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Clinical Judgements of Self-Dramatisation
A Test of the Sexist Hypothesis

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Summary: It has been claimed that the diagnosis of histrionic personality disorder is inherently sexist. To estimate the extent to which psychiatrists are influenced by sexist prejudice in their judgements about self-dramatisation (the central trait in the histrionic cluster), we conducted a study in which male and female subjects rated the degree of self-dramatisation portrayed in videotaped vignettes. The results did not support the sexist hypothesis that dramatic behaviour would more often be attributed to a woman than to a man, especially by male raters.

Paul Chodoff (1982) has argued eloquently for the influence of cultural and historical forces in shaping the traits and behaviors that psychiatrists call hysterical. In his view, male domination of Western cultural institutions has determined our definition of femininity, and has been responsible in great degree for the pressures that can exaggerate and distort that femininity into the clinical picture of the histrionic (hysterical) personality disorder.

The germ of this hypothesis can be found in Chodoff's earlier work on the subject:

> In the first place the historical development of the concept of "hysteria" made it inevitable that traits characteristic of women rather than men would be described since, as we have pointed out, only in women was the diagnosis made in the great majority of cases. Also the descriptions were being made entirely by male psychiatrists who may have elicited responses which might not have been obtained by a woman examiner. Thus, what has resulted in the case of the hysterical personality, is a picture of women in the words of men, and, as a perusal of these traits will show, what the description sounds like amounts to a caricature of femininity! (Chodoff & Lyons, 1958).

These ideas permit the implication that the psychiatric diagnosis of histrionic personality disorder is inherently sexist, that it arises from political motives, and that, because of centuries of cultural conditioning, it has more to do with what the psychiatrist expects to see than with the patient's actual behavior. It is important to note that Chodoff himself does not make this claim (he has been more interested in the genesis, description, and treatment of histrionic traits than in whether they are valid attributes that can be reliably recognised by clinicians), but he is sensitive to the charge that "the whole concept of hysteria [is] a particularly heinous example of psychiatric male chauvinism." (Chodoff, 1982).

It is distressing to think that psychiatrists who make the diagnosis of histrionic personality disorder are engaging, willy-nilly, in a sexist act. It is also troubling to think that their judgements of a patient's attributes are determined more by general cultural prejudices than by the clinical method, which rests on an appreciation of the patient as an individual.

In order to gauge the extent to which psychiatrists and others are influenced by sexist prejudice in their clinical judgements of particular patients, we studied their ability to differentiate non-dramatic from dramatic behavior in a man and a woman. We chose the issue of dramatic behavior because it is central to the concept of the histrionic personality disorder (Slavney, 1978), and we utilized male and female "patients" because the sexist hypothesis should predict that there would be a greater tendency for dramatic behavior to be attributed to a woman than to a man, especially by male raters.

Method

An experiment was designed in which male and female subjects were asked to rate the degree of self-dramatisation portrayed in videotaped clinical vignettes. In each of the four vignettes used, the sex of the "patient" and the degree of self-dramatisation were controlled as described below.

A man and a woman, both middle-aged professional actors, portrayed patients complaining to a psychiatrist of depression. The symptom of depression was chosen because it is the commonest reason for the hospitalisation of patients with histrionic personality disorders (Slavney & McHugh, 1974).

The actors each gave two performances: in one they were asked to be non-dramatic in manner (i.e. sober, subdued); in the other they were asked to be dramatic, though not to the point of burlesque. One of the authors (P. S.) took the role of the psychiatrist. In each of the four

performances staged in this way the script (Appendix) was identical: the only variables were the sex of the actor and the manner of portrayal.

The use of videotaped interviews to control for "information variance" is a standard research technique (Andreasen *et al*, 1982). The performances were videotaped by a professional crew in a studio setting, so that the lighting and sound levels were comparable for all vignettes. Each performance lasted just over a minute, and when shown was preceded on the screen by a title which said: "Please observe the following interview". The vignettes were shot from the perspective of the psychiatrist, so that viewers (subjects) saw only the actor, dressed in business clothes and seated in a chair.

Subjects were drawn from the personnel of the Johns Hopkins Hospital, and in particular from the Department of Psychiatry and Behavioral Sciences, not only because they were readily available, but because they constituted an appropriate study population. Potential subjects were asked to participate in a research project that involved watching a short videotape and answering a single question. During a five-day recruitment period all general psychiatry full-time faculty and residents were approached, as well as most nurses on the psychiatric inpatient units and a variety of other clinical and non-clinical personnel. Subjects were recruited until 55 had viewed each performance. No one who was invited to participate refused.

Subjects had individual screenings of one of the performances, which were shown sequentially, so that successive subjects rated different "patients". The screenings were done at the subject's convenience, and no attempt was made to determine which performance a particular subject saw. When groups of subjects presented themselves at the same time, they decided the order in which they would take part.

Subjects did not know the nature of the judgement they would make until after they had seen the vignette. The experimental situation thus resembled the clinical one, in which psychiatrists may know nothing of the patient's personality before the initial interview.

Subjects recorded their sex, country of birth, and professional affiliation on the first page of a two-page form. The tape was then shown, and afterwards subjects turned the page, where the question, "How would you rate the patient's presentation of his/her complaint?" appeared. Subjects could endorse one of four answers ("Not at all dramatic", "Somewhat dramatic", "Quite dramatic", and "Highly dramatic"), though for scoring purposes responses were dichotomized into "non-dramatic" ("Not at all" and "Somewhat") and "dramatic" ("Quite" and "Highly"). Subjects were asked not to reveal the nature of the question to other possible participants.

Statistical methods included 2 × 2 cross-tabulations of data, as well as binary multiple regression using the dichotomous rating as an outcome variable.

Results

The results of the study (Table I) did not support the sexist hypothesis that dramatic behavior would more readily be attributed to a woman than to a man, especially by male raters.

Inspection of the results for the non-dramatic performances revealed no difference in the ratings given to the

TABLE I

Characteristics of subjects and their ratings of the four vignettes

	Performances			
	Non-dramatic		*Dramatic*	
Subjects	*Male*	*Female*	*Male*	*Female*
Sex				
Male	25	22	25	25
Female	30	33	30	30
Country of birth				
USA	53	48	51	49
Other	2	7	4	6
Professional affiliation				
Psychiatrist, faculty	1	9	5	13
Non-psychiatric physician, faculty	2	1	2	1
Psychiatric resident	8	7	8	7
Medical student	6	8	9	5
Psychiatric nurse	14	12	11	13
Non-psychiatric nurse	1	1	0	2
Psychologist	7	4	5	2
Social worker	2	1	2	1
Occupational therapist	2	1	2	2
Non-clinical staff (e.g. clerical, administrative, technical, library)	12	11	11	9
Rating				
Dramatic	2	2	42	36
Non-dramatic	53	53	13	19

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male and female "patients". In each case, only two of the 55 subjects characterized the performance as dramatic. These results confirmed the validity of the performances as non-dramatic, as well as the ability of subjects to identify them as such.

For the two dramatic performances, a substantial proportion of subjects characterized them appropriately. There was no overall tendency to rate the female "patient" as more dramatic than the male one ($P_1 = 42/55$, $P_2 = 36/55$, $\chi^2 = 1.59$, n.s.). Further, although sample sizes were small, when the sex of the "patient" was controlled, none of the following attributes had an effect on the characterisation of the performance: the sex of the rater, whether the rater was clinically trained or not, and whether the rater was a physician or a medical student as opposed to a nurse.

To permit a more detailed assessment of the effect of each independent variable when controlling for the others, binary multiple regression was performed with the dichotomized rating of dramatization as the outcome. The three independent variables entered into the prediction equation were rater sex, rater-"patient" sex concordance, and whether the rater was clinically trained. None of these predictors individually approached statistical significance, and the three predictors combined accounted for only 1.5% of the variance ($R^2 = 0.015$).

Discussion

Psychiatric practice is grounded in the clinical method, one of whose principles is that diagnostic judgements should rest on the careful assessment of each patient. Although as members of a culture we may bring to those judgements certain preconceptions and biases, as members of a profession we try to ensure that prejudice does not determine our practice.

The influence of the patient's sex on judgements of mental health (Broverman *et al*, 1970), diagnostic assignment (Warner, 1978), and psychiatric nosology (Kaplan, 1983; Williams & Spitzer, 1983) has been investigated and debated with abstract examples. In this study we have tried to bring the discussion one step closer to the actual practice of clinicians through the use of videotaped vignettes. Although the experimental design did not assess whether male and female psychiatrists *elicit* different responses from male and female patients, it did allow for many raters to judge the behavior of the same "patients" under controlled conditions.

The critical test of the sexist hypothesis was in the comparison between ratings of the non-dramatic vignettes. If a cultural bias to see women as more dramatic than men is so powerful that it determines diagnostic practice in individual cases, its effect should have been seen here. The brevity of the vignettes should also have worked in favour of the sexist hypothesis, because prejudice is more likely to operate when little specific information about an individual is available.

The results of the study refute the view that sexist prejudice renders psychiatrists incapable of differentiating dramatic from non-dramatic behavior in women, but they cannot be taken to confirm the opposite opinion—that sexist prejudice has no influence whatever on diagnostic judgement. In order to investigate the latter hypothesis, studies are needed in which more subtle degrees of self-dramatisation are portrayed, and in which the same raters are asked to grade a series of "patients" based on the degree of self-dramatisation they manifest.

It is of interest that 29% of the raters of the dramatic vignettes misclassified them (i.e. judged them to be non-dramatic), as opposed to a misclassification rate of only four percent for the non-dramatic vignettes. We believe this difference may have been due to two factors. First, television is "cooler" than real life, so that what appeared to be quite dramatic in the studio was less so on the screen. Second, some raters may have perceived the emotionally-charged reaction of the "patient" in the dramatic portrayals as an appropriate response to the threat of losing a job (especially if that threat was unfair), and thus not as an excessively histrionic one.

The results of this study support the opinion that clinical judgements of self-dramatisation for individual patients depend more on the behavior of those patients than on their sex. To say that such judgements are inherently sexist when made in the case of a female patient is itself a form of prejudice: a political, rather than a scientific, claim. And yet such challenges are not without benefit, for they may lead psychiatrists to re-examine their methods. As Jaspers (1963) reminds us, self-scrutiny is essential, especially as regards prejudice, since

> it is different to keep psychology and psychopathology wholly free from value-judgements, which often prove to be an expression of some background philosophy. The simple *separation of observation and value-judgement* is something that must be required of every psychopathologist in his work, not so that all human values must be relinquished but that, on the contrary, we shall possess truer, clearer, and profounder values the more we observe before we judge . . . This principle of keeping simple observation and value-judgement apart is easy to accept in theory but in practice it calls for such a high degree of self-discipline and real objectivity that we can never take it for granted at any time.

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Appendix

Script of videotaped vignettes

Psychiatrist: Why did you come to the hospital?

Patient: I've been very depressed.

Psychiatrist: How long have you felt that way?

Patient: Two weeks or so.

Psychiatrist: How did your depression begin?

Patient: Well, I guess it started at work. I'm responsible for a big project and, because some other people fell behind, I couldn't meet a deadline. My boss–he's never liked me—was very angry about it. He called me into his office and said: "Unless your performance improves, you'd better start looking for another job." I was speechless—and I was hurt—because it wasn't my fault, but I couldn't say anything, so I just left. Ever since then I've been depressed.

Psychiatrist: What does it feel like to be depressed?

Patient: Awful. I just mope around. I can't concentrate and I can't sleep. I just keep thinking how unfair it is.

Psychiatrist: Has your mood been so low that you've thought of taking your life?

Patient: Oh no. Things are bad, but they're not that bad.

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