Antisocial Personality Disorder. The within-subjects portion of this test did not reveal a difference in diagnostic impression between the vignettes, as evidenced by the non-significant interaction (Pillai's Trace = .086, $F(12, 597) = 1.47$, $p = .13$, partial $\eta^2 = .029$). As shown in Figure 1, the between-subject effects indicate that there is a significant interaction when participants

gave an initial diagnostic impression (not the forced-choice diagnostic selection) of Borderline Personality Disorder, ($F = 2.82, p < .05$). A post hoc test revealed that this finding was due to the significant difference between the heterosexual male and the heterosexual female vignettes ($p < .05$), in that the Borderline Personality Disorder diagnosis was given significantly more often to heterosexual females than to heterosexual males. As shown in Figures 2 and 3, the non-significant between-subject effects are evidenced by the following interactions: forced-choice diagnostic selection ($F = 2.23, p = .067$) and initial diagnostic impression of Antisocial Personality Disorder ($F = 1.71, p = .149$).

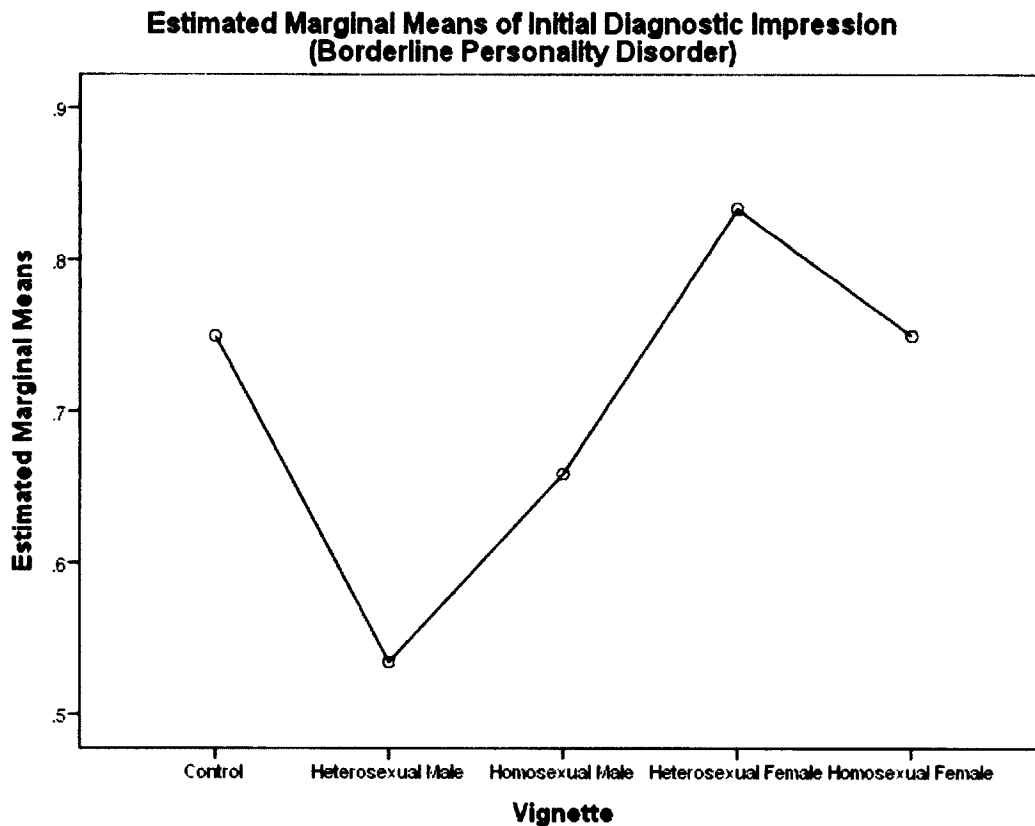


Figure 1 *Differences in Initial Diagnostic Impressions for Each Vignette*

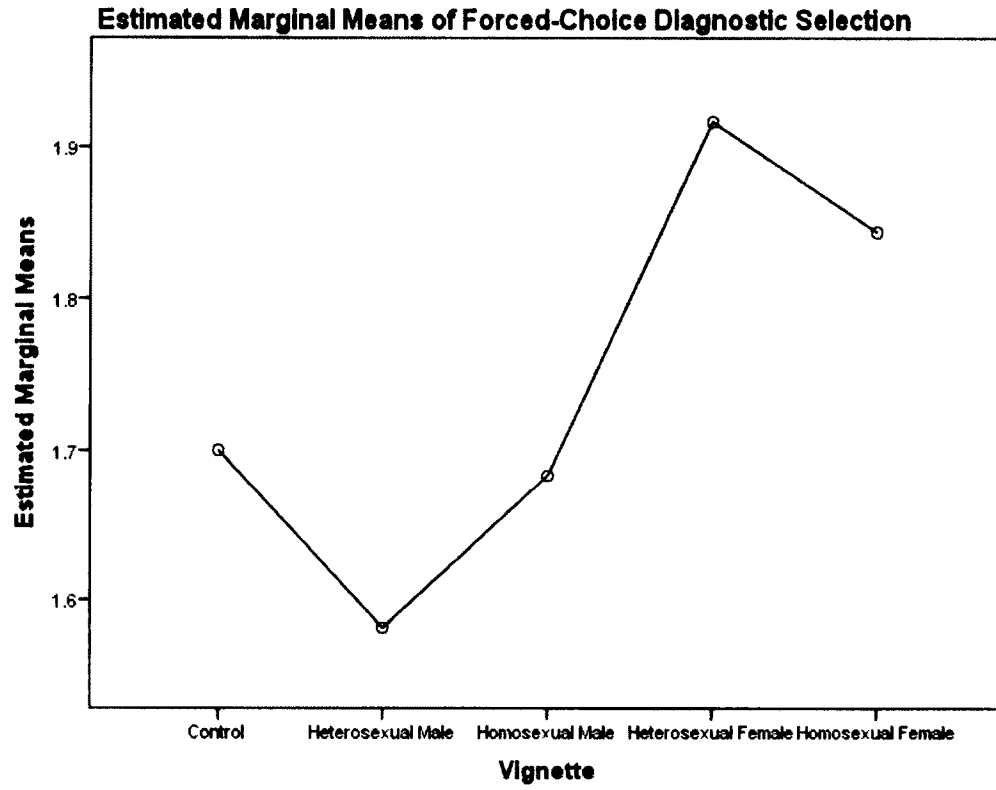


Figure 2 *Differences in Forced-Choice Diagnostic Selection for Each Vignette*

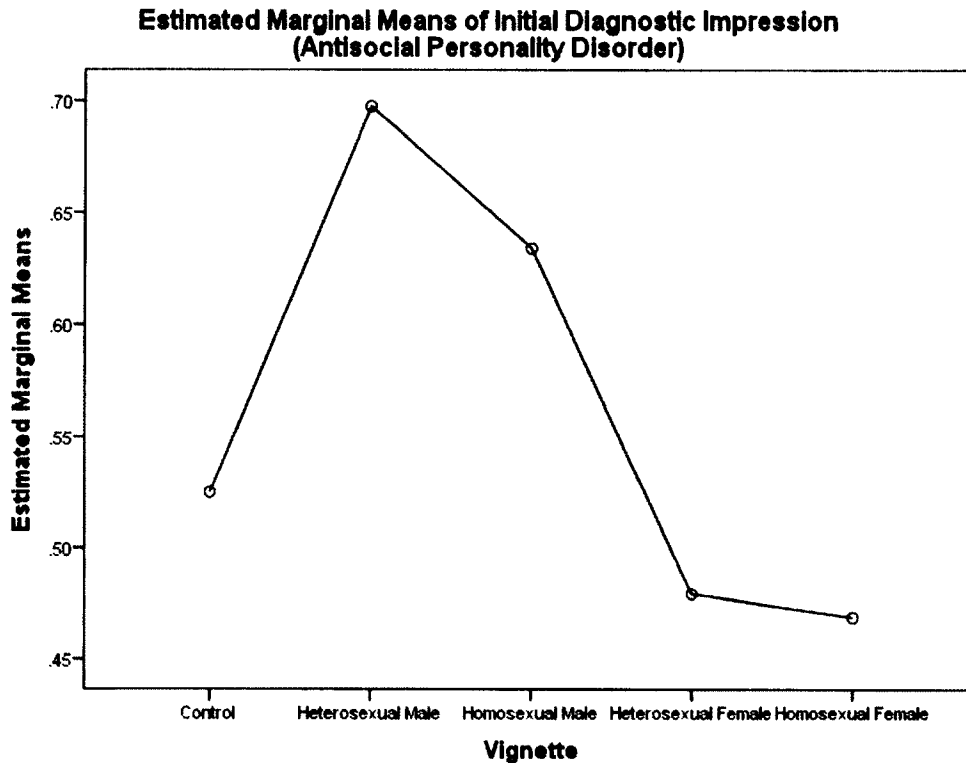


Figure 3 *Differences in Initial Diagnostic Impressions for Each Vignette*

Additionally, a MANOVA was used to test the prediction in Hypothesis 1 that females would receive more frequent diagnoses of Borderline Personality Disorder; whereas, males would receive more frequent diagnoses of Antisocial Personality Disorder. The within-subjects portion of this test revealed a difference in diagnostic impression between the vignettes, as evidenced by the significant interaction (Pillai's Trace = .073, $F(6, 400) = 2.51, p = .02$). As shown in Figure 4, the between-subject effects indicate that there is a significant interaction when participants gave an initial diagnostic impression (not the forced-choice diagnostic selection) of Borderline Personality Disorder, ($F = 4.50, p = .01$). A post hoc test revealed that this finding was due to the significant difference between the male and female vignettes ($p = .01$), in that the Borderline Personality Disorder diagnosis was given significantly more often to

females than to males. As shown in Figure 5, the between-subject effects indicate that there is a significant interaction when participants gave an initial diagnostic impression (not the forced-choice diagnostic selection) of Antisocial Personality Disorder, ($F = 3.27$, $p = .04$). A post hoc test revealed that this finding was due to the significant difference between the male and female vignettes ($p = .04$), in that the Antisocial Personality Disorder diagnosis was given significantly more often to males than to females.

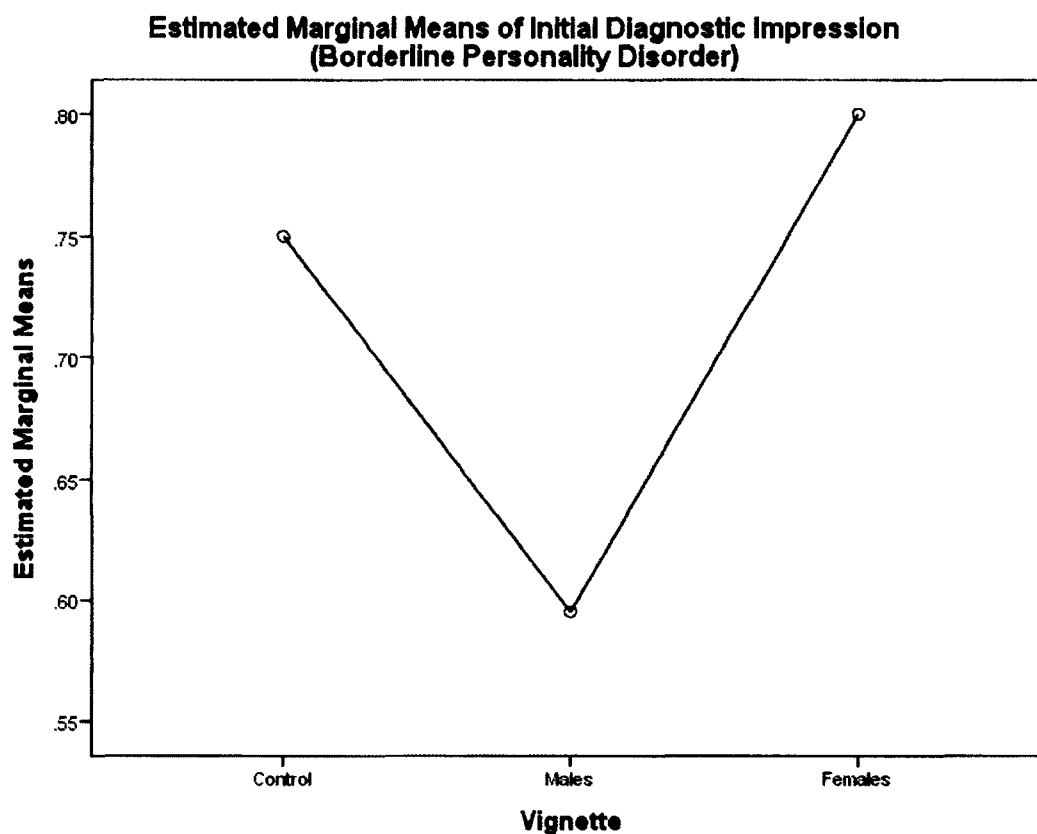


Figure 4 *Differences in Initial Diagnostic Impressions of Borderline Personality Disorder for Males and Females*

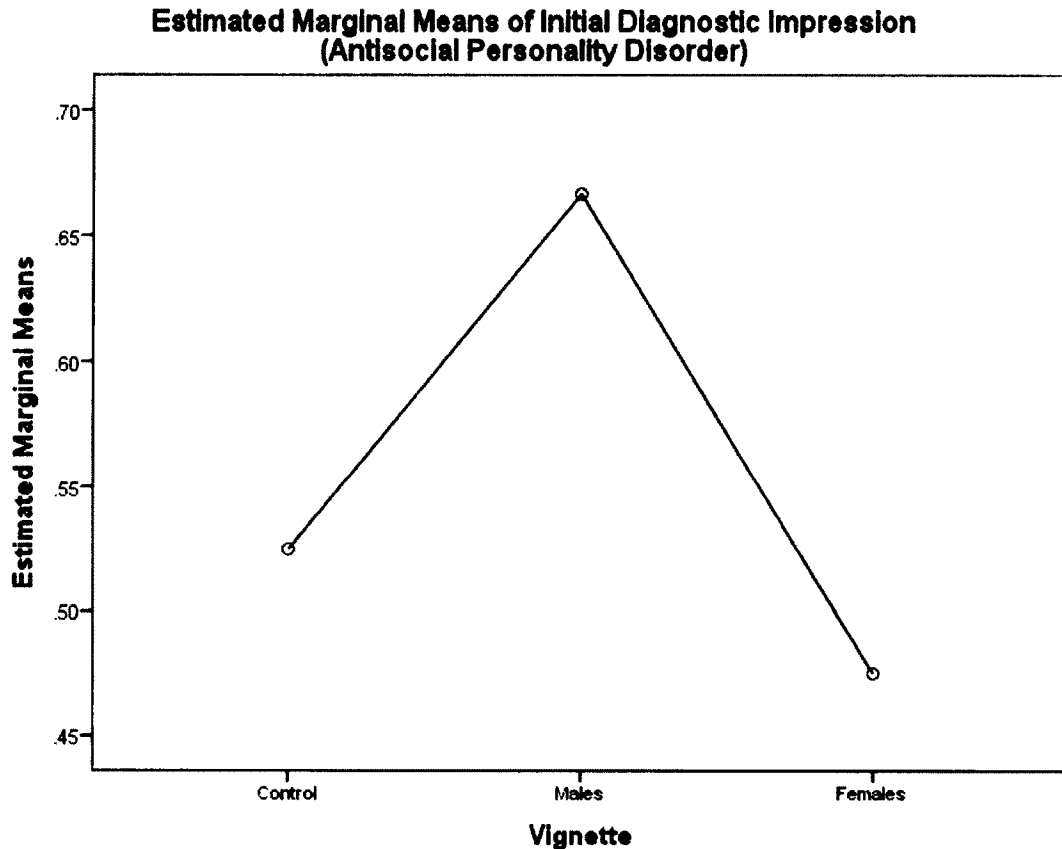


Figure 5 *Differences in Initial Diagnostic Impressions of Antisocial Personality Disorder for Males and Females*

A MANOVA was used to test the prediction in Hypothesis 2 that individuals seen as displaying more traditionally feminine attributes (heterosexual women and gay men) would be rated higher on traits of negative affectivity; whereas, individuals seen as displaying more traditionally masculine attributes (heterosexual men and lesbians) would be rated higher on traits of antagonism and disinhibition. The within-subjects examination revealed no significant overall difference between the attributes associated to the individual portrayed in each vignette (Pillai's Trace = .033, $F(8, 398) = .837$, $p = .571$). See Figures 6 and 7.

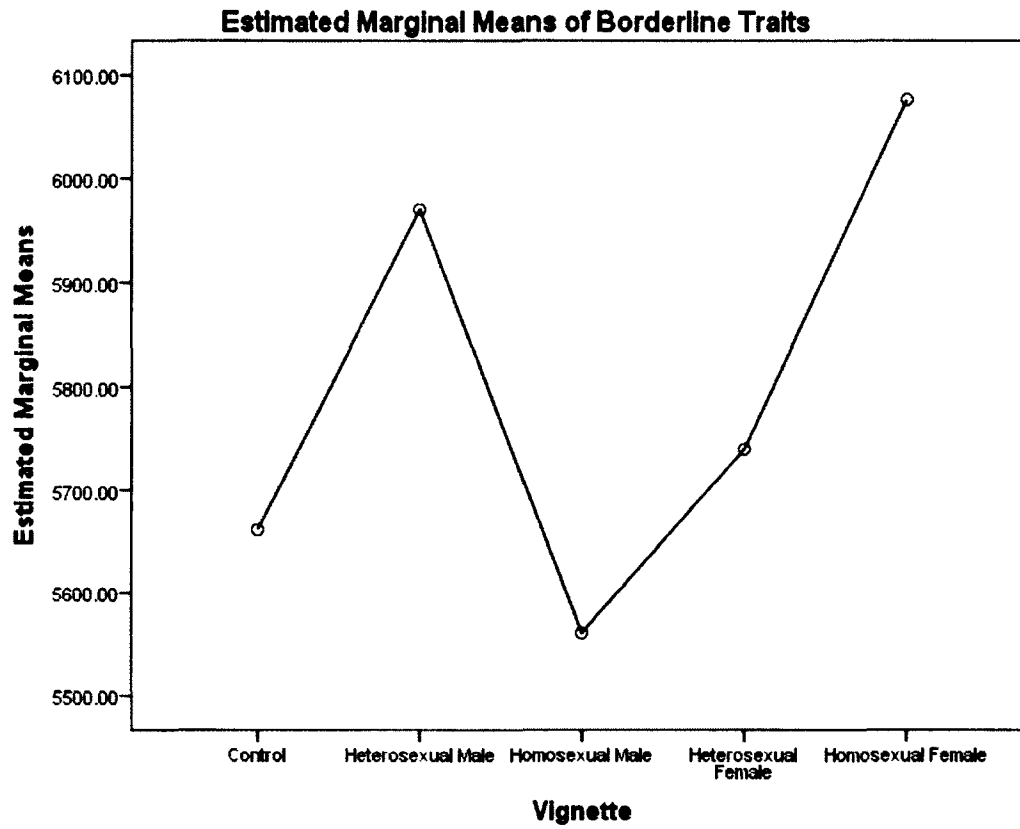


Figure 6 *Differences in Traits of Negative Affectivity for Each Vignette*

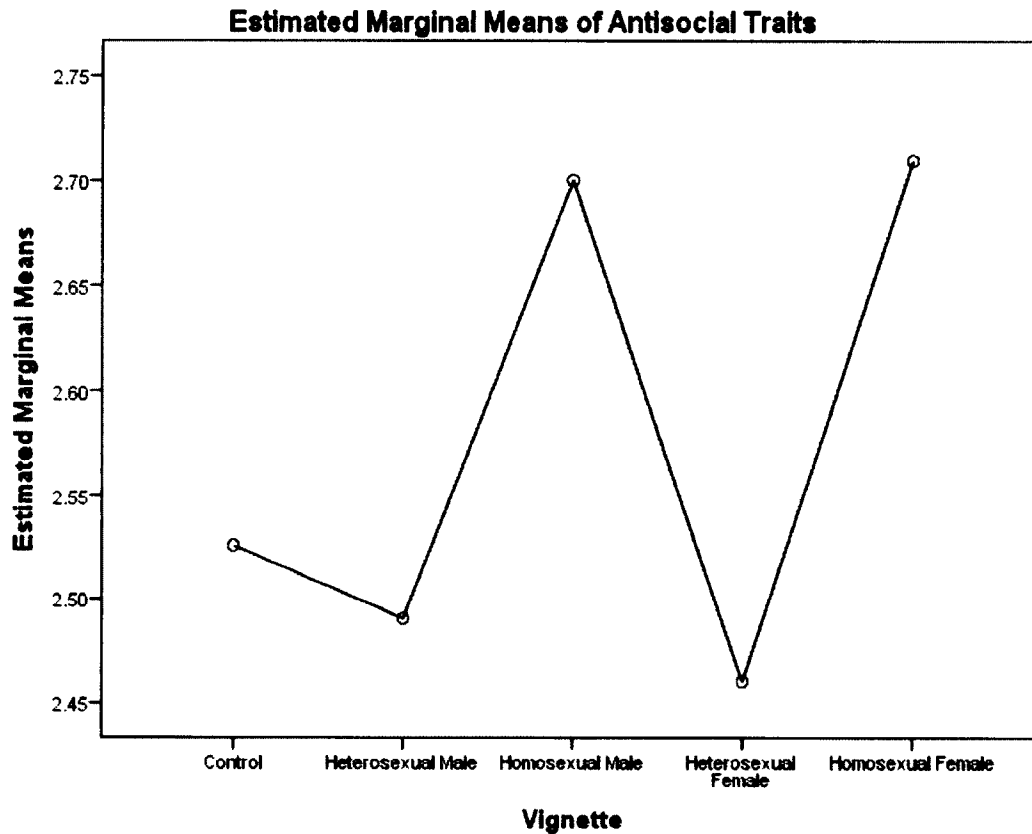


Figure 7 *Differences in Traits of Antagonism and Disinhibition for Each Vignette*

Additionally, a MANOVA was used to test the prediction in Hypothesis 2 that females would be rated higher on traits of negative affectivity in comparison to males; whereas, males would be rated higher on traits of antagonism and disinhibition in comparison to females. The within-subjects examination revealed no significant overall difference between the attributes associated to the individual portrayed in each vignette (Pillai's Trace = .002, $F(4, 402) = .11$, $p = .981$). See Figures 8 and 9.

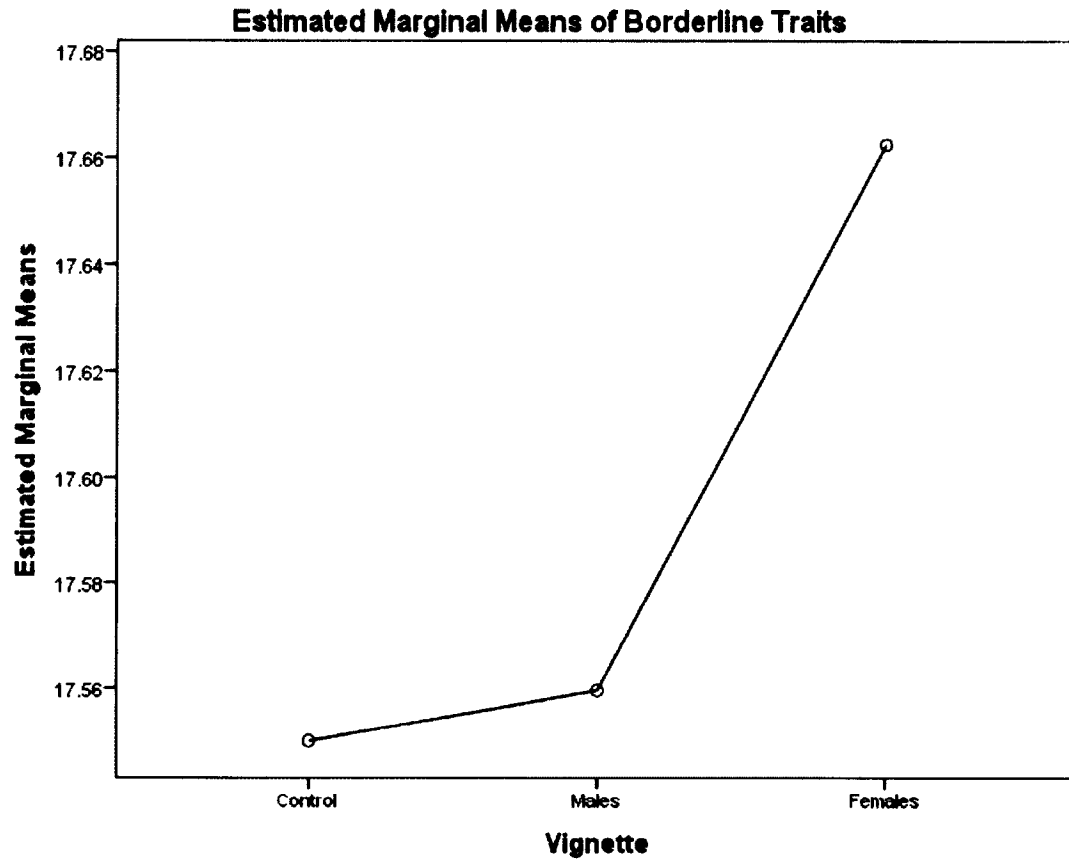


Figure 8 *Differences in Traits of Negative Affectivity for Males and Females*

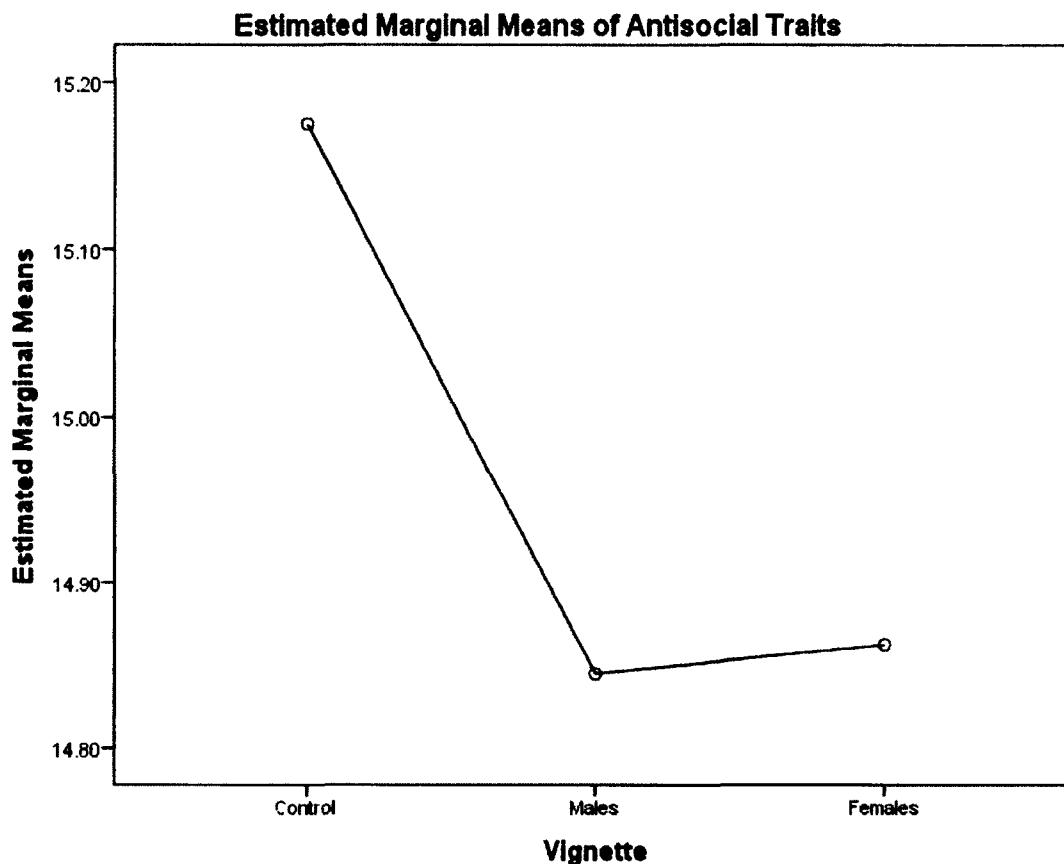


Figure 9 *Differences in Traits of Antagonism and Disinhibition for Males and Females*

Hypothesis 3 stated that participants scoring higher in conservatism on the Attitudes Toward Women Scale would display higher rates of gender bias and inversion stereotype bias in their diagnosis of personality disorders and rating of personality traits than individuals scoring higher in egalitarianism on the Attitudes Toward Women Scale. In regard to diagnostic impressions, a MANCOVA revealed no significant overall differences between the vignettes (Pillai's Trace = .023, $F(3, 196) = 1.545$, $p = .204$). The between-subject effects, using ATW total score as a covariate, indicate that there is a significant interaction when participants gave an initial diagnostic impression (not the forced-choice diagnostic selection) of Borderline Personality Disorder ($F = 4.021$,

$p < .05$). Further analysis revealed that this finding was due to the significant difference between the heterosexual male and the heterosexual female vignettes ($p < .05$), in which the diagnosis of Borderline Personality Disorder was assigned less frequently when participant's views of women were more egalitarian. The non-significant between-subject effects, using the ATW as a covariate, are evidenced by the following interactions: forced-choice diagnostic selection ($F = 1.043, p = .308$); initial diagnostic impression of Antisocial Personality Disorder ($F = 1.531, p = .217$). In regard to perception of traits, a MANCOVA revealed a significant overall difference between the vignettes when the ATW was used as a covariate (Pillai's Trace = .033, $F(2, 197) = 3.343, p < .05$). However, the between-subject effects using the ATW as a covariate are non-significant: borderline traits ($F = 1.291, p = .257$); antisocial traits ($F = 3.213, p = .075$).

Hypothesis 4 stated that participants scoring higher in negative attitudes toward homosexual individuals, as measured by performance on the Attitudes Toward Lesbians and Gay Men Scale-Revised, would display higher rates of gender bias and inversion stereotype bias in their diagnosis of personality disorders and ratings of personality traits than individuals scoring higher in positive attitudes toward homosexual individuals on the Attitudes toward Lesbians and Gay Men Scale-Revised. In regard to diagnostic impressions, a MANCOVA revealed no significant overall differences between the vignettes (Pillai's Trace = .008, $F(3, 196) = .558, p = .644$). In regard to perception of traits, a MANCOVA revealed no significant overall differences between the vignettes (Pillai's Trace = .003, $F(2, 197) = .341, p = .712$).

Additional Analyses

A test of correlation was performed on all participants' total scores on the two attitude scales used in the current study. A significant positive correlation was found between the Attitudes Toward Women Scale (ATW) and the Attitudes Toward Lesbian and Gay Men Scale (ATLG), $r_s = .39, p = .00$. A test of correlation was also performed with the two created subscales of the Brief Assessment of Traits - 37 (BAT-37). A significant positive correlation was found between the created Borderline and Antisocial subscales, $r_s = .29, p = .00$.

As shown in Table 5, the items of the BAT-37 Borderline subscale and Antisocial subscale within each vignette were also examined. Significant positive correlations were maintained for the control vignette, $r_s = .45, p = .00$, and for the heterosexual female vignette, $r_s = .49, p = .00$. All other vignettes maintained a positive relationship; however, these relationships were not significant.

Table 5

Correlations between Borderline and Antisocial Traits on the BAT-37

Vignette	Correlation
Control	.45**
Heterosexual Male Vignette	.20
Heterosexual Female Vignette	.49**
Homosexual Male Vignette	.15
Homosexual Female Vignette	.06

Note. Borderline = Borderline Subscale of the Brief Assessment of Traits - 37; Antisocial = Antisocial Subscale of the Brief Assessment of Traits - 37.

** $p \leq .01$

Demographic Factors and Attitudes Toward Women and Homosexuals

Both prior to and after presentation of the clinical vignette, all participants were asked demographic questions (see Appendices B & H). Participant responses to five of these questions were examined in relation to scores on the Attitudes Toward Women Scale (ATW) and the Attitudes Toward Lesbians and Gay Men Scale (ATLG) in order to examine how their responses may have been related to differences in their views toward women and homosexual individuals.

Initially, a MANOVA was completed to examine the relationship between participant gender and scores on the ATW and ATLG scales. No significant differences were found between gender and attitudes toward women or attitudes toward homosexual individuals (Pillai's Trace = .027, $F(4, 402) = 1.39, p = .24$). Another MANOVA was completed to examine the relationship between participant race and scores on the ATW and ATLG scales. No significant differences were found between race and attitudes toward women or attitudes toward homosexual individuals (Pillai's Trace = .061, $F(12, 394) = 1.03, p = .42$). A third MANOVA was completed to examine the relationship between participant sexual orientation and scores on the ATW and ATLG scales. No significant differences were found between sexual orientation and attitudes toward women or attitudes toward homosexual individuals (Pillai's Trace = .049, $F(6, 400) = 1.66, p = .13$).

Additional MANOVAs were completed to examine the relationships between participant political and religious views and scores on the ATW and ATLG scales. There was a significant overall difference in regard to political views (Pillai's Trace = .195, $F(8, 398) = 5.37, p = .00$). A univariate test further revealed a significant difference on

ATW scores ($F = 2.92, p = .00$) and on ATLG scores ($F = 2.27, p = .00$). Post hoc analyses indicated a significant difference on ATW scores between Democrats and Republicans ($p = .00$) and between Democrats and Independents ($p < .01$). In comparing these three groups, Democrats scored the highest on the ATW ($M = 68.90$), Independents scored second highest ($M = 65.38$), and Republicans scored the lowest ($M = 60.76$). Post hoc analyses further indicated a similar significant difference on ATLG scores between Democrats and Republicans ($p < .01$) and between Democrats and Independents ($p < .05$). In comparing these three groups, Democrats scored the highest on the ATLG ($M = 39.48$), Independents scored second highest ($M = 38.15$), and Republicans scored the lowest ($M = 36.65$). See Tables 6 and 7.

Table 6

Relationship between Political Party Affiliation and Scores on the Attitude Toward Women Scale (ATW)

	<i>n</i>	<i>M</i>	<i>p</i>
Democrat	136	68.90	
Independent	39	65.38	.01*
Republican	17	60.76	.00*

* significant difference compared to Democratic Party

Table 7

Relationship between Political Party Affiliation and Scores on the Attitude Toward Lesbians and Gay Men Scale (ATLG)

	<i>n</i>	<i>M</i>	<i>p</i>
Democrat	136	39.48	
Independent	39	38.15	.02*
Republican	17	36.65	.00*

* significant difference compared to Democratic Party

There was also a significant overall difference in regard to religious views (Pillai's Trace = .327, $F(22, 384) = 3.41, p = .00$). A univariate test further revealed a significant difference on ATW scores ($F = 3.77, p = .00$) and on ATLG scores ($F = 5.06, p = .00$). Post hoc analyses indicated a significant difference on ATW scores between Agnostics and Protestants ($p = .01$), between Agnostics and Non-Denominational Christians ($p < .01$), and between Agnostics and Jewish individuals ($p = .02$). In comparing these four groups, Agnostics scored the highest on the ATW ($M = 69.44$), Non-Denominational Christians and Protestants scored similarly ($M = 64.83$ and $M = 64.81$, respectively), and Jewish individuals scored the lowest ($M = 63.44$). Post hoc analyses further indicated significant differences on ATLG scores between Protestants and Agnostics ($p = .00$), between Protestants and Atheists ($p = .00$), between Protestants and Catholics ($p < .01$), between Protestants and Spiritual/Non-Affiliated individuals ($p = .03$), and between Agnostics and Jewish Individuals ($p = .04$). In comparing these six groups, the following mean scores were obtained: Spiritual/Non-Affiliated individuals

($M = 39.71$), Agnostics ($M = 39.67$), Atheists ($M = 39.61$), Catholics ($M = 39.31$), Jewish individuals ($M = 37.72$), and Protestants ($M = 36.33$). See Tables 8 and 9.

Table 8

Relationship between Religious Views and Scores on the Attitude Toward Women Scale (ATW)

	<i>n</i>	<i>M</i>	<i>p</i>
Agnostic	52	69.44	
Non-Denominational Christian	24	64.83	.01*
Protestant	21	64.81	.01*
Jewish	18	63.44	.02*

* significant difference compared to Agnostic religious views

Table 9

Relationship between Religious Views and Scores on the Attitude Toward Lesbian and Gay Men Scale (ATLG)

	<i>n</i>	<i>M</i>	<i>p</i>
Protestant	21	36.33	
Jewish	18	37.72	.04**
Catholic	26	39.31	.00*
Atheist	33	39.61	.00*
Agnostic	52	39.67	.00*
Spiritual/Non-Affiliated	7	39.71	.03*

* significant difference compared to Protestant religious views

** significant difference compared to Agnostic religious views

Demographic Factors and Diagnostic Decision-Making

Multiple MANOVAs were performed to investigate the influence that various covariates may have had on the diagnostic impressions provided by participants. The covariates of interest were gender, sexual orientation, political views, religious views, theoretical orientation, current year in the program, number of abnormal psychology courses taken as part of training, number of multicultural courses taken as part of training, and number of face-to-face client contact hours accrued during training. In regard to current year in the program, a MANCOVA revealed significant overall differences between the vignettes (Pillai's Trace = .028, $F(3, 196) = 1.906, p = .03$). The between-subject effects, using current year in program as a covariate, indicate that there is a significant interaction when participants gave an initial diagnostic impression (not the forced-choice diagnostic selection) of Antisocial Personality Disorder ($F = 3.991, p < .05$). Further analysis revealed that this finding was not due to a significant difference between any of the vignettes. Rather, it was a trend for all vignettes ($p < .05$), in which the diagnosis of Antisocial Personality Disorder was assigned more frequently as the participant spent more time in training. The non-significant between-subject effects, using current year in program as a covariate, are evidenced by the following interactions: forced-choice diagnostic selection ($F = .011, p = .92$); initial diagnostic impression of Borderline Personality Disorder ($F = .004, p = .95$). None of the remaining covariates significantly influenced the participants' diagnostic decision making: gender (Pillai's Trace = .006, $F(3, 196) = .36, p = .78$), sexual orientation (Pillai's Trace = .021, $F(3, 196) = 1.43, p = .24$), political views (Pillai's Trace = .008, $F(3, 196) = .551, p = .65$), religious views (Pillai's Trace = .002, $F(3, 196) = .113,$

$p = .95$), theoretical orientation (Pillai's Trace = .005, $F(3, 196) = .319$, $p = .81$), number of abnormal psychology courses taken (Pillai's Trace = .02, $F(3, 196) = 1.31$, $p = .27$), number of multicultural courses taken (Pillai's Trace = .018, $F(3, 196) = 1.18$, $p = .32$), and number of face-to-face client contact hours accrued (Pillai's Trace = .016, $F(3, 196) = 1.05$, $p = .37$).

CHAPTER FOUR

DISCUSSION

The purpose of the current study was to examine the effects of gender role biases, as well as gender inversion stereotypes of homosexual individuals, on diagnostic impressions of persons presenting for treatment who are displaying difficulties in personality functioning. The overall results indicated significant findings related to gender role biases, but minimal effects related to inversion stereotype biases, on diagnostic decision-making, as evidenced by the fact that the majority of predictions were not confirmed for homosexual individuals. More specifically, an individual's sexual orientation did not impact diagnostic impression or attributes assigned to the individual. However, diagnostic impressions were influenced by an individual's gender. Results further indicated that diagnostic decision-making was influenced by participants' personal views of women, but not by personal views of homosexual individuals.

Participants in the study were recruited from graduate-level training programs in psychology. All participants were given one of five clinical vignettes, in which the symptom profile of the individual was identical, but the gender and sexual orientation were manipulated. The control vignette did not indicate the individual's gender or sexual orientation. Following the presentation of the vignette, participants were asked to provide an initial diagnostic impression, choose the most applicable diagnosis from a list of provided diagnoses, and assess personality traits of the individual described in the

vignette. Participants were also assessed for their views of women (conservative vs. egalitarian conceptualizations of roles and rights) and of homosexual individuals (positive vs. negative cognitive and affective responses).

Findings and Implications

Diagnostic Impressions

It was hypothesized that individuals seen as displaying more traditionally feminine attributes (heterosexual women and gay men) would receive more frequent diagnoses of Borderline Personality Disorder; whereas, individuals seen as displaying more traditionally masculine attributes (heterosexual men and lesbians) would receive more frequent diagnoses of Antisocial Personality Disorder. Results failed to fully support this prediction. When prompted for an initial diagnostic impression, participants did not provide significantly different diagnoses based on the sexual orientation of the individual described in the vignette. However, participants initially assigned the diagnosis of Borderline Personality Disorder significantly more often to heterosexual women when compared to heterosexual men. This finding was not replicated for homosexual females and males. Additionally, when all women and men (heterosexual and homosexual) were grouped, the final prediction of the first hypothesis was supported. Specifically, when asked to give an initial diagnostic impression, men were more commonly diagnosed with Antisocial Personality Disorder, and women were more commonly diagnosed with Borderline Personality Disorder. Participants were then given a list of diagnoses and asked to choose the one most applicable to the individual described in the vignette. In this forced-choice item, there were no significant differences in diagnostic impressions for gender or sexual orientation.

Of the 43 participants assigned the heterosexual male vignette, 23 (53%) gave an initial diagnostic impression of Borderline Personality Disorder. Of the 48 participants assigned the heterosexual female vignette, 40 (83%) gave an initial diagnosis of Borderline Personality Disorder. Although not significant, a similar gender disparity in terms of initial diagnosis of Borderline Personality Disorder was shown between homosexual women (75%) and homosexual men (66%). With regard to the initial diagnostic impression of Antisocial Personality Disorder, both gender and sexual orientation differences were observed, yet not significant. Heterosexual males (70%) received the diagnosis of Antisocial Personality Disorder more than heterosexual females (48%), homosexual women (47%), and homosexual men (63%).

The above-noted gender findings are supported in the literature. Becker and Lamb (1994) showed that even when women and men presented with identical symptomatology, they received different diagnoses. Similarly, Crosby and Sprock (2004) found that clinicians assigned different personality disorder diagnoses based on client sex. More specifically, Becker and Lamb (1994) found that men were more often diagnosed with Antisocial Personality Disorder, and women were more often diagnosed with Histrionic and Borderline Personality Disorders. Findings supported the disproportionate diagnosis of Borderline Personality Disorder in women when compared to men presenting with identical symptoms, as participants diagnosed women with Borderline Personality Disorder significantly more often than men. Additionally, the disproportionate diagnosis of Antisocial Personality Disorder in men when compared to women presenting with identical symptoms was also supported. Interestingly, when asked to choose a diagnosis from a list (forced-choice diagnostic impression, as opposed

to an initial, open diagnostic response), the disproportionate diagnoses between genders were lost. This is likely because participants were allowed to list as many diagnoses in the initial, open format (including borderline features and antisocial features), but were forced to choose only one diagnosis in the forced-choice format.

The above-noted sexual orientation findings are not supported in the literature. Eubanks-Carter & Goldfried (2006) found that when psychologists evaluated case vignettes that were varied by sexual orientation and gender, the individual who was depicted as a male and assumed by the participants to be homosexual was more likely to receive a diagnosis of Borderline Personality Disorder. This finding was not supported, as no significant differences were found with regard to sexual orientation and diagnostic impression.

Personality Trait Impressions

It was hypothesized that individuals seen as displaying more traditionally feminine attributes (heterosexual women and gay men) would be rated higher on traits of negative affectivity; whereas, individuals seen as displaying more traditionally masculine attributes (heterosexual men and lesbians) would be rated higher on traits of antagonism and disinhibition. Results failed to support this prediction. It was also hypothesized that females would be rated higher on traits of negative affectivity in comparison to males; whereas, males would be rated higher on traits of antagonism and disinhibition in comparison to females. Results failed to support this prediction. When rating personality traits of the individual described in the vignette, participants did not assign significantly different traits based on the sexual orientation or the gender of the individual described in the vignette.

The above-noted findings are contrary to much of the literature available in this area. For example, Sprock et al. (1990) explored whether traits associated with Borderline Personality Disorder varied along a female-male dimension and found that almost all criteria for the disorder were rated as more characteristic of women, with the exception of inappropriate and intense anger, which was rated as a strongly masculine trait. Similarly, Cleary (1987) found that men are more likely to display problems with suicide, antisocial behaviors, and drug and alcohol abuse. With regard to homosexual individuals, Boysen et al. (2006) found that individuals listed traits as being applicable to the mental health of gay men that are traditionally seen as being applicable to the mental health of women, including traits consistent with anxiety, eating, mood, and personality disorders. In the current study, these findings were not replicated, as there were no significant differences in the assignment of traits with regard to the sexual orientation or the gender of the individual described in the vignette.

One possible explanation of the findings is offered by Akhtar (1995), who stated that social factors may be related to the reported prevalence rates in personality disorders. This indicates that society has evolved with regard to views of gender roles, and that as a result, women and men have been allowed greater freedom to engage in various means of self-expression. This indicates that the expression of antisocial traits in women may now be more acceptable, which may partially explain the finding of the current study that antisocial traits were comparable in the male and female vignettes. Another possible explanation of the findings is that the dimensional model of personality assessment proposed in *DSM-5* is less vulnerable to the effects of gender bias in diagnostic assessment than is the current categorical model.

Attitudes Toward Women

It was hypothesized that participants scoring higher in conservatism on the Attitudes Toward Women Scale would display higher rates of gender bias and inversion stereotype bias in their diagnosis of personality disorders and rating of personality traits than individuals scoring higher in egalitarianism on the Attitudes Toward Women Scale. Results primarily failed to support this prediction. Participants' attitudes toward women did not have a significant influence on diagnostic impression when comparing homosexual and heterosexual individuals. However, attitudes toward women did influence the initial diagnostic impression of Borderline Personality Disorder when comparing heterosexual males and heterosexual females. Specifically, when participants' views of women were more egalitarian, the diagnosis of Borderline Personality Disorder was assigned less frequently. As evidenced in results of the first hypothesis, this finding was a significant influence in the disparity in assigning the diagnosis of Borderline Personality Disorder in heterosexual women and heterosexual men. With regard to personality traits, participants' attitudes toward women did not have a significant influence on the traits assigned to the individual described in the vignette, regardless of sexual orientation or gender.

These findings are partially consistent with the literature. In a study exploring the relationship between patient sex and bias in personality disorder diagnosis, in which participants were assessed for having traditional or nontraditional sex role beliefs, Crosby and Sprock (2004) found that males received more diagnoses of Antisocial Personality Disorder and that females received more diagnoses of Borderline Personality Disorder. Further, with regard to personality traits, females were rated as possessing more histrionic

traits than males. Available literature also suggests that this bias would extend to homosexual individuals, as stereotypes about homosexual individuals have been found to be based on dominant stereotypes of heterosexual men and women, which when applied to homosexual individuals, are based on the inversion theory of homosexuality (Kite and Deaux, 1987). In the current study, when views of women were more egalitarian, the diagnosis of Borderline Personality Disorder was assigned to heterosexual women less frequently. However, these findings were not extended with regard to personality traits or to the comparison of diagnoses of homosexual and heterosexual individuals.

Attitudes Toward Lesbians and Gay Men

It was hypothesized that participants scoring higher in negative attitudes toward homosexual individuals, as measured by performance on the Attitudes Toward Lesbians and Gay Men Scale-Revised, would display higher rates of gender bias and inversion stereotype bias in their diagnosis of personality disorders and ratings of personality traits than individuals scoring higher in positive attitudes toward homosexual individuals on the Attitudes toward Lesbians and Gay Men Scale-Revised. Results failed to support this prediction. Participants' attitudes toward lesbians and gay men did not have a significant influence on diagnostic impression when comparing men and women or when comparing homosexual and heterosexual individuals. Participants' attitudes toward lesbians and gay men also did not have a significant influence on the personality traits assigned to the individual described in the vignette, regardless of sexual orientation or gender.

Research has suggested that negative attitudes toward homosexuals are related to mental health professionals' bias in the assessment of homosexual individuals. For example, Gordon (2010) found that psychologists' clinical judgments (diagnostic

impression, functioning ratings, and perception of client attractiveness) of homosexual individuals were affected by levels of heterosexual identity development. In addition, research has consistently supported a correlation between negative attitudes toward homosexual individuals and less egalitarian views of women, indicating that individuals holding negative attitudes toward homosexual individuals would be predicted to also hold biased attitudes toward women. However, these findings were not supported by the current study, as attitudes toward lesbians and gay men did not have a significant influence on diagnostic impression or on personality traits assigned when comparing men and women, or when comparing homosexual and heterosexual individuals.

Additional Analyses

Attitudes and Trait Relationships

Findings of the current study indicate that as attitudes toward women became more egalitarian, attitudes toward lesbians and gay men became more positive. In addition, findings indicate that as participants attributed traits of Borderline Personality Disorder to the individual portrayed in the vignette, they also attributed traits of Antisocial Personality Disorder. This finding supports the results of the pilot study, which indicated that both personality disorders were accurately portrayed in the clinical vignettes used. However, when the relationship of attributes was explored within each vignette, the positive relationship was maintained, but the significance of that relationship was lost, with the exception of the control and heterosexual female vignettes. This indicates that once gender and sexual orientation were identified, there was an alteration in attributes endorsed by participants for the majority of the experimental vignettes.

Attitudes and Political/Religious Orientations

Findings of the current study indicate that participants' political and religious orientations had an impact on their attitudes toward women and homosexual individuals. Specifically, with regard to political orientation, Democrats displayed more egalitarian views of women than both Independents and Republicans. With regard to religious orientation, Agnostics displayed more egalitarian views of women than Protestants, Non-Denominational Christians, and Jewish individuals. Further, Protestants displayed less accepting attitudes toward homosexual individuals than Agnostics, Atheists, Catholics, and Spiritual/Non-Affiliated individuals. In addition, Jewish individuals displayed less accepting attitudes toward homosexual individuals than Agnostics. These trends should be a focus in future research with respect to the impact that political and religious views may have on services provided to women and homosexual individuals.

Demographic Variables and Diagnostic Decision-Making

Various demographic characteristics of participants were considered with regard to their impact on diagnostic decision-making. These characteristics included gender, sexual orientation, political views, religious views, theoretical orientation, current year in program, number of abnormal psychology courses taken as part of training, number of multicultural courses taken as part of training, and number of face-to-face client contact hours accrued during training. Only one of these factors was found to have a significant influence on diagnostic decision-making. Interestingly, participants who were further along in their training programs initially rated the individual in the vignette with Antisocial Personality Disorder more often than individuals in the beginning years of their training programs. This diagnostic impression was consistent for all vignettes and

not specific to gender or sexual orientation. None of the remaining factors was found to have a significant influence on participants' diagnostic decisions. One potential reason for this finding could be the general lack of significant findings in the current study when compared to past research. Another potential reason could be the current trend toward better integration of multicultural emphasis in training programs, which may reduce diagnostic biases. However, given the above-noted findings regarding the effects of certain demographic factors on attitudes toward women and homosexual individuals, the trend toward integration of multiculturalism in training programs needs to become a greater focus in order to ensure that clinical work with these populations is not affected by biases that continue to persist within the culture.

Limitations

One limitation may have been the use of students in doctoral training programs, as opposed to practicing psychologists. Although one of the objectives of the current study was to use students in training programs in order to assess the efficacy of the current trend toward multiculturalism and diversity within training programs in the field of psychology, the likelihood of less developed diagnostic skills in this population is a possible concern. If the study had been conducted using practicing psychologists, the chances of assessing greater diagnostic experiences and more refined diagnostic skills would have been increased. In addition, the use of students (i.e., a younger generation of participants) may have resulted in a participant sample that held more liberal and progressive ideas and values than what may have been represented in an older sample of practicing psychologists. If psychologists with experience had been used, it is possible that the sample would have been more balanced in regard to liberal vs. conservative

beliefs. However, the field of psychology does traditionally attract individuals with more liberal and progressive belief systems (Bilgrave & Deluty, 2002); therefore, the degree of impact that using an older sample of practicing psychologists may have had is questionable.

Another possible limitation may have been the limited number of participants. Although the sample size was appropriate statistically, a larger sample would have allowed for a greater response set, as well as for a larger number of individuals reviewing and providing diagnostic impressions for each of the five clinical vignettes. Furthermore, a larger sample possibly would have resulted in greater variability with regard to demographic variables. For example, the majority of participants were female, Caucasian, heterosexual, and affiliated with the Democratic Party. Of particular concern is gender and political affiliation, as past studies have consistently shown that females and individuals who identify as liberal hold more progressive views than males and individuals who identify as conservative with regard to gender and sexual orientation issues. In the current study, the majority of participants provided responses that indicated very tolerant views regarding gender roles and views of homosexual individuals. Had the sample been larger, the chances of it including more males and more conservative individuals and representing greater variability in these views would have possibly been increased. However, as stated previously, the field of psychology does traditionally attract women and individuals with more liberal ideals; therefore, the participants appear to be representative of the population of interest, and the degree of impact that using a larger sample may have had is therefore uncertain.

A final possible limitation is related to the effects of social desirability. An attempt was made to control for the effects of participants providing socially desirable responses by not providing the exact purpose of the study (exploration of the effects of gender and sexual orientation on diagnostic decision making) to participants prior to their completion of the study. An additional attempt was made to control for the effects of participants providing socially desirable responses by presenting a portion of the demographic questions (questions specifically assessing multicultural and diversity issues) after all other portions of the study had been completed. However, the scales used in the study had a high degree of face validity. Specifically, both the Attitudes Toward Women Scale and the Attitudes Toward Lesbians and Gay Men Scale assess individuals' views of gender roles and attitudes toward homosexual individuals in an overt manner by providing direct statements and asking participants to indicate whether or not, or to what degree, they agree with the statements. It is possible that scales assessing gender role and sexual orientation attitudes in a more subtle manner may have resulted in less concern about social desirability; however, at the time of the current study, no such scales were available.

Future Research

Future research exploring the effects of gender and sexual bias on diagnostic decision-making could be designed in order to provide more in-depth assessment of the variables of interest. More specifically, it would be beneficial to design such studies in ways that provide a better representation of the ways that the gender and sexual orientation of clients influence the actual work of diagnosticians in the field. The current study assessed what future psychologists would do given a hypothetical patient

presentation, and the results indicated that sexual orientation has little impact on diagnostic decision-making. However, past research has indicated that diagnostic bias does exist, especially with regard to the diagnosis of personality disorders between genders. In addition, past research has consistently shown that many individuals working within the field of psychology continue to hold inversion stereotypes of homosexual individuals. Therefore, it would be beneficial to assess the diagnostic decisions of current practicing psychologists (versus students in training) in order to determine if the observed participant behavior generalizes to actual practice.

It would also be beneficial for future research to assess the effects that the greater focus recently placed on multiculturalism and diversity within psychology has had on the diagnostic practices of psychologists. Specifically, it would be beneficial to compare the diagnostic bias present within the older generations of clinicians to the diagnostic bias within current psychologists and future psychologists (i.e., psychology trainees). This could be accomplished by designing studies so that samples of both newer and older cohorts of practicing psychologists, as well as samples of psychology doctoral trainees are utilized.

Future research within the area could also be extended to examine the effects of patient presentation on diagnostic decision making, as opposed to only examining the effects of reported patient characteristics and symptomology. This would allow for a greater assessment of potential biases and for an exploration of client desirability factors, as it is possible that there may be diagnostic differences between reading about a patient and having a patient actually present, reporting his or her sexual orientation and current symptoms. This could be accomplished by using videotaped intake sessions, or by using

confederates who present for assessment with current psychologists and psychology trainees, as opposed to using vignettes that are varied by gender and sexual orientation.

A final goal for future research in the area of diagnostic bias could be to utilize current and/or improved assessment tools. More specifically, future research should aim to create scales of gender and sexual orientation bias that are less vulnerable to the effects of social desirability. Traditionally, these scales have a high level of face validity, which likely impedes the reliable measurement of actual attitudes and beliefs. Newer scales, that more subtly measure attitudes, are required in order to effectively address the problem of social desirability. In addition, since more information and tools are now available regarding the proposed changes in personality assessment, future research could also more efficiently look at the differences in diagnostic biases in personality assessment between the current system, in which individuals are placed into discrete categories of specific diagnoses, and the system proposed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, in which individuals are rated on a series of personality traits along continua. Findings suggest that a dimensional model of personality assessment may be less vulnerable to the effects of gender bias in diagnostic decision-making than the current categorical model. At the time of the implementation of the current study, DSM-5 was not released, and the assessment tools for diagnosing personality disorders based on the proposed new system were therefore not available for use in research or practice. However, since the completion of data collection, DSM-5 and the proposed assessment measures have been released. Future research should therefore utilize these tools in order to better assess potential differences in diagnosis between the two systems.

Conclusion

The current study explored the effects of attitudes of future psychologists regarding gender roles and sexual orientation on the diagnosis of Borderline and Antisocial Personality Disorders from both a categorical and a dimensional trait perspective. Findings indicated that women were diagnosed with Borderline Personality Disorder more than men, and that men were diagnosed with Antisocial Personality Disorder more than women. In addition, conservative political and religious affiliations were found to correlate with more negative views of women and of homosexual individuals. With regard to the method of personality assessment, results indicated that the above-noted gender differences in diagnosis were evident when participants were asked to provide a categorical diagnosis, but not when they were asked to assign personality traits to the individual described in the vignette. This may indicate that the proposed dimensional model of personality assessment is less vulnerable to gender bias in diagnostic decision-making than the current categorical model.

The study failed to support other predictions, such as the presence of inversion stereotypes of homosexual individuals with regard to the ways the two personality disorders were diagnosed in gay men and lesbian women. Potential causes of these unexpected findings include the fact that participants in the study endorsed significantly egalitarian attitudes regarding both homosexual individual and the gender roles of women. This may be partially due to the fact that individuals in the field of psychology often hold more liberal and progressive views or to the fact that there has been a recent focus on inclusion of multicultural and diversity issues in psychology training programs. Also, the attitude scales used in the current study were face-valid with regard to the

variables of interest, which may have resulted in some degree of socially desirable responding in participants.

Research consistently has indicated that diagnostic bias does exist, especially with regard to the diagnosis of personality disorders between genders. In addition, past research consistently has shown that many individuals working within the field of psychology continue to hold inversion stereotypes of homosexual individuals. It is possible that these problems are improving as society, as well as the field of psychology, evolves; however, it is important to ensure that the phenomena continue to be explored so that they can be adequately addressed in training programs. Therefore, it would be beneficial for future research to focus on improving the ability to assess the possible effects of clinician bias on assessment and diagnosis. This can partially be achieved by looking at the actual practice of psychologists and psychologists in training, by comparing the practices of these two groups, and by the development of attitude scales that more subtly assess these biases.

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APPENDIX A

HUMAN USE COMMITTEE APPROVAL



LOUISIANA TECH
UNIVERSITY
MEMORANDUM

OFFICE OF UNIVERSITY RESEARCH

TO: Ms. Beatrice Mosier and Dr. Alicia Ford
FROM: Barbara Talbot, University Research
SUBJECT: HUMAN USE COMMITTEE REVIEW
DATE: October 22, 2013

In order to facilitate your project, an EXPEDITED REVIEW has been done for your proposed study entitled:

**“Effects of Gender Bias and Gender Inversion Stereotypes on
Assessment of Personality Traits and Diagnosis of Personality Disorders”**

HUC 1109 REVISION-ADD ADDENDUM

The proposed study's revised procedures were found to provide reasonable and adequate safeguards against possible risks involving human subjects. The information to be collected may be personal in nature or implication. Therefore, diligent care needs to be taken to protect the privacy of the participants and to assure that the data are kept confidential. Informed consent is a critical part of the research process. The subjects must be informed that their participation is voluntary. It is important that consent materials be presented in a language understandable to every participant. If you have participants in your study whose first language is not English, be sure that informed consent materials are adequately explained or translated. Since your reviewed project appears to do no damage to the participants, the Human Use Committee grants approval of the involvement of human subjects as outlined.

Projects should be renewed annually. *This approval was finalized on October 22, 2013 and this project will need to receive a continuation review by the IRB if the project, including data analysis, continues beyond October 22, 2014.* Any discrepancies in procedure or changes that have been made including approved changes should be noted in the review application. Projects involving NIH funds require annual education training to be documented. For more information regarding this, contact the Office of University Research.

You are requested to maintain written records of your procedures, data collected, and subjects involved. These records will need to be available upon request during the conduct of the study and retained by the university for three years after the conclusion of the study. If changes occur in recruiting of subjects, informed consent process or in your research protocol, or if unanticipated problems should arise it is the Researchers responsibility to notify the Office of Research or IRB in writing. The project should be discontinued until modifications can be reviewed and approved.

If you have any questions, please contact Dr. Mary Livingston at 257-2292 or 257-5066.

A MEMBER OF THE UNIVERSITY OF LOUISIANA SYSTEM

P.O. BOX 3092 • RUSTON, LA 71272 • TELEPHONE (318) 257-5075 • FAX (318) 257-5079
AN EQUAL OPPORTUNITY UNIVERSITY

APPENDIX B

PRE-VIGNETTE QUESTIONNAIRE

1. What is your gender?
 - a. Female
 - b. Male
 - c. Transgendered

2. What is your age?
 - a. 18 – 28
 - b. 29 – 39
 - c. 40 – 50
 - d. 51 – 61
 - e. 62 – 72
 - f. 73 – 83

3. What is your race?
 - a. African American
 - b. Asian
 - c. Caucasian
 - d. Hispanic / Latino(a)
 - e. Native American / Alaska Native
 - f. Native Hawaiian / Pacific Islander
 - g. Bi/Multiracial
 - h. Other (please specify)

4. What is your sexual orientation?
 - a. Bisexual
 - b. Heterosexual
 - c. Homosexual
 - d. Other (please specify)

5. Which of the following best describes your political views?
 - a. Democrat
 - b. Independent
 - c. Republican
 - d. Other (please specify)

6. Which of the following best describes your religious views?
 - a. Agnostic
 - b. Atheist
 - c. Buddhist
 - d. Christian (Catholic)
 - e. Christian (Protestant)
 - f. Christian (Non-denominational)
 - g. Christian (Other)
 - h. Hindu
 - i. Islam
 - j. Judaism
 - k. Other (please specify)

7. In what type of training program are you currently enrolled?
 - a. Clinical Psychology (Ph.D.)
 - b. Clinical Psychology (Psy.D.)
 - c. Combined Clinical / School (Psy.D.)
 - d. Combined Clinical / Counseling / School (Ph.D.)
 - e. Counseling Psychology (Ph.D.)
 - f. Counseling Psychology (Psy.D.)
 - g. Combined Counseling / School (Ph.D.)
 - h. School Psychology (Ph.D.)
 - i. School Psychology (Psy.D.)
 - j. Industrial & Organizational Psychology (Ph.D.)
 - k. Industrial & Organizational Psychology (Psy.D.)
 - l. Other (please specify)

8. Currently, what is the highest degree you have been awarded?
 - a. Associate's Degree
 - b. Bachelor's Degree
 - c. Master's Degree
 - d. Doctorate
 - e. Other (please specify)

9. What is the field of the highest degree you have obtained at this point?
 - a. General Psychology
 - b. Counseling (including Mental Health, Marriage & Family, Rehabilitation, and other specialties)
 - c. Counseling Psychology
 - d. Clinical Psychology
 - e. School Psychology
 - f. Industrial & Organizational Psychology
 - g. Social Work
 - h. Sociology
 - i. Other Psychology or Mental Health-related field (please specify)
 - j. Other Field -- not Psychology or Mental Health-related (please specify)

10. What is your current level in your training program?
 - a. 1st year
 - b. 2nd year
 - c. 3rd year
 - d. 4th year
 - e. 5th year
 - f. 6th year or beyond (not yet attended internship)
 - g. On internship currently
 - h. All but dissertation (ABD)

11. As part of your training program, how many practicum placements have you completed (including both required and supplemental)?
- 0
 - 1
 - 2
 - 3
 - 4 or more
12. What have been the settings of your practicum experiences? Check all that apply.
- Child Guidance Clinic
 - Community or Private Hospital – Health / Medical Population
 - Community or Private Hospital – Psychiatric Population
 - Department Clinic (psychology clinic run by department or school)
 - Veteran’s Affairs Medical Center
 - College Counseling Center
 - Community Mental Health Center
 - Prison / Corrections (Adult)
 - Prison / Corrections (Child / Adolescent)
 - Private Practice
 - School (primary or secondary)
 - Substance Abuse Center
 - Other (please specify)
13. Throughout your training, how many hours of direct, face-to-face client contact have you accrued up to this point (does not include support activity time such as progress note or report writing, intervention planning, or supervision received)?
- 0 to 50 hours
 - 51 to 100 hours
 - 101 to 150 hours
 - 151 to 200 hours
 - 201 to 250 hours
 - 251 to 300 hours
 - 301 to 350 hours
 - 351 to 400 hours
 - 401+ hours
14. How would you best describe your theoretical orientation?
- Behavioral
 - Cognitive / Cognitive-Behavioral
 - Humanistic (including Client/Person-Centered, Existential, and Gestalt)
 - Interpersonal
 - Psychoanalytic / Psychodynamic
 - Eclectic
 - Integrative
 - Undecided / Not Yet Developed
 - Other (please specify)

15. Have you taken courses in the following areas? Check all that apply.
- a. Adult Psychopathology
 - b. Child Psychopathology
 - c. Cognitive Psychology
 - d. Couples / Family Therapy
 - e. Group Therapy
 - f. Health Psychology
 - g. History / Foundations of Psychology
 - h. Intellectual / Achievement Assessment
 - i. Multiculturalism / Diversity
 - j. Neuropsychology
 - k. Objective Personality Assessment
 - l. Projective Personality Assessment
 - m. Physiological Psychology / Neuroanatomy
 - n. Professional Issues / Ethics
 - o. Psychopharmacology
 - p. Social Psychology
 - q. Supervision
 - r. Techniques of Psychotherapy
 - s. Theories of Personality
 - t. Theories of Psychotherapy
 - u. Other (please specify)

APPENDIX C

VIGNETTES

The patient is 25 years old and presented to the emergency room following involvement in an altercation with the patient's significant other, after which, the patient threatened suicide. It is noted that the significant other accompanied the patient to the hospital, requesting that the patient be "locked up." Records indicate that the patient has a history of psychiatric hospitalizations and involvement with law enforcement secondary to engaging in behaviors that have been described as erratic and dangerous to both the patient and others.

The patient's mother and father divorced when the patient was three years of age, and the patient was reportedly sexually abused by the stepfather from five to eight years of age. The patient was removed from the mother's care at the age of nine and placed into the foster care system. The patient had difficulty at all foster care placements and often engaged in disruptive behaviors. The patient therefore resided within several foster homes until the age of 18, at which time the patient began living independently. The patient began displaying severe behavioral problems in childhood, to include fighting with other children and starting fires. In early adolescence, the patient began associating with a group of peers who frequently engaged in sexual, drug-using, and illegal activities. The patient began using drugs and being involved with the legal system at the age of 14. The patient first became a parent at the age of sixteen and currently has four young children; however, the children are not cared for or financially supported by the patient.

The patient has been arrested on several occasions for charges of assault and drug possession. The patient's longest incarceration was a two-year sentence that the patient received as a result of stabbing a significant other during an altercation at a bar. The patient has a history of threatening suicide and making suicidal gestures while incarcerated. This behavior often occurs after the patient has been reprimanded or had privileges denied by jail staff. After each suicide threat or attempt, the patient is transferred to the infirmary and therefore not required to complete work detail duties or to sleep in the cell with other inmates, which are activities the patient reports "hating."

The patient also has a history of inpatient psychiatric hospitalizations for reasons including becoming enraged and violent toward others, engaging in self-injurious behaviors, and drug overdoses. The patient's behavior while hospitalized somewhat mimics the behavior displayed during incarcerations, as the patient appears to initially be progressing well; however, interpersonal problems with staff and/or other patients usually result in disruptive and violent outbursts by the patient. During the patient's most recent hospitalization, the patient was discovered having sexual intercourse with a younger patient who was of limited intellectual functioning.

Interpersonally, the patient can initially appear quite charming and charismatic. However, upon feeling slighted by others, the patient becomes cold, ruthless, violent, and destructive. It is noted that the patient shows no remorse for these behaviors and continuously blames others for the problems experienced. The patient has a history of chaotic interpersonal relationships. The patient often feels that others are attempting to cause harm and reacts in an extreme manner. The patient has difficulty with family members, coworkers, and significant others. Receiving attention from others usually

results in an improvement in the patient's mood; however, once alone, the patient is unable to sustain these positive feelings. When alone, the patient ruminates about perceived insults by others and fantasizes about taking revenge. The patient also experiences violent outbursts of anger. In fact, the altercation that prompted the current hospital visit began when the patient's significant other was late returning home from work. The patient became angry, accused the significant other of being unfaithful and unloving, physically attacked the significant other, and then threatened to commit suicide when the significant other attempted to leave the home that the two share.

The patient is a 25-year-old heterosexual male who presented to the emergency room following involvement in an altercation with his girlfriend, after which, he threatened suicide. It is noted that the patient's girlfriend accompanied him to the hospital, requesting that he be "locked up." Records indicate that the patient has a history of psychiatric hospitalizations and involvement with law enforcement secondary to engaging in behaviors that have been described as erratic and dangerous to both the patient and others.

The patient's mother and father divorced when the patient was three years of age, and the patient was reportedly sexually abused by his stepfather from five to eight years of age. The patient was removed from his mother's care at the age of nine and placed into the foster care system. The patient had difficulty at all foster care placements and often engaged in disruptive behaviors. The patient therefore resided within several foster homes until the age of 18, at which time he began living independently. The patient began displaying severe behavioral problems in childhood, to include fighting with other children and starting fires. In early adolescence, the patient began associating with a group of peers who frequently engaged in sexual, drug-using, and illegal activities. The patient began using drugs and being involved with the legal system at the age of 14. He has never maintained gainful employment for any significant period of time.

The patient has been arrested on several occasions for charges of assault and drug possession. The patient's longest incarceration was a two-year sentence that he received as a result of stabbing a former girlfriend during an altercation at a bar. The patient has a history of threatening suicide and making suicidal gestures while incarcerated. This behavior often occurs after the patient has been reprimanded or had privileges denied by jail staff. After each suicide threat or attempt, the patient is transferred to the infirmary and therefore not required to complete work detail duties or to sleep in the cell with other inmates, which are activities the patient reports "hating."

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Interpersonally, the patient can initially appear quite charming and charismatic. However, upon feeling slighted by others, the patient becomes cold, ruthless, violent, and destructive. It is noted that he shows no remorse for these behaviors and continuously blames others for the problems he experiences. The patient has a history of chaotic interpersonal relationships. He often feels that others are attempting to cause him harm, and he reacts in an extreme manner. The patient has difficulty with family members, coworkers, and significant others. Receiving attention from others usually results in an improvement in his mood; however, once alone, he is unable to

sustain these positive feelings. When alone, the patient ruminates about perceived insults by others and fantasizes about taking revenge. The patient also experiences violent outbursts of anger. In fact, the altercation that prompted the current hospital visit began when the patient's girlfriend was late returning home from work. The patient became angry, accused the girlfriend of being unfaithful and unloving, physically attacked her, and then threatened to commit suicide when she attempted to leave the home that the two share.

The patient is a 25-year-old homosexual male who presented to the emergency room following involvement in an altercation with his boyfriend, after which, he threatened suicide. It is noted that the patient's boyfriend accompanied him to the hospital, requesting that he be "locked up." Records indicate that the patient has a history of psychiatric hospitalizations and involvement with law enforcement secondary to engaging in behaviors that have been described as erratic and dangerous to both the patient and others.

The patient's mother and father divorced when the patient was three years of age, and the patient was reportedly sexually abused by his stepfather from five to eight years of age. The patient was removed from his mother's care at the age of nine and placed into the foster care system. The patient had difficulty at all foster care placements and often engaged in disruptive behaviors. The patient therefore resided within several foster homes until the age of 18, at which time he began living independently. The patient began displaying severe behavioral problems in childhood, to include fighting with other children and starting fires. In early adolescence, the patient began associating with a group of peers who frequently engaged in sexual, drug-using, and illegal activities. The patient began using drugs and being involved with the legal system at the age of 14. He has never maintained gainful employment for any significant period of time.

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The patient is a 25-year-old heterosexual female who presented to the emergency room following involvement in an altercation with her boyfriend, after which, she threatened suicide. It is noted that the patient's boyfriend accompanied her to the hospital, requesting that she be "locked up." Records indicate that the patient has a history of psychiatric hospitalizations and involvement with law enforcement secondary to engaging in behaviors that have been described as erratic and dangerous to both the patient and others.

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The patient is a 25-year-old homosexual female who presented to the emergency room following involvement in an altercation with her girlfriend, after which, she threatened suicide. It is noted that the patient's girlfriend accompanied her to the hospital, requesting that she be "locked up." Records indicate that the patient has a history of psychiatric hospitalizations and involvement with law enforcement secondary to engaging in behaviors that have been described as erratic and dangerous to both the patient and others.

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APPENDIX D

***DSM-IV-TR* DIAGNOSTIC IMPRESSION FORM**

Based on the clinical vignette you have just read, what is your initial diagnostic impression of the individual presented? Base your impression on Axis I and/or Axis II criteria consistent with DSM-IV-TR nosology.

Based on the clinical vignette you have just read, which of the following diagnoses seems MOST appropriate to assign to the individual presented?

1. Antisocial Personality Disorder
2. Bipolar I Disorder
3. Bipolar II Disorder
4. Borderline Personality Disorder
5. Dysthymic Disorder
6. Histrionic Personality Disorder
7. Major Depressive Disorder
8. Narcissistic Personality Disorder

APPENDIX E

BRIEF ASSESSMENT OF TRAITS – 37

BRIEF ASSESSMENT OF TRAITS – 37 **Client's name:** _____
 © 2010 Tony R. Young & W. Reese Mayer

Instructions: On each page, you will see several clusters of three related statements. Please indicate how well each of the clusters describes the patient by circling the corresponding number (see key below).

- 0** = Does not describe him/her at all
1 = Mildly describes him/her
2 = Moderately describes him/her
3 = Describes him/her extremely well

When he/she is having a problem with drugs and/or alcohol, he/she...

- | | | | | |
|---|----------|----------|----------|----------|
| 1. is emotionally intense
gets upset very easily
has big mood swings | 0 | 1 | 2 | 3 |
| 2. is often nervous
worries a lot
often seems "on edge" | 0 | 1 | 2 | 3 |
| 3. does what others tell them to do
"follows" others
doesn't like making decisions | 0 | 1 | 2 | 3 |
| 4. doesn't like being alone
is not independent
is afraid of rejection by significant others | 0 | 1 | 2 | 3 |
| 5. is pessimistic
expects the worst
focuses on the negative | 0 | 1 | 2 | 3 |
| 6. has low self-esteem
feels that they are worthless
believes they can't do anything right | 0 | 1 | 2 | 3 |
| 7. feels guilty often
blames themselves a lot
feels guilty for no real reason | 0 | 1 | 2 | 3 |
| 8. cuts or harms themselves on purpose
thinks about suicide
has threatened suicide | 0 | 1 | 2 | 3 |

9.. feels "down" often almost always feels depressed doesn't "bounce back" from bad moods	0	1	2	3
10. doesn't trust others is suspicious of others thinks others want to harm them	0	1	2	3
11. prefers to be alone dislikes most social events is quiet around most other people	0	1	2	3
12. seems "disconnected" from the world stays distant from others is not interested in world affairs	0	1	2	3
13. has very few close friends avoids romantic relationships doesn't want to be close to others	0	1	2	3
14. doesn't show emotions seems "too calm" to people doesn't get upset or excited when others would	0	1	2	3
15. doesn't have much enjoyment is not made happy by anything has little interest in anything	0	1	2	3
16. doesn't feel bad about hurting others doesn't care about others' problems doesn't care about people's feelings	0	1	2	3
17. uses people to get what they want manipulates people can be charming to get what they want	0	1	2	3
18. thinks they deserve special treatment is self-centered has a high opinion of themselves	0	1	2	3
19. likes being the center of attention shows off to others likes showy clothing and jewelry	0	1	2	3

- | | | | | |
|---|---|---|---|---|
| 20. gets mad easily
has a "hot temper"
gets overly angry about little things | 0 | 1 | 2 | 3 |
| 21. intimidates other people
is aggressive
can be verbally or physically abusive | 0 | 1 | 2 | 3 |
| 22. doesn't cooperate with others
resists following rules
has problems with authority figures | 0 | 1 | 2 | 3 |
| 23. tells a lot of lies
makes things up when telling stories
is often dishonest | 0 | 1 | 2 | 3 |
| 24. does things without thinking
acts on the "spur of the moment"
is impulsive | 0 | 1 | 2 | 3 |
| 25. gets distracted easily
has difficulty concentrating
has trouble paying attention for long | 0 | 1 | 2 | 3 |
| 26. takes risks
does dangerous things sometimes
gets bored easily | 0 | 1 | 2 | 3 |
| 27. is not responsible
does not keep promises
does not follow through with commitments | 0 | 1 | 2 | 3 |
| 28. is a perfectionist
wants everything to be flawless
has extremely high standards | 0 | 1 | 2 | 3 |
| 29. talks about things over and over
can't seem to "let things go"
gets obsessed with certain topics | 0 | 1 | 2 | 3 |
| 30. believes "their way" is the right way
doesn't like changing their routine
can't be convinced to change their mind | 0 | 1 | 2 | 3 |

- | | | | | |
|--|---|---|---|---|
| 31. needs everything to be in order
likes details, lists, and schedules
dislikes when anything is out of place | 0 | 1 | 2 | 3 |
| 32. avoids anything that's risky
almost never takes chances
is very careful not to get injured or sick | 0 | 1 | 2 | 3 |
| 33. has unusual sensations
hears things that no one else can hear
feels things that other people don't feel | 0 | 1 | 2 | 3 |
| 34. has very strange thoughts sometimes
has unusual views of reality
has very odd beliefs | 0 | 1 | 2 | 3 |
| 35. says and does things that are very odd
seems strange to other people
dresses in unusual or inappropriate ways | 0 | 1 | 2 | 3 |
| 36. has thoughts that are hard to follow
has thoughts that are disorganized
has thoughts that are hard to understand | 0 | 1 | 2 | 3 |
| 37. acts like their surroundings are strange
seems detached from reality at times
sometimes seems in a daze. | 0 | 1 | 2 | 3 |

APPENDIX F

ATTITUDES TOWARD WOMEN SCALE –

SHORT VERSION

Attitudes Towards Women Scale (Spence, Helmrich & Stapp, 1978) – Short version

Instructions: The statements listed below describe attitudes toward the roles of women in society which different people have. There are no right or wrong answers, only opinions. You are asked to express your feeling about each statement by indicating whether you (1) agree strongly, (2) agree mildly, (3) disagree mildly, or (4) disagree strongly.

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

1	2	3	4
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

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

1	2	3	4
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

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

1	2	3	4
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

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

1	2	3	4
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

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

1	2	3	4
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

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

1	2	3	4
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

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

1	2	3	4
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

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

1	2	3	4
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

- 9.* A woman should be free as a man to propose marriage.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
10. Women should worry less about their rights and more about becoming good wives and mothers.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
- 11.* Women earning as much as their dates should bear equally the expense when they go out together.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
- 12.* Women should assume their rightful place in business and all the professions along with men.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
13. A woman should not expect to go to exactly the same places or to have quite the same freedom of action as a man.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
14. Sons in a family should be given more encouragement to go to college than daughters.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
15. It is ridiculous for a woman to run a locomotive and for a man to darn socks.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
16. In general, the father should have greater authority than the mother in the bringing up of children.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
17. Women should be encouraged not to become sexually intimate with anyone before marriage, even their fiancés.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly

- 18.* The husband should not be favored by law over the wife in the disposal of family property or income.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
19. Women should be concerned with their duties of childbearing and house tending rather than with desires for professional or business careers.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
20. The intellectual leadership of a community should be largely in the hands of men.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
- 21.* Economic and social freedom is worth far more to women than acceptance of the ideal of femininity which has been set up by men.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
22. On the average, women should be regarded as less capable of contributing to economic production than are men.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
23. There are many jobs in which men should be given preference over women in being hired or promoted.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
- 24.* Women should be given equal opportunity with men for apprenticeship in the various trades.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly
- 25.* The modern girl is entitled to the same freedom from regulation and control that is given to the modern boy.
 1 2 3 4
 Agree strongly Agree mildly Disagree mildly Disagree strongly

APPENDIX G

ATTITUDES TOWARD LESBIANS AND

GAY MEN SCALE – REVISED

Attitudes Toward Lesbians (ATL):

1. Lesbians just can't fit into our society.
2. A woman's homosexuality should not be a cause for job discrimination in any situation.*
3. Female homosexuality is bad for society because it breaks down the natural divisions between the sexes.
4. State laws regulating private, consenting lesbian behavior should be abolished.*
5. Female homosexuality is a sin.
6. The growing number of lesbians indicates a decline in American morals.
7. Female homosexuality in itself is not problem, unless society makes it a problem.*
8. Female homosexuality is a threat to many of our basic social institutions.
9. Female homosexuality is an inferior form of sexuality.
10. Lesbians are sick.

Attitudes Toward Gay Men (ATG):

1. Male homosexual couples should be allowed to adopt children the same as heterosexual couples.*
2. I think male homosexuals are disgusting.
3. Male homosexuals should not be allowed to teach school.
4. Male homosexuality is a perversion.
5. Male homosexuality is a natural expression of sexuality in men.*
6. If a man has homosexual feelings, he should do everything he can to overcome them.
7. I would not be too upset if I learned that my son were a homosexual.*
8. Sex between two men is just plain wrong.
9. The idea of male homosexual marriages seems ridiculous to me.
10. Male homosexuality is merely a different kind of lifestyle that should not be condemned.*

APPENDIX H

POST-VIGNETTE QUESTIONNAIRE

1. How many courses have you taken in your training program that were specifically related to multiculturalism and diversity issues?
 - a. 0
 - b. 1
 - c. 2
 - d. 3
 - e. 4 or more

2. How many workshops or training programs have you attended that have been related specifically to multiculturalism and diversity issues?
 - a. 0
 - b. 1
 - c. 2
 - d. 3
 - e. 4 or more

3. How many classes have you taken in your training program that were specifically related to abnormal psychology, psychopathology, or the diagnosis of mental disorders?
 - a. 0
 - b. 1
 - c. 2
 - d. 3
 - e. 4 or more

4. How many workshops or training programs have you attended that have been related to abnormal psychology, psychopathology, or the diagnosis of mental disorders?
 - a. 0
 - b. 1
 - c. 2
 - d. 3
 - e. 4 or more

5. Considering the faculty, staff, and students in your training program, overall, how diverse do you consider the program (including race, socioeconomic status, religion, gender, and sexual orientation)?
 - a. Not at all diverse (nearly everyone is the same, demographically)
 - b. Mildly diverse (there is some diversity with regard to demographic characteristics, but the majority of individuals are the same)
 - c. Moderately diverse (there is a good deal of diversity with regard to demographic characteristics)
 - d. Very diverse (there is more diversity among demographic variables than there is similarity)

6. Considering the campus on which your training program is located, overall, how diverse do you consider the environment (including race, socioeconomic status, religion, gender, and sexual orientation)?
 - a. Not at all diverse (nearly everyone is the same, demographically)
 - b. Mildly diverse (there is some diversity with regard to demographic characteristics, but the majority of individuals are the same)
 - c. Moderately diverse (there is a good deal of diversity with regard to demographic characteristics)
 - d. Very diverse (there is more diversity among demographic variables than there is similarity)

7. In your personal life, how comfortable do you feel interacting with individuals who display diversity in sexual orientation (i.e., people with sexual orientations different from your own sexual orientation)?
 - a. Not at all comfortable
 - b. Mildly comfortable
 - c. Moderately comfortable
 - d. Completely comfortable
 - e. Not applicable -- I have had no known interactions with individuals of diverse sexual orientations in my personal life

8. In your professional life as a mental health provider, how comfortable do you feel working with clients who display diversity in sexual orientation (i.e., clients with sexual orientations different from your own sexual orientation)?
 - a. Not at all comfortable
 - b. Mildly comfortable
 - c. Moderately comfortable
 - d. Completely comfortable
 - e. Not applicable – I have had no known professional interactions with clients of diverse sexual orientations

9. In your personal life, how comfortable do you feel interacting with individuals who display diversity in gender identification (i.e., people who are transgendered or questioning gender-related issues)?
 - a. Not at all comfortable
 - b. Mildly comfortable
 - c. Moderately comfortable
 - d. Completely comfortable
 - e. Not applicable – I have had no known interactions with individuals displaying diversity in gender identification in my personal life

10. In your professional life as a mental health provider, how comfortable do you feel interacting with individuals who display diversity in gender identification (i.e., people who are transgendered or questioning gender-related issues)?
 - a. Not at all comfortable
 - b. Mildly comfortable
 - c. Moderately comfortable
 - d. Completely comfortable
 - e. Not applicable – I have had no known professional interactions with clients displaying diversity in gender identification

11. With respect to the supervision you have received as part of your training program, how much emphasis was placed on multicultural and diversity issues as they are related to therapy with clients?
 - a. Not much emphasis (multicultural / diversity issues were rarely or never discussed)
 - b. Some emphasis (multicultural / diversity issues were discussed when a specific client scenario warrants such attention)
 - c. Much emphasis (multicultural / diversity issues were considered in relation to all clients seen for therapy)

12. As part of your training program, how much formal education or training related to diversity awareness have you received in each of the following areas? For each area, indicate whether you have received no training, minimal training, moderate training, or extensive training.
 - a. Age / Generational Issues
 - b. Cultural Issues (general)
 - c. Disability Issues
 - d. Gender Issues (male and female)
 - e. Gender Issues (transgender)
 - f. Immigration Issues
 - g. Language Issues
 - h. Political Issues
 - i. Religious Issues
 - j. Racial / Ethnic Issues
 - k. Sexual Orientation Issues
 - l. Socioeconomic Issues
 - m. Other (please specify)