1989

Personality disorders as gender roles

Glenda J. Olivier

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project

Part of the Gender and Sexuality Commons, and the Psychology Commons

Recommended Citation


This Thesis is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.
PERSONALITY DISORDERS AS GENDER ROLES

---

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

---

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Psychology

---

by
Glenda J. Olivier

June 1989
PERSONALITY DISORDERS AS GENDER ROLES

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

by
Glenda J. Olivier
June 1989

Approved by:

Gloria A. Cowan, Ph.D., Chair, Psychology

Geraldine B. Stahly, Ph.D.

Nancy E. Rose, Ph.D.
ABSTRACT

Landrine's (1987) Social Role hypothesis proposes that personality disorders represent the role/role stereotype of both sexes. Perceived gender distribution of eleven personality disorders was examined. This study found that undergraduates (n=220) attributed to descriptions of five of the personality disorders (Antisocial, Paranoid, Histrionic, Dependent, and Borderline) the gender, social class, race and marital status of the group that receives that diagnosis most often. Thus Landrine's (1987) model was supported in terms of these particular disorders. The remaining six personality disorders were attributed characteristics that were white, middle-class and single, with gender not attributed in any consistent manner. Personality disorder categories need to be evaluated further from class, race, and marital status as well as gender to determine the validity of these categories. Future research should determine whether these categories are social constructions or represent socialized behaviours.
ACKNOWLEDGEMENTS

I wish to thank Gloria Cowan, Chair of my thesis committee, for her confidence in me, her guidance and support in the completion of my thesis. I would also like to thank the other two committee members: First, Geri Stahly, for her participation on my committee and her helpful comments on the draft. Secondly, Nancy Rose, for her encouragement and faith in me that I could complete this thesis. In addition, I would like to thank Eileen for her support and friendship—you have been a wonderful friend. I would also like to thank Beverley who spent many hours of her time with love and belief in me when I doubted myself. Finally, I would like to acknowledge H. Landrine's contribution to psychology which led me to do this thesis.
# TABLE OF CONTENTS

List of tables.......................................................................................... vi

Introduction.............................................................................................. 1

Method........................................................................................................ 14

  Subjects.................................................................................................... 14

  Procedure................................................................................................. 14

  Analysis.................................................................................................... 15

Results......................................................................................................... 16

Discussion................................................................................................. 20

Appendix A: Personality Disorders.......................................................... 28

References................................................................................................. 46
LIST OF TABLES

1. Predictions of the Status Characteristics
   of DSM-III-R Personality Disorders..............16
INTRODUCTION

It has been well documented that Personality Disorders tend to be reliably distributed by sex: The Paranoid, Compulsive, and Antisocial personality disorder labels are most likely to be found among men (Chesler, 1972, 1980; Kaplan, 1983; Kass, Spitzer & Williams, 1983), whereas the Dependent, Histrionic, and Borderline personality disorders tend to be found among women (Casteneda & Franco, 1986; Celani, 1976; Chesler, 1972; Chodoff, 1982; Kass et al., 1983; Lerner, 1974; Soloff & Millward, 1983).

Researchers have tried to explain these epidemiological patterns. Explanations include the hypotheses that the attribution of certain personality disorder labels to women represents the operation of a double-standard against them (Broverman, Clarkson, Rosenkrants & Vogel, 1970; Kaplan, 1983) and a sexist bias in therapy in associating feminine stereotypes with pathology (Chesler, 1972; Kaplan, 1983). Others argue that the personality disorder categories as a whole resemble women's gender-roles so that women receive these labels in the absence of psychopathology (Chesler, 1972).

Several theories have tried to explain the sex difference in treatment rates. One theory suggests that the higher rates of mental illness among women is because of
differences in the behavior of women due to their gender and marital roles (Gove, 1978). Another sex role related theory is based on Gilligan's (1979) and Miller's (1976) work. Gilligan suggests that identity for men and women occur at different stages in their life. Men's identity precedes intimacy, whereas women's sex roles facilitate the achieving intimacy before identity. Kaplan (1983), points out that women who have not established an identity before marriage may well have relationship difficulties and could be at risk for mental health problems. Thus, women's dependence on relationships renders them vulnerable to affective disorders in the loss of an intimate relationship. Also, women's subordinate roles in society may facilitate stress in their lives, such as incest, rape, and marital violence which can heighten women's vulnerability to mental illness (Miller, 1976).

Still others have suggested that the data on psychiatric diagnostic labels applied to women are artifacts of gender differences in help-seeking behaviour and the expression of symptomatology (Gove, 1978) and thereby reflect rates of treatment rather than rates of psychopathology in women (Phillips & Segal, 1969). Regarding gender specificity, personality disorder labels do not simply reflect the gender roles and stereotypes of women because some of these labels are more commonly diagnosed in
men; for example, Antisocial, Paranoid and Obsessive Compulsive disorders (Kass et al., 1983). The characteristics entailed in the male prevalent disorders do not resemble gender stereotypic behavior of women (Kass et al., 1983) but resemble more the masculine stereotype.

An alternative to these hypotheses is the Social Role or Equivalence Hypothesis (Landrine, 1987). Landrine (1987) argued that each personality disorder is by and large equivalent to the role and role-stereotype of the specific status group for whom that disorder is prevalent. Thus, the personality disorders represent the roles and role stereotypes of both sexes, and socialization into the roles accounts for the epidemiological distribution of the disorders. Those personality disorder labels that represent women's many roles (social class, ethnicity and marital status) are socialized in women, and those representing men's various roles (by social class, ethnicity and marital status) are socialized in men.

Not all women and men receive personality disorder labels, however. Landrine (1987) suggests that this is because people differ in the extent to which they will fulfill (act-out or fully adopt) the role attached to their status position. Some people consciously reject aspects of their gender x social class x ethnicity x marital status role, while others do not, and some people are more fully or
successfully socialized than others. Only those who adopt their role will receive the personality disorder label that is synonymous with that role. Thus, Landrine (1987) argued that successfully socialized (gender-stereotyped) persons will receive a personality disorder label, while relatively non-stereotypic persons—socialization failures—are considered normal. Landrine (1987) uses the term socialization to refer not only to primary and secondary socialization for roles, but also to the, "ongoing typified structured interactions of daily life, because it is in these daily interactions—with their contingencies . . . and self-fulfilling prophecies—that we acquire, as well as maintain, role attributes. Only successful socialization as defined here leads to the fulfillment of the role and thereby to receiving the personality disorder label equivalent to that role. Such socialization is possible, "whenever the interactional contexts and sequences in which roles are acquired and maintained are essentially homogeneous" (p. 348).

To understand certain concepts of Landrine's model, it is important to understand what she believes society construes as normal. The characteristics from stereotype research indicate that the attributes of prototypical normalcy and the attributes for the dominant group (upper-class white males) are synonymous. Some of the
characteristics that are considered descriptions of the dominant group are as follows: intelligence, ambitiousness, abstract thinking, emotional control, competitiveness, industriousness, and a sense of autonomous self (Banfield, 1970; Feagin, 1975; Huber & Form, 1973). This group of characteristics does appear to be the same as what society construes as prototypically normal (Broverman et al.; Jourard, 1974).

Landrine (1987) suggests that psychological disorders such as the personality disorders are equivalent to the total fulfillment of the roles of those status groups which exhibit the disorders most often. For example, one diagnosis that seems to be closely tied to social roles is that of Histrionic personality disorder, which is often ascribed to white young middle-class women (Berger, 1971; Kass, Spitzer & Williams, 1983; Lerner, 1974). The stereotype of a young middle-class female includes the following characteristics: an obsession with her physical appearance, provocativeness, romanticism, dependency (Lott, 1981); to be intuitive and sensitive (Lerner, 1974); to have no sense of responsibility (Talleck, 1987; Friedman, 1985), and to have thoughts that only reflect her husband's (Lott, 1981).

Individuals with Histrionic personality disorder are often described as women who have thoughts of fantasy surrounding romance (Shapiro, 1965). They also tend to have
a lack of deep emotions or ideas; show no significant evidence of intellectual abilities, and are demanding and provocative in their behavior (Berger, 1971; Cameron, 1965; Celani, 1976; Chodoff, 1974, 1982; DSM-III-R, 1986; Lerner, 1974). Thus, it seems that the symptoms of the Histrionic personality disorder are equivalent to the fulfillment of the role of a young white middle-class woman. Both have characteristics that include dependency, full of romantic notions, provocativeness and an obsession with physical appearance.

Likewise, the Dependent and Borderline personality disorders tend to be found among white middle-class women (Casteneda & Franco, 1986; Celani, 1976; Kass et al., 1983; Lerner, 1974; Soloff & Millward, 1983). Alternatively, there is evidence that the Antisocial and Paranoid personality disorders are more likely to be found by men (Chesler, 1972, 1980; Kaplan, 1983; Kass, Spitzer & Williams, 1983) and reflect stereotypes specific to class x gender x ethnic categories. Therefore, according to Landrine (1987), "if the disorders and fulfilled roles (stereotypes) are the same, and assuming that the public is aware of stereotypes, then students should attribute to the description of each disorder the status characteristics of the group that exhibits that disorder--diagnostic prototypes should seem to be ordinary social stereotypes" (p. 349).
To date, Landrine has found some empirical support for the Social Role/Equivalence hypothesis. In one study Landrine (1987) gave five different case histories which were stereotypes of class x gender to a sample of clinical psychologists and psychiatrists (who differed by sex, age, and theoretical orientation) and asked them to attribute diagnoses to these "cases" with an explicit reminder that the cases might be normal. The first case was a stereotype of lower-class people. The stereotype was copied verbatim from Schatzman & Strauss (1965) on lower-class linguistic characteristics; descriptions of affect, from Sennett & Cobb (1972); and the remaining characteristics from Bayton, McAlister & Hammer (1956) and Feagin (1972a, 1972b, 1975). The second case was a stereotype of young lower class men with class descriptive statements copied verbatim from Banfield (1970, pp. 53-54 and 162-164). The third case was a stereotype of single middle-class women. This stereotype description was based on work by Lott (1981, pp. 79, 81) and Lerner (1974, pp. 159, 160-161), Kreps (1970), and Harris & Voorhees (1981). The fourth case was a stereotype of married upper-class men with their stereotypic description copied verbatim from Banfield (1970, pp. 48-50). The fifth case was a stereotype of married middle-class women with statements comprised from Broverman et al. (1972) and Lott (1981). As predicted, Landrine (1987) found that
irrespective of the sex or theoretical orientation of the clinician, the stereotype of lower-class men was labeled antisocial; the stereotype of single middle-class women was labeled histrionic/hysterical; the stereotype of married middle-class women was labeled dependent; and the stereotype of the upper-class men was labeled normal.

In a second study Landrine (1987) reversed the procedure and gave the DSM-III descriptions of Paranoid, Compulsive, Histrionic, Antisocial, Schizoid, Narcissistic, Dependent, and Borderline personality disorders (labeled with their code number only) to introductory psychology students at Stanford University and instructed them to predict the sex, race, social class, age and marital status of the persons described.

As predicted, the description of the Histrionic was labeled a white single upper or middle-class woman. The description of a Dependent was labeled a white married middle-class woman. The Antisocial was labeled a black single male of lower class and the Paranoid description was labeled a white single middle-class male. The Compulsive was labeled a white middle-class male, either single or married. The Borderline, Schizoid and Narcissistic descriptions were labeled white and single but not attributed to either sex consistently.

These results match the epidemiological distribution of
these disorders with the exception of the Borderline and Compulsive disorders. Research indicates that Borderline personality disorder is more prevalent among women than men (Kaplan, 1983; Soloff & Millward, 1983; Casteneda & Franco, 1986). There also is conflicting evidence regarding the gender distribution of the Compulsive personality disorder. Turns (1985) in a large scale multicentered epidemiological study sponsored by the NIMH found that unmarried women of middle-class had a higher risk level for this disorder than men. This has also been supported by a later study conducted by the NIMH in the United States (Burvill, 1987). The Compulsive personality disorder was found to be one of four most common diagnoses given to women. However, the DSM-III-R (1987) indicates that this disorder is more prevalent among men than women.

Landrine's (1987) study had two methodological difficulties. First, the Stanford subjects were young (M=19 years, 8 months old) and upper and middle-class. Although they may have relied on social stereotypes to attribute status characteristics to the DSM-III personality disorders these stereotypes may have been specific to their class and age groups. Second, the Stanford subjects received the eight personality disorder descriptions in a within-groups design; thus, order effects may have occurred.

Landrine (1988) replicated the Stanford undergraduate
study with a sample of older (19-46 years old) working and lower class students from California State University, San Bernardino. These subjects received the personality disorder descriptions in a random order and again all subjects rated the eight personality disorders. As predicted, the students correctly identified the major status attributes of the personality disorders that are reliably distributed by sex, and their attributions matched those obtained with the Stanford sample. In another study, Landrine (1988) predicted that the two new personality disorder categories, the Sadistic and Self-Defeating personality disorders, also would be perceived as selectively assigned to men and women respectively. This prediction was based on the hypothesis that these new personality disorders represent the gender roles/stereotypes of both sexes. Research by Kass, MacKinnon and Spitzer (1986) in a "field test," using psychiatric residents at Columbia-Presbyterian, asked the residents to rate about 300 patients using the criteria for Self-Defeating personality disorder prior to its inclusion to the DSM-III-R. It was found that three times more women than men would be given the diagnosis. Walker (1987) suggests that the new personality disorder, Self-Defeating, lumps all violence victims into one diagnostic category, and this is a dis-service to those people who have been victimized by another
person's violent behavior. Also one of the major criticisms of this new category is the "lack of precise differentiation between the criteria specified to identify characterological traits and the more transient, state-like affect, cognition, and behavior of those clients who have been battered women, incest, child abuse and sexual assault victims" (Walker, 1987, p. 18). This new category according to Walker (1987) is based on "old sex-role stereotyped notions." Likewise, the counterpart diagnosis, the Sadistic personality disorder, would be diagnosed among males rather than females (Walker, 1986).

In Landrine's study (1988) all of the introductory psychology students in the sample did in fact perceive the Sadistic personality disorder as a man and the Self-Defeating personality disorder as a woman. This pattern of results across four studies strongly suggests that each personality disorder represents the role/stereotype of the specific group that tends to receive the label most often and implies that status groups might receive these labels for that reason alone (Landrine, 1987).

One difficulty inherent in Landrine's (1987, 1988) studies is that each subject received all of the personality disorders to evaluate. This methodology entails the implicit demand that subjects compare and contrast the descriptions, and such a demand may have led them to
differentially attribute sex and social class to the diagnostic prototypes. Thus, it is possible that the pattern of status attributions to the disorders was an artifact of Landrine's methodology.

The purpose of the present study was to replicate Landrine's (1987, 1988) studies on personality disorders using the DSM-III-R (1987) personality disorder descriptions including three personality disorders (Avoidant, Passive-Aggressive and Schizotypal) that Landrine (1987, 1988) did not previously test. Another primary purpose was to use a methodology that does not elicit differential attributions and, thereby provides a more stringent test of the Social/Role Equivalence hypothesis. In this study, subjects received a single personality disorder description stimulus and were asked to respond with status attributions of gender, social class, ethnicity, marital status, and age. Predictions were the same as those in Landrine (1987, 1988) except for the Borderline, and Compulsive personality disorders and three new additional categories: Avoidant, Passive-Aggressive, and Schizotypal. It was predicted that the following descriptions would replicate Landrine's (1987, 1988) studies. The Antisocial would be labeled a black single lower class man; the description of a Histrionic would be labeled an unmarried white upper or middle-class woman; the description of a Dependent would be labeled a
white, married, middle-class woman; the Paranoid, description would be labeled a single middle-class man; and the Narcissistic and Schizoid descriptions would be single middle-class and not attributed to either gender.

New predictions were made regarding the gender ascribed to the Borderline in accord with research by Casteneda & Franco (1986), Kass et al. (1983), and Soloff & Millward (1983). It was expected that the Borderline would be labeled a white single middle-class woman. In addition, the Compulsive description would be perceived as not gender specific. This prediction was based on conflicting research regarding the sex ratio of this disorder (Burvill, 1987; DSM-III-R, 1986; Turns, 1985). No predictions were made for the Avoidant, Passive-Aggressive and Schizotypal disorders as the literature does not suggest specific gender distribution (Kass et al., 1983). Landrine's previous studies (1987, 1988) did not include these personality disorders. No predictions were made regarding typical age of each occupant of each personality disorder.
METHOD

Subjects

The subjects consisted of 70 men and 150 women undergraduate students at California State University, San Bernardino, with an age range of 16 to 60, with a mean of 23.30. This sample was composed of 147 Caucasians, 34 Blacks, 26 Hispanics, and 12 Asians. Twenty-seven of the subjects were married, 177 were single, and 16 were separated/divorced.

Procedure

Each student received instructions that read: "On the attached page a person is described in terms of the way he/she typically behaves. Read the description very carefully. Then, try to predict the groups (or categories) to which this person belongs. BE AS ACCURATE AS YOU CAN."

The questionnaires consisted of nearly verbatim descriptions of the following Personality Disorders from DSM-III-R (1987): Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, Compulsive, and Passive-Aggressive. (See Appendix A for the descriptions). The descriptions were shortened, and some of the clinical terms were replaced with equivalent lay-terms. Gender references were removed, and the disorders were described in gender neutral terms. Each description was
labeled with its DSM-III-R code number only. For the purpose of this study, each subject received one description only. Twenty of each of the 11 personality disorder descriptions were randomly distributed. At the bottom of the DSM-III-R description, the student was asked to predict the sex, race, age, social class, and marital status of the personality disorder described. The questions regarding each characteristic was phrased as follows: This person is most likely to be, male (or) female; wealthy, middle-class (or) poor; black (or) white, single (or) married; subjects were asked to predict the exact age of the individual.

Analysis

Chi-square analyses of the frequency of each characteristic—gender, social class, ethnicity, and marital status were performed to assess the effects of these status characteristics on each of the eleven personality disorders.
RESULTS

Table 1 gives the results of the student's predictions of the status characteristics of the eleven personality disorders and the Chi-Square analyses of those predictions.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Sex</th>
<th>Social Class</th>
<th>Race</th>
<th>Marital Status</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>F= 5 M=15</td>
<td>U= 5 M=11 L= 4</td>
<td>W=17 B= 3</td>
<td>Married= 7 Single =13</td>
<td>x=31.2</td>
</tr>
<tr>
<td></td>
<td>$\chi^2$= 5.0*</td>
<td>$\chi^2$= 4.30</td>
<td>$\chi^2$= 9.8**</td>
<td>$\chi^2$= 1.80</td>
<td></td>
</tr>
<tr>
<td>Schizoid</td>
<td>F=10 M=10</td>
<td>U= 4 M=14 L= 2</td>
<td>W=17 B= 3</td>
<td>Married= 3 Single =17</td>
<td>x=30.6</td>
</tr>
<tr>
<td></td>
<td>$\chi^2$= 0</td>
<td>$\chi^2$=12.40**</td>
<td>$\chi^2$= 9.8**</td>
<td>$\chi^2$= 9.80**</td>
<td></td>
</tr>
<tr>
<td>Histrionic</td>
<td>F=15 M= 4</td>
<td>U= 6 M=15 L= 1</td>
<td>W=17 B= 3</td>
<td>Married= 1 Single =19</td>
<td>x=22.6</td>
</tr>
<tr>
<td></td>
<td>$\chi^2$= 5.0*</td>
<td>$\chi^2$=15.31**</td>
<td>$\chi^2$= 9.80**</td>
<td>$\chi^2$=16.20**</td>
<td></td>
</tr>
<tr>
<td>Narcissistic</td>
<td>F=10 M=10</td>
<td>U= 7 M=13 L= 0</td>
<td>W=20 B= 0</td>
<td>Married= 2 Single =18</td>
<td>x=24.2</td>
</tr>
<tr>
<td></td>
<td>$\chi^2$= 0</td>
<td>$\chi^2$= 6.05*</td>
<td>$\chi^2$=20.00**</td>
<td>$\chi^2$=12.80**</td>
<td></td>
</tr>
<tr>
<td>Dependent</td>
<td>F=19 M= 1</td>
<td>U= 1 M=15 L= 4</td>
<td>W=17 B= 3</td>
<td>Married=14 Single = 6</td>
<td>x=26.1</td>
</tr>
<tr>
<td></td>
<td>$\chi^2$=16.2**</td>
<td>$\chi^2$=16.31**</td>
<td>$\chi^2$= 9.80**</td>
<td>$\chi^2$= 7.20</td>
<td></td>
</tr>
<tr>
<td>Antisocial</td>
<td>F= 2 M=18 L=15</td>
<td>U= 0 M= 5 B=16 L=15</td>
<td>W= 4 B=16</td>
<td>Married= 2 Single =18</td>
<td>x=26.0</td>
</tr>
<tr>
<td></td>
<td>$\chi^2$=12.8**</td>
<td>$\chi^2$=13.20**</td>
<td>$\chi^2$= 7.20**</td>
<td>$\chi^2$=12.8**</td>
<td></td>
</tr>
</tbody>
</table>

(table continues)
### Disorder | Sex | Social Class | Race | Marital Status | Age
--- | --- | --- | --- | --- | ---
Borderline | F=16 M=4 | U=3 M=15 L=2 | W=18 B=2 | Married 2 Single 18 | x=22.8

\[ \chi^2 = 7.20^{**} \chi^2 = 10.44 \chi^2 = 12.80^{**} \chi^2 = 12.80^{**} \]

Compulsive | F=9 M=11 | U=1 M=19 L=0 | W=19 B=1 | Married 8 Single 12 | x=27.4

\[ \chi^2 = 0.80 \chi^2 = 27.67^{**} \chi^2 = 16.20^{**} \chi^2 = 0.80 \]

Avoidant | F=12 M=8 | U=2 M=17 L=1 | W=16 B=4 | Married 2 Single 18 | x=22.5

\[ \chi^2 = 0.80 \chi^2 = 24.12^{**} \chi^2 = 7.20^{**} \chi^2 = 12.80^{**} \]

Schizotypal | F=9 M=11 | U=1 M=12 L=7 | W=16 B=4 | Married 2 Single 18 | x=27.5

\[ \chi^2 = 0.20 \chi^2 = 9.11^{*} \chi^2 = 7.20^{**} \chi^2 = 12.80^{**} \]

Passive | F=8 M=12 | U=1 M=17 L=2 | W=17 B=3 | Married 6 Single 14 | x=26.8

\[ \chi^2 = 0.80 \chi^2 = 24.12^{**} \chi^2 = 9.80^{**} \chi^2 = 7.20^{**} \]

Note. For Sex above F=Female, M=Male. For Social Class U=Upper, M=Middle, L=Lower. For Race, W=White, B=Black.

* = p<.05, ** = p<.01
df = 1 for all analyses except social class where df = 2.

As predicted the Paranoid was seen as a white middle-class male (mean age of 31.2). The Histrionic was predicted as a white middle-class woman (mean age 22.60). The Dependent was accurately predicted as a young white married middle-class woman (mean age of 26.0). Likewise, the Antisocial was perceived as a single black lower class male...
(mean age of 26.0). The Narcissistic was seen as white, single, middle-class, and with sex not attributed in any consistent manner with a mean age of 24.0. The Schizoid was perceived a white, single, middle-class and perceived as either male or female with a mean age of 30.6. These findings replicated Landrine's (1987, 1988) studies.

The findings for the Borderline and Compulsive disorder were as follows. As predicted, the Borderline description was perceived as a young white, single, middle-class female (mean age of 22.8). This particular result is different from Landrine's previous research, but the results of this study are consistent with the epidemiological patterns of this disorder by Kass et al. (1983). The Compulsive description was perceived as white, single, and middle-class (mean age of 27.40); however, the marital status and gender descriptions failed to reach statistical significance. This was in accordance with the prediction of this study based on research that gender is not a reliable characteristic of this disorder (Burvill, 1987; DSM-III-R, 1986; Kass et al., 1983; Turns, 1985).

The students perceived the additional personality disorders, Passive, Schizotypal, and Avoidant, that were not previously tested as white, single, and middle-class with sex not attributed in any consistent manner. Thus supporting the sex-ratio distribution of these disorders.
cited by Kass et al. (1983). Although not predicted, it should be noted that of the 11 personality disorders, 10 were predicted middle-class; 8 were predicted single; and 10 were expected to be white. It is interesting to note that 5 out of the 11 personality disorders were gender typed, 2 were male (the Paranoid and Antisocial) and 3 were female (the Histrionic, Dependent, and Borderline).
DISCUSSION

The results of this study show that a sample of undergraduates correctly identified the major gender status characteristics of those disorders which tend to be diagnosed by gender: Histrionic, Borderline, Dependent, Antisocial, and Paranoid (Kass et al., 1983 tables 1 & 2). As the undergraduate students had little knowledge about psychology or diagnostic categories, they must have relied on their own general understanding of social stereotypes and schema based on society's consideration of those stereotypes (Landrine, 1987). These particular disorders may represent the role/stereotype of the specific group that tends to receive these labels most often. Thus, Landrine's (1987) model is supported in terms of these particular categories.

This finding implies that the distribution for the above epidemiological patterns may not be only a result of clinical bias against women (Broverman et al., 1970; Kaplan, 1983) or that the categories themselves as a whole resemble only women's gender roles (Chesler, 1972). Therefore, according to Landrine, "the reason may be that gender-role categories and personality disorder categories are simply flip sides of the same stereotyped coin" (p. 12). Landrine further questions why gender-roles and stereotypes are synonymous to the personality disorders. One level of
explanation that Landrine (1988) offers is that the personality disorders are equivalent to the total fulfillment of gender stereotypic roles. Thus, the gender stratification constructed by society causes distress, self-destructive behaviour, limitations, and inconsistency, whose total fulfillment is then defined as psychopathological. Therefore, gender roles not only are labeled as psychopathological by society, but the total fulfillment of gender roles themselves also cause psychopathology. The second level of explanation Landrine (1987) suggests is that the reason gender roles are equivalent to psychopathology is political so that gender stratification can continue by changing individuals through therapy rather than focusing attention on changing the gender roles themselves. The implications of re-defining gender roles are that society might eradicate both the personality disorders and the social roles associated with them. It would seem important to examine further if these personality disorders are a simple reification of gender roles which may act to provide and maintain gender stratification by labeling people rather than traits as problematic. Kelly (1983) suggested that a goal for the 1980's was to "integrate more directly sex role 'personality' research on clinical disorders."

The Schizoid, Narcissistic, Schizotypal, Avoidant, Passive and Compulsive disorders were not expected to be
typically male or female, but were seen as white, single and middle-class. The research on the epidemiology of these six disorders has suggested that these disorders are not predicted by gender (Kass et al., 1983). It may be that some of the personality disorders are not predicted by gender, but that some of the other major status characteristics, such as class, ethnicity and marital status, are more reliable predictors of these particular disorders. Landrine's Social Role hypothesis (1987, 1988), which indicates that the distribution of all the personality disorders occurs because the personality disorders represent the gender role/role stereotype of each sex, is not applicable to all of the personality categories. Perhaps the interaction of class x marital status x ethnicity for these personality disorders has a more important role than gender in the distribution of these personality disorders.

Previous research by Landrine (1987) has suggested that the role and role-stereotype of the poor are indistinguishable from the majority of the symptoms of schizophrenia (excluding delusions and hallucinations). Thus, Landrine (1987) offers the idea that there is a direct relationship between clinical and social class categories. Stereotype research has found that the generalized stereotype according to Smedley & Bayton (1978) is "influenced by the perception as to the distribution of the classes in a given racial
group" (p. 530). Bayton (1956) and Landrine's (1985) findings in stereotype research indicate that both social class and race are implicit variables in stereotypes. Therefore, if there is a direct relationship between clinical and social class taxonomies, the white, single, middle-class may have a variety of status characteristics that we define as psychopathological irrespective of gender and label 'Personality Disorders.'

If stratification of society in terms of who is subordinate is applied not only to status characteristics but also to psychopathology, then it seems reasonable that lower class and single ethnic minorities and women will have a specific set of characteristics if fulfilled completely (sex x social status x ethnicity x marital status) that is defined as psychopathology. For example, Schizophrenia in terms of social status, Antisocial as depicted in ethnicity and social status, and Depression in terms of marital status. Thus, each level of stratification will have its own characteristics that if fulfilled completely will be attributed as psychopathology or will be psychopathological.

All of the personality disorders with the exception of Antisocial in this particular study were given a white, predominantly single, middle-class status. It is interesting to note that in Landrine's (1987) study, with the exception of the prediction for Antisocial, all the rest
of the personality disorders were attributed to the middle-
class. In addition, Landrine's (1988) study, with the
exception of the Paranoid and Borderline personality
disorders, were also assigned to the middle-class category.
Social roles which are defined by class, and which interact
with ethnicity and gender can be viewed as rigid and
limiting. For example, it has been previously noted that
perhaps the level of mental illness for women might be due
to their limiting and subordinate roles in society. In
addition, their social class will then have an important
effect upon the type of mental illness they have. Thus a
white/black lower class woman, regardless of ethnicity, who
fulfills the lower class stereotype role is equivalent to
Schizophrenia (Landrine, 1987). And a white middle-class
woman who fulfills her stereotype role is likely to be
attributed a personality disorder such as Histrionic or
Dependent (Chesler, 1972; Lerner, 1974). Maybe middle-class
character disorders are not seen as deeply psycho-
pathological or as more functional than lower class
disorders, such as Schizophrenia.

Landrine (1987) suggests that the purpose of the con-
cordance of the epidemiological patterns of the personality
disorders in stereotypes is to attempt to maintain strati-
fication of society. One way that this stratification is
maintained by the dominant group is the fulfillment of the
stereotypic role of the married middle-class female. This particular role fulfills the "family ethic" by the woman staying at home and thus becoming dependent upon her husband. She also does not become part of the work force, thus the dominant group, the upper-class males in society still maintain power within society.

The clinical taxonomies which are based on what is normal and abnormal behaviour also reinforce the stratification system. Those behaviours that are considered acceptable attributes in society are reinforced and given social rewards which maintain power for the dominant group, whereas those behaviours that are considered abnormal are attempted through the process of therapy to be differentially changed. This then reinforces the social stratification by providing differential values in terms of society's behaviour; this, in turn, benefits the dominant group. Therefore, the types and symptoms of mild and severe psychopathology and the concept of normalcy can be predicted from society's stratification system (Landrine, 1987). For example, the upper-class white male is considered normal, the white middle-class stereotypic role if totally fulfilled is equivalent to a personality disorder. And the lower class stereotypic role if totally fulfilled is equivalent to more severe forms of psychopathology, such as Schizophrenia. It might be important to become just as aware of class-
socialization and class-stereotypes as well as gender stereotypes in these clinical taxonomies.

This study had two limitations with the results. First the CSUSB students were young (mean age 23.30) and mostly white, single and middle-class. Although they may have relied on social stereotypes to attribute characteristics to the personality descriptions, these may have been specific to their class, ethnicity, marital status, and age groups. This may have affected the results. The subjects may have projected the status attributes of someone of their own group, rather than the attributes of the stereotype description they read. Also they are most likely to know someone in their own social class.

Secondly, it could be that the results obtained from this study were an artifact of the type of method used. Subjects may respond in a similar fashion to the questionnaire format which asked for specific information, such as class, race, gender and marital status. The design of the questionnaire required the subjects to choose either, male/female, black/white, married/single, wealthy/middle-class/poor, and the subjects may have seen the description they read as both male/female, or black and white, yet were forced to choose between the two conditions.

These disorders need further examination to understand more of the epidemiological patterns and to distinguish
whether these categories are merely social constructions or represent socialized behaviours. Landrine’s Social Role Hypothesis (1987) may be one important component in understanding why the epidemiological patterns do occur. The personality disorder categories need to be evaluated further from both class and gender stereotypes to determine the validity or biases of these categories.
APPENDIX A: PERSONALITY DISORDERS

Person 301.00

This person shows a pervasive and unwarranted tendency, beginning by early adulthood and present in a variety of contexts, to interpret the actions of people as deliberately demeaning or threatening. Almost invariably he/she has a general expectation of being exploited or harmed by others in some way. Frequently this person with this disorder will question, without justification, the loyalty or trustworthiness of friends or associates. Often the person is pathologically jealous, questioning without justification the fidelity of his or her spouse or sexual partner. Confronted with a new situation, the person may read hidden demeaning or threatening meanings into benign remarks or events, e.g., suspect that a bank has deliberately made a mistake in his/her account. Often this person is easily slighted and quick to react with anger or counterattack; he/she may bear grudges for a long time, and never forgive slights, insults, or injuries. He/she is reluctant to confide in others because of a fear that the information will be used against him/her. He/she is typically hypervigilant and takes precautions against any perceived threat. He/she tends to avoid blame even when it is warranted and is often viewed by
others as guarded, secretive, devious, and scheming. When he/she is in a new situation he/she intensely and narrowly searches for confirmation of his/her expectations, with no appreciation of the total context. His/her final conclusion is usually precisely what he/she expected in the first place. Often, he/she thinks that others are taking special notice of him/her or saying vulgar things about him/her. He/she is usually argumentative and exaggerates difficulties, "making mountains out of moleshills." He/she often finds it difficult to relax, usually appears tense, and has a tendency to counterattack when perceiving any threat. He/she is critical of others but has great difficulty accepting criticism. His/her emotions may appear "cold" to others. He/she has no true sense of humor and is usually serious. He/she takes pride in always being objective, rational, and unemotional. He/she lacks passive, soft, sentimental, and tender feelings. Occasionally, others see this person as a keen observer who is energetic, ambitious, and capable; but more often he/she is viewed as hostile, stubborn, and defensive. This person tends to be rigid and unwilling to compromise, and may generate uneasiness and fear in others. This person often has an inordinate fear of losing independence or the power to shape events according to his/her own wishes. This person usually avoids intimacy except with those in whom he/she has absolute trust. He/she
displays an excessive need to be self-sufficient, to the point of egocentricity and exaggerated self-importance. This person avoids participation in group activities unless he/she is in a dominant position. This person is often interested in mechanical devices, electronics, and automation. He/she is generally uninterested in art or aesthetics. This person is keenly aware of power and rank and of who is superior or inferior, and is often envious and jealous of those in positions of power. This person dislikes people he/she sees as weak, soft, sickly, or defective. (This is a Paranoid Personality Disorder).

This person is most likely to be:
1. Male _______ Female _______
2. Wealthy _____ Middle-class ____ Poor ____
3. ______ years old
4. Black _____ White ______
5. Married ____ Single _____

Person 301.20

This person shows a pervasive pattern of indifference to social relationships and a restricted range of emotional experience and expression, beginning by early adulthood and present in a variety of contexts. This person neither desires nor enjoys close relationships, including being part of a family. He/she prefers to be a "loner," and has no close friends or confidants (or only one) other than first-
degree relatives. This person almost always chooses solitary activities and indicates little if any desire to have sexual experiences with another person. He/she is indifferent to the praise and criticism of others. This person claims that he/she rarely experiences strong emotions such as anger and joy, and in fact displays little emotion. He/she appears cold and aloof. This person is often unable to express aggressiveness or hostility. He/she seems vague about goals, is indecisive in actions, self-absorbed, and absentminded. (This person is Schizoid Personality Disorder).

Person 301.22

This person shows a pervasive pattern of peculiarities in thinking, appearance, and behavior, and deficits in interpersonal relatedness, beginning by early adulthood and present in a variety of contexts. The person's thoughts include suspiciousness, the ideas that people are referring to him/her, odd beliefs, and magical ways of thinking about events. For example, he/she is superstitious, believes in clairvoyance, telepathy, or "sixth sense," and believes that "others can feel his/her feelings." As a child he/she had bizarre fantasies. He/she also has illusions such as sensing the presence of a force or person not actually present (e.g., "I felt an evil presence in the room"). Often his/her speech is marked with peculiarities, and is
digressive, vague, or inappropriately abstract. Concepts may be expressed unclearly or oddly, or words may be used in an unusual way. He/she appears odd and eccentric in behavior and appearance. For example, he/she is often unkempt, displays unusual mannerisms, and talks to him/herself. Trying to interact with him/her is difficult; he/she displays inappropriate or constricted emotions, appearing silly and aloof and rarely reciprocating gestures or facial expressions such as smiling or nodding. This person has no close friends or confidants (or only one) other than first-degree relatives, and is extremely anxious in social situations involving unfamiliar people. Varying mixtures of anxiety, depression, and other bad moods are common. Because of this person's peculiarities of thinking, he/she is prone to eccentric convictions. (This person is Schizotypal Personality Disorder).

Person 301.70

This person shows a pattern if irresponsible and anti-social behavior beginning in childhood or early adolescence and continuing into adulthood. In childhood this person lies, steals, vandalizes, initiates fights, runs away from home, and is physically cruel. In adulthood this person fails to honor his/her financial obligations, act as a responsible parent or to plan ahead, and has an inability to work consistently. He/she fails to conform to social norms
and repeatedly performs acts that are grounds for arrest, such as destroying property, harassing others, stealing, and having an illegal occupation. This person tends to be irritable and aggressive and gets repeatedly into physical fights and assaults, including spouse- or child-beating. He/she shows reckless behavior without regard to personal safety by frequently driving while intoxicated or getting speeding tickets. Typically, this person is promiscuous (defined as never having sustained a monogamous relationship for more than a year). Also, he/she generally has no remorse about the effects of his/her behavior on others; he/she may even feel justified in having hurt or mistreated others. After age 30 sexual promiscuity and fighting and criminality may diminish in this person. In early adolescence this person characteristically uses tobacco, alcohol, and other drugs and engages in voluntary sexual intercourse unusually early for his/her peer group. This person shows signs of personal distress, including complaints of tension, an inability to tolerate boredom, depression, and the conviction (often correct) that others are hostile toward him/her. These interpersonal difficulties and bad moods tend to persist into his/her late adult life. Almost invariably this person has difficulty sustaining lasting, close, warm, and responsible relationships with family, friends or sexual partners. (This person
is Antisocial Personality Disorder).

Person 301.83

This person shows a pervasive pattern of instability in self-image, interpersonal relationships, and mood, beginning by early adulthood and present in a variety of contexts. He/she shows uncertainty about several life issues, such as self-image, sexual orientation, long-term goals or career choice, types of friends or lovers to have, or which values to adopt. This person often experiences his/her feelings of instability as lack of self-image and chronic feelings of emptiness or boredom. His/her interpersonal relationships are usually unstable and intense, and may be characterized by alternation of extremes of overidealization and devaluation. This person has difficulty tolerating being alone, and he/she will make frantic efforts to avoid real or imagined abandonment. Emotional instability is common; this may be evidenced by his/her marked mood shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours or, only rarely, more than a few days. In addition, this person often has inappropriately intense anger, or lack of control of his/her anger, with frequent displays of his/her temper or recurrent physical fights. This person tends to be impulsive, particularly in activities that are potentially self-damaging, such as shopping sprees, psychoactive substance abuse, reckless
driving, casual sex, shoplifting, and binge eating. Recurrent suicidal threats, gestures, and other self-mutilating behaviors are common in this person. This behavior may serve to manipulate others, may be a result of his/her intense anger, or may counteract feelings of "numbness" and depersonalization that arise during periods of his/her extreme stress. This person often shows social contrariness and a general pessimistic outlook. He/she alternates between dependency and self-assertion. (This person is Borderline Personality Disorder).

Person 301.50

This person shows a pervasive pattern of excessive emotionality and attention-seeking by early adulthood and present in a variety of contexts. This person constantly seeks or demands reassurance, approval or praise from others and is uncomfortable in situations in which he/she is not the center of attention. This individual displays rapidly shifting and shallow expression of attention. He/she is overly reactive which is intensely expressed; minor stimuli give rise to emotional excitability. His/her emotions are often expressed with inappropriate exaggeration, for example, this person, may appear much more sad, angry, or delighted than would seem warranted. He/she is very self-centered, with little or no tolerance for the frustration of delayed gratification. His/her actions are directed to
obtaining immediate self-satisfaction. This person is typically attractive and seductive, often to the point of looking flamboyant and acting inappropriately. He/she is typically overly concerned with physical attractiveness. In addition, this person's style of speech tends to be expressionistic and lacking in detail. For example, this person may describe his/her vacation as "Just fantastic!" without being able to be more specific. This person is lively and dramatic and is always drawing attention to him/herself. He/she is prone to exaggeration in his/her interpersonal relations and often acts out a role such as that of "victim" or "princess" without being aware of it. This person craves novelty, stimulation and excitement and quickly becomes bored with a normal routine. Others frequently perceive him/her as superficial, charming and appealing, but lacking genuineness. This person is often quick to form friendships, but once a relationship is established, he/she can become egocentric and inconsiderate. This person may constantly demand reassurance because he/she has feelings of helplessness and dependency. He/she is often inconsistent in his/her actions and may be misinterpreted by others. In relationships he/she attempts to control the opposite sex or to enter into dependent relationships. Flights into romantic fantasy are common. This person may be promiscuous or naive and sexually un-
responsive; or normal in their sexual adjustment. Usually this person shows little interest in intellectual achievement, and careful analytical thinking, but this person is often creative and imaginative. This person is easily influenced by others or by fads. This person is apt to be overly trusting of others and suggestible, and shows an initially positive response to any strong authority figure, who he/she thinks can provide a magical solution for his/her problems. This person often adopts convictions strongly and readily, but his/her judgement is not firmly rooted, and he/she often plays hunches. This person complains of poor health, such as weakness, or subjective feelings of depersonalization. (This person is Histrionic Personality Disorder).

**Person 301.81**

This person shows a pervasive pattern of grandiosity (in fantasy or behavior), hypersensitivity to the evaluation of others, and lack of empathy that begins by early adulthood and is present in a variety of contexts. This person has a grandiose sense of self-importance. He/she tends to exaggerate his/her accomplishments and talents, and expects to be noticed as "special" even without appropriate achievements. He/she often feels that because of his/her "specialness," his/her problems are unique, and can be understood only by other special people. This person frequently
alternates between his/her sense of self-importance and with feelings of his/her special unworthiness. For example, this person who ordinarily expects an A and receives a grade of A minus may, at that moment, express the view that he or she is thus revealed to all as a failure. Conversely, having gotten an A, this person may feel fraudulent, and unable to take genuine pleasure in his/her real achievement. This person is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love, and with chronic feelings of envy for those whom he/she perceives as being more successful than him/her. Although these fantasies frequently substitute for realistic activity, when such goals are actually pursued by this person it is often with a driven, pleasureless quality and an ambition that cannot be satisfied. Self-esteem is almost invariably very fragile; this person may be preoccupied with how well he or she is doing and how well he or she is regarded by others. This often takes the form of an almost exhibitionist need for constant attention and admiration. This person may constantly fish for compliments, often with great charm. In response to criticism, he or she may react with rage, shame, or humiliation, but masks these feelings with an aura of cool indifference. This person's interpersonal relationships are invariably disturbed. A lack of empathy (inability to recognize and experience how others feel) is
common. For example, this person may be unable to understand why a friend whose father has just died does not want to go to a party. This person expects unreasonable expectations of especially favourable treatment. For example this person may assume that he or she does not have to wait in line when others must. This person takes advantage of others to achieve his/her own ends, or for self-aggrandizement. Friendships are often made only after the partner is often treated as an object to be used to bolster this person's self-esteem. This person is often depressed. He/she is painfully self-conscious and preoccupied with grooming and remaining youthful. Personal deficits, defeats, or irresponsible behavior that this person does may be justified by rationalization or lying. His/her feelings may be faked in order to impress others. (This person is Narcissistic Personality Disorder).

Person 301.82

This person shows a pervasive pattern of social discomfort, fear of negative evaluation, and timidity, beginning by early adulthood and present in a variety of contexts. He/she is somewhat concerned about how others assess him/her and this person is easily hurt by criticism and is devastated by the slightest hint of disapproval. This person is generally unwilling to enter into relationships unless given an unusually strong guarantee of
in a variety of contexts. This person is unable to make everyday decisions without an excessive amount of advice and reassurance from others, and will even allow others to make most of his/her important decisions. For example, this person will typically assume a passive role and allow his or her spouse to decide where they should live, what kind of job he or she should have, and with which neighbours they should be friendly. As a child this person allowed his or her parent(s) to decide what he or she should wear, with whom to associate, how to spend free time and what school or college to attend. This excessive dependence on others leads to difficulty in initiating projects or doing things on one’s own. This person tends to feel uncomfortable or helpless when alone, and will go to great lengths to avoid being alone. He/she is devastated when close relationships end, and tends to be preoccupied with fears of being abandoned. This person is easily hurt by criticism and disapproval, and tends to subordinate him/herself to others, agreeing with people even when believing them to be wrong, for fear of being rejected. This person volunteers to do things that are unpleasant or demeaning in order to get others to like him/herself. This person lacks self-confidence, and tends to belittle his/her abilities and assets. For example, this person with this disorder constantly refers to himself/herself as "stupid." He/she may
at times seek, or stimulate overprotection and dominance in others. (This person is Dependent Personality Disorder).

**Person 301.40**

This person shows a pervasive pattern of perfectionism and inflexibility, beginning by early adulthood and present in a variety of contexts. This person constantly strives for perfection, but this adherence to his/her own overly strict and often unattainable standards frequently interferes with actual completion of tasks and projects. No matter how good an accomplishment, it often does not seem "good enough." Preoccupation with rules, efficiency, trivial details, procedures, or form interferes with the ability to take a broad view of things. For example, this person, having misplaced a list of things to be done, will spend an inordinate amount of time looking for the list rather than spending a few moments re-creating the list from memory and proceed with accomplishing the tasks. This person poorly allocates time the most important tasks being left to the last moment. This person is always mindful of his/her relative status in dominant-submissive relationships. Although he/she might resist the authority of others, he/she stubbornly and unreasonably insists that people conform to his/her way of doing things. Work and productivity are prized to the exclusion of pleasure and interpersonal relationships. Often, this person is pre-
occupied with logic and intellect and intolerance of emotional behavior in others. When pleasure is considered, it is something to be planned and worked for. However, this person usually keeps postponing the pleasurable activity, such as a vacation, so that it may never occur. Decision making is avoided, postponed, or protracted, perhaps because this person has an inordinate fear of making a mistake. For example, assignments cannot be completed on time because this person ruminates about priorities. This indecisiveness may cause this person to retain his/her worn or worthless objects even when they have no sentimental value. This person tends to be excessively conscientious, moralistic, scrupulous, and judgmental of him/herself and others, for example, he/she would consider it "sinful" for a neighbour to leave their child's bicycle out in the rain. This person tends to be stingy with his/her emotions and material possessions. He/she tends not to express his/her feelings and rarely gives compliments or gifts. His/her everyday relationships have a conventional, formal, and serious quality. Others often perceive this person as stilted or "stiff." This person may complain of difficulty expressing his/her tender feelings. This person may experience considerable distress because of his/her indecisiveness and general ineffectiveness. His/her speech may be circumstantial and this individual is often depressed. This
person has an unusually strong need to be in control. When he/she is unable to control others, a situation, or his/her environment, he/she often thinks about the situation and becomes angry, although the anger is usually not expressed directly. (For example, he/she may be angry when service in a restaurant is poor, but instead of complaining to the management, thinks about how much he/she will leave as a tip). Frequently this person is extremely sensitive to social criticism, especially if it comes from someone with considerable status or authority. (This person is Obsessive Compulsory Personality Disorder).

Person 301.84

This person shows a pervasive pattern of passive resistance to demands for adequate social and occupational performance, beginning by early adulthood and present in a variety of contexts. The resistance is expressed indirectly rather than directly, and results in pervasive and persistent social and occupational ineffectiveness even when more self-assertive and effective behavior is possible. This person passively expresses covert aggression: He/she habitually resents and opposes demands to increase or maintain a given level of functioning. This occurs most clearly in work situations, but it is also evident in social functioning. The resistance is expressed indirectly through such maneuvers as procrastination, dawdling, stubbornness,
intentional inefficiency, and "forgetfulness." This person obstructs the efforts of others by failing to do their share of the work. For example, when an executive gives this person some material to review for a meeting the next morning, rather than complain that he/she has no time to do the work, this person may misplace or misfile the material and thus attain the goal by passively resisting the demand. This person becomes sulky, irritable, or argumentative when asked to do something they do not want to do. This person often protests to others about how unreasonable the demands being made on him/her are, and resent useful suggestions from others concerning how to be more productive. As a result of the resentment of demands, he/she unreasonably criticizes or scorns the people in authority who are making the demands. Often this person is dependent and lacks self-confidence. Typically, he/she is pessimistic about the future, but has no realization that his/her behavior is responsible for his/her difficulties. (This is Passive-Aggressive Personality Disorder).
REFERENCES


