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Worriers and Warriors: Should diagnostic criteria for psychological disorders be gender specific?

Are women the worriers because they present to services with their worries, and vocalise their concerns more? Do they fill clinicians' offices where male 'warriors', hiding behind their shields of masculinity, rarely go? Whilst there is evidence to suggest this is true[1], we should be careful not to stereotype gender response to psychological disorders. But equally, differentiating these responses could greatly benefit diagnostic criteria. The issue of defining gender arises here, but for the purpose of this essay, it can be simplified to 'the physical and/or social condition of being male or female'[2].

Psychological disorders have a complex nature, but can be defined by the DSM-IV as a 'clinically significant behavioural or psychological syndrome or pattern that occurs in an individual which is associated with present distress or disability'[3]. This is a broad definition, covering a wide variety of conditions, such as anxiety disorders and personality disorders. In order to differentiate between them, diagnostic criteria can be used to determine whether a set of symptoms meets the diagnosis for a specific psychological disorder. The most commonly used diagnostic criteria is the Diagnostic and Statistical Manual of Mental Disorders (DSM)[4] or the International Classification of Diseases (ICD)[5].

Klose and Jacobi (2004)[6] found that there are higher rates of depression and anxiety disorders in women globally, whereas men display higher rates of schizoid and antisocial disorders. However, prevalence rates do not completely inform us on how diagnostic criteria could be adjusted for each gender. Therefore, perhaps a key question to consider is: how do psychological disorders manifest themselves differently in each gender?

Depression, for example, exemplifies the discrepancy between how genders may present symptoms for the same psychological disorder. Despite men being four times more likely to die from suicide, doctors are twice as likely to diagnose depression in women (Oquendo et al., 2002)[7]. Cochran & Rabinowitz (2000)[8], suggest an explanation for this could be men

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[1] Mental Health Foundation: 'Mental Health Stastistics: Men and Women'- https://www.mentalhealth.org.uk/statistics/mental-health-statistics-men-and-women [Accessed 29th February 2020]

[2] Cambridge Dictionary: definition of 'Gender'- (https://dictionary.cambridge.org/dictionary/english/gender)

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6 Klose, M. & Jacobi, F. 2004. 'Can gender differences in the prevalence of mental disorders be explained by sociodemographic factors?'. Arch Womens Ment Health. 7(133).

7 Oquendo M. A., Kamali M., Ellis S. P., Grunebaum M. F., Malone K. M., Brodsky B. S., Mann J. J. 2002. 'Adequacy of antidepressant treatment after discharge and the occurrence of suicidal acts in major depression: A prospective study'. American Journal of Psychiatry, 159(10), pp:1746-1751.

8 Cochran S. V., Rabinowitz F. E. .2000. 'Men and depression: Clinical and empirical perspectives'. San Diego, CA: Academic Press.

externalising their depressed feelings through male-typical behaviours including aggression, irritability, violence or substance abuse, none of which are on the diagnostic criteria for major depressive disorder (MDD) in the DSM. This, coupled with the ubiquitous 'warrier', masculine stereotype to be self-sufficient and invulnerable, means that much male depression remains undiagnosed and untreated. Consequently, this emphasises the need for a gender-specific diagnostic criteria for major depressive disorder (MDD), particularly as many male-typical symptoms of depression do not adhere to the traditional criteria.

Haley et al. (2013)[9] speculated that the criteria for women could also be more specific and consider the timing of their depression. More than half of women with MDD experience increased depressive symptoms in the premenstrual phase of the menstrual cycle due to fluctuations of reproductive hormones, whereas men have relatively stable gonadal hormones. Furthermore, post-partum depression affects mothers more severely than fathers. In Verker et al.'s study (2003)[10], 3 months post-partum showed 9.3% newly diagnosed depression in mothers, and 3.4% in fathers, showing the greater vulnerability that women have to post-natal depression, compared to males. Therefore, this supports the argument that diagnostic criteria for depression could be more gender-specific, as other factors, such as hormone fluctuation during menstruation/pregnancy/menopause, should be considered as they may increase a woman's susceptibility to depression.

Anxiety disorders also have varying clinical presentation between genders. For example, Dorte M. Christiansen (2015)[11] suggested that females are more likely to exhibit comorbid conditions, especially other anxiety disorders, which could be attributed to women reporting a higher degree of internalising conditions than men. This supports having a gender-specific diagnostic criteria, that would address co-morbidity. However, an alternative view is that whilst there may be gender differences in symptom profiles, these may be limited to the content of phobias, social fears, obsessions and compulsions[12]. Hence, a gender specific diagnostic criteria would not be as necessary as there may be more similarities than differences. There is evidence that an exception to this idea could be OCD, where diagnosed males are associated with a higher degree of impairment, and are more likely to have tics and even brain injury, compared to diagnosed females (Segalàs et al. 2010)[13].

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[9] *Haley CL, Sung SC, Rush AJ, Trivedi MH, Wisniewski SR, Luther JF, Kornstein SG*, 2013, 'The clinical relevance of self-reported premenstrual worsening of depressive symptoms in the management of depressed outpatients: a STAR*D report.' *J Womens Health (Larchmt). 22(3, pp):219-29.*

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[13] C. Segalàs, P. Alonso, E. Real, 2010, 'Suicide in patients treated for obsessive–compulsive disorder: A prospective follow-up study', *Journal of Affective Disorders,* 123(3), pp: 300-308

Another important difference to note is the coping style of the genders. Carter et. Al (2011)[14] found that boys use a more avoidant coping mechanism in middle childhood when dealing with stressful situations, whereas girls develop a more preoccupied and anxious coping mechanism in personal relationships. This idea is supported by Taylor et al. (2000)[15], who found that men are more likely to cope by taking action and escaping a threatened situation; whereas, women are more likely to exhibit affiliative behaviour and look for the help of others. Therefore, anxiety disorders could be much more easily identified by clinicians if the gender's respective coping mechanism were considered in the diagnostic criteria. A limitation to this study could be that these differences in gender coping strategies could be culture-bound to Western culture, as less difference is seen in East Asian and African samples (deBruijn et al., 2009)[16].

There is clear discrepancy between the prevalence of eating disorder symptoms in males and females, and the associated negative body images and compensatory behaviours. Strigel-Moore et al. (2009)[17] gave members of a health maintenance organisation a survey about their health. The results suggested that men were more likely to overeat, whereas women were more prone to body checking (ie. ritualistic weighing) and avoidance (ie. not wearing tight fitting clothes), binge eating, fasting and vomiting. Body dissatisfaction in males is typically characterised by a desire to be muscular, as opposed to being slim, resulting in 90% of young males reporting doing excessive exercise and 66% reporting changing their diet in order to increase muscle mass. 15% are even willing to use substances, such as anabolic steroids to achieve their body goal (Field et al., 2014)[18]. Conversely, females are driven by the thin-obsessed, societal norms to excessively lose weight. Hence, gender-specific criteria may be beneficial in reducing the under diagnosis of eating disorders in males, as the DSM-5 focuses on 'low weight' and 'fear of gaining', which opposes how eating disorders may manifest themselves in males. This idea is further supported by Meyer et al. (2005)[19], who argued that women who suppress their feelings of anger are more likely to express bulimic tendencies, whereas men who act on their anger are more vulnerable to develop these behaviours. Therefore, the causes for eating-disorders may differ between genders too, which the diagnostic criteria does not consider. However, it is important to note that much of this research is from the US- hence, findings could be culture-specific and not applicable to the whole population.

There is evidence to suggest that diagnostic criteria for personality disorders may not require a gender specific approach. Boggs et al.'s (2005)[20], examined relations among

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14 J. Carter, D. Meyerson, K. Grant, R. Kilmer, 2011, 'Posttraumatic growth among children and adolescents: A systematic review', *Clinical Psychology Review, 31(6), pp: 949-964*

15 Taylor, S. E., Klein, L. C., Lewis, B. P., Gruenewald, T. L., Gurung, R. A. R., & Updegraff, J. A. (2000). 'Biobehavioral responses to stress in females: Tend-and-befriend, not fight-or-flight'. *Psychological Review, 107*(3), pp: 411–429.

16 A. deBruijn, H. van Bakel, A.van Baar, 2009, 'Sex differences in the relation between prenatal maternal emotional complaints and child outcome', Early Human Development, 85(5), pp:319-324

17 R. Striegel-Moore, F. Rosselli, N. Perrin, L. DeBar, G. Wilson, A. May, 2008, 'Gender difference in the prevalence of eating disorder symptoms', *International Journal of Eating Disorders*, 42(5)

18 C. Hardman, J. Scott, M. Field, A.Jones, 2014, 'To eat or not to eat. The effects of expectancy on reactivity to food cues', *Appetite*, 76, pp:153-160

19 Meyer, C., Leung, N., Waller, G., Perkins, S., Paice, N., & Mitchell, J. (2005). Anger and Bulimic Psychopathology: Gender Differences in a Nonclinical Group. *International Journal of Eating Disorders*, *37*(1), pp: 69–71

20 Boggs CD, Morey LC, Skodol AE, Shea MT, Sanislow CA, Grilo CM, et al. 2005. 'Differential impairment as an indicator of sex bias in DSM–IV criteria for four personality disorders'. *Psychological Assessment*. 17(1), pp:492–496.

diagnostic criteria for borderline, avoidant and obsessive compulsive personality disorders and levels of functional impairment in males and females. Results found that there is little gender bias with diagnostic criteria relating to the same degree of impairment in both genders, suggesting there may be no need for gender-specific criteria here. These findings were further supported by Serrita et al. (2007)[21], who investigated gender bias by using differential item functioning (DIF), which is a psychometric method for evaluating whether criterions are expressed the same across different groups. There were four items that men were more likely to endorse than women with the same level of latent trait. These included "irritability and aggressiveness" and "reckless disregard for safety of self or others"[22]. Equally, there were also a number of traits biased towards women, such as "lacks close friends or confidants other than first-degree relatives" and "almost always chooses solitary activities." As a result of these gender-biased traits, Serrita et al. found that men had overall higher scores on schizoid, antisocial and narcissistic personality disorders (as they generally exhibit more aggression than females do), whereas women scored higher for borderline, histrionic and obsessive-compulsive scales. Therefore, one view may be that having gender specific criteria could inhibit the over/underdiagnosis of these specific conditions; however, Serrita argues that overall relatively little gender bias can be seen here, as only a few traits were biased (consistent with Boggs et al.'s findings[18]). An important limitation to note about this study is that it only combined data from college students and military recruits- hence these findings may only be relevant to specific groups of people.[19]

There is some evidence that a gender-specific criteria could be helpful in some personality disorders. For example, paranoid personality disorder, has a key criterion of "perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or counterattack"[20], which is much less likely to be endorsed by women than men. This could be explained by women possibly being less willing to admit aggressive behaviour during interviews[19]. Therefore, paranoid personality disorder would benefit from a gender-specific diagnosis criteria- one which surfaces any aggressive behaviours that a woman has displayed. However, this may be less important for other conditions, ie. borderline, histrionic and dependent personality disorders.

Psychotic disorders, such as schizophrenia, manifest themselves differently in men and women, making it difficult to develop unbiased diagnostic criteria. For example, women are "more likely to have more prominent mood symptoms"[20]. Goldstein et al. (2010)[23] reinforced this idea, as he suggested that females with schizophrenia have more affective symptoms, such as paranoia, and auditory hallucinations. Alternatively, males with schizophrenia express more negative symptoms, such as flat or constricted affect, and social withdrawal. The failure to acknowledge this increased expression of mood symptoms in men, could be a factor in the overdiagnosis of schizophrenia in women. Consequently, having a gender-specific criteria could reduce this overdiagnosis, and create a more

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[21] Jane, J Serrita et al. 2007. 'Gender bias in diagnostic criteria for personality disorders: an item response theory analysis.' *Journal of abnormal psychology*. 116(1), pp: 166-75. Available from: doi:10.1037/0021-843X.116.1.166

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[23] Kathryn M. Abel, Richard Drake & Jill M. Goldstein (2010) Sex differences in schizophrenia, *International Review of Psychiatry*, 22:5, pp:417-428

accurate diagnosis criteria for men. However, one should not aim for an equal diagnosis ratio of men and women, as this may be ignoring the actual sex differences in the disorder- such as Goldstein et al. who hypothesised that men are biologically more likely to have schizophrenia than women.

After exploring the nature of psychological disorders and how they present themselves differently in both males and females, it is suggested that some conditions would benefit from a gender-specific diagnosis criteria. These include paranoid personality disorder, schizophrenia, depression and eating disorders. However, other conditions, including avoidant and borderline personality disorder, may be relatively unaffected by adjusting the diagnosis criteria, as gender differences were minimal. Overall, 'psychological disorders' is too broad to conclude whether or not diagnosis criteria should be gender-specific, due to the complex nature of each individual disorder. However, it is still important for clinicians to be aware of these gender differences, in order to make the most accurate diagnoses for their fields.

Perhaps most importantly, whilst certain traits that are associated with a psychological disorder are more prevalent in one gender, that is not to say that both genders do not exhibit these symptoms. Therefore, instead of creating gender-specific diagnosis criteria, it could be argued that the criteria should be extended to consider all symptoms that both genders express. However, extending the diagnostic criteria too much may lead to overdiagnosis. Furthermore, the issue of 'gender' arises here: if an individual does not fall under the 'male' or 'female' category, it further makes it difficult to create a gender-specific diagnostic criteria suitable for the entire population.

What is clear, is that in order for diagnostic criteria to be applied, men and women should not feel stigmatised for seeking help or being diagnosed with a psychological disorder. Our 'warriors' should feel supported and accepted in removing their protective shields in order to receive treatment. Equally, the 'worriers' should not face discrimination, but be able to express their anxieties in order to reach out and get support.

Word count: 1966

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