Gender Differences in Premorbid Social Adjustment and Intimacy Motivation in Schizophrenia

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The present study compared the relationship between motivation for intimacy and level of premorbid adjustment for men and women with schizophrenia. A sample of 34 schizophrenic patients (14 male and 20 female) were studied. Stories told in response to six TAT cards were scored for Intimacy Motivation (IM). Levels of Premorbid adjustment (PA) and Asociativity (ASOC) were assessed. A statistically significant interaction between gender and level of PA indicated that males with good PA had higher IM than those with poorer whereas females with good PA had lower IM than females with poor PA. The same interaction was obtained for the measure of ASOC. Findings are discussed in relation to sociocultural expectations for women. Some implications for differential treatment needs of male and female schizophrenics are suggested. © 1998 John Wiley & Sons, Inc. J Clin Psychol 54: 35–48, 1998.

Social withdrawal, or asociality, is a hallmark symptom of schizophrenia, extending well beyond periods of acute psychosis. Historically, asociality has been considered an integral part of the diagnosis of schizophrenia, since Kraepelin (1919) defined “dementia praecox” as a mental disorder with early onset and a deteriorating course. Current diagnostic systems (e.g., DSM-III-R/DSM-IV) view evidence of significant social withdrawal as one of the key features necessary to meet criteria for schizophrenia. Social withdrawal prior to the prodrome/onset of schizophrenia (commonly referred to as premorbid adjustment) is a key prognostic indicator, particularly for shorter term outcome (McGlashan, 1986; Strauss & Carpenter, 1974). Thus, a person with a history of better social/school functioning in childhood, adolescence and early adulthood would be more likely to have fewer hospitalizations, and better social functioning after the onset of illness (Childers & Harding, 1990; Goldstein, 1978; Guy, Liaboe & Wallace, 1986; Pretntky, Lewine, Watt, & Fryer, 1980).

This study was supported in part by grant #R29MH43613 to Dr. Haas.
A growing body of research findings (e.g., Angermeyer, Goldstein, & Kuehn, 1989; Farina, Garmezy, & Barry, 1963; Goldstein, Tsuang, & Faraone, 1989; Mueser, Bellack, Morrison, & Wade, 1990; Salokangas, 1983, 1990; Westermeyer & Harrow, 1984; Zigler & Levine, 1981) have revealed significant gender differences in both premorbid adjustment and social functioning in schizophrenia. For example, Foerster, Lewis, Owen, and Murray (1991), Goldstein, Tsuang and Faraone (1989), Salokangas (1983, 1990), and Zigler & Levine (1981) have reported that male schizophrenics evidence lower levels of premorbid adjustment overall than females. Likewise, Dworkin (1990) has reported greater social withdrawal and poorer premorbid competence for males than for females. There is also evidence that social withdrawal prior to the onset of illness may be of different types by gender. For example, prospective studies of “high risk” children with potential for developing schizophrenia have revealed sex-linked differences in premorbid behavior, with males falling in the more “actively maladjusted” groups and females in the more “quietly” withdrawn and dependent (Watt & Lubensky, 1976; Watt, Stolorow, Lubensky, & McClelland, 1970).

In addition to findings of overall gender difference in premorbid functioning, the relationship between premorbid behavior and outcome variables appears to be different for male and female schizophrenics. Premorbid behavior has been found to be a better predictor of outcome for males than for females (Farina, Garmezy, Zalusky, & Becker, 1962). Using data from a 10-year longitudinal study conducted to study course of illness, Goldstein (1988) also observed the link between gender, premorbid adjustment, and outcome, reporting that males tended to have poorer outcome and also had significantly poorer premorbid social functioning than females. Both Salokangas (1990) and Pogue–Geile and Harrow (1985) reported findings that men with poor early childhood premorbid adjustment also displayed more negative symptoms and less working capacity; these associations were not confirmed for women. The gender differences noted in the association between premorbid adjustment and course of illness suggests that social withdrawal, particularly for women, may not be the only salient dimension of interpersonal functioning to consider important as an indicator of course of illness. Thus far, however, few researchers have focused on identifying alternate factors which may account for the gender-related heterogeneity in the relationship between premorbid adjustment and social outcome measures.

The need for intimacy and relationships with others has been a burgeoning area of research in the study of normative development, gender, and social relatedness. Women have consistently expressed greater needs for intimacy and relationships than men (Chodorow, 1978), and tend to define a sense of self and well-being in terms of their relationships with others more than men do (Gilligan, 1982). Although empirical studies of intimacy motivation in schizophrenia have not been undertaken, various theorists of personality development (e.g., Erickson, 1963; Kohut, 1984; Sullivan, 1953; Winnicott, 1968) have noted the importance of a capacity for intimacy as a prerequisite for healthy, interpersonal relationships. Their theories have in common the view that an individual’s psychological development unfolds in relation to his or her world of relationships. Thus, the development of a capacity for intimacy would have a significant impact on the quality of an individual’s future interpersonal relationships. Although intimacy may be a factor which contributes to variability in level of interpersonal functioning prior to onset of schizophrenia, the relationships between premorbid adjustment, and the internal need for intimacy has yet to be demonstrated empirically. Given that the degree of social withdrawal experienced as a part of the course of schizophrenia appears to be different for men and women, consideration of these commonly found differences in intimacy needs may help to further illuminate some of the gender-related findings in the lifetime course of schizophrenia.

One methodological limitation in the study of gender and psychosocial factors in schizophrenia has involved the prevailing use of behavioral assessments of interpersonal competence. These measures most often simply describe number of contacts or number of friends but offer
less insight into the processes which may underlie the observable behavior. Examining internal psychological processes may have implications for better understanding gender-related differences in social functioning. For example, a more differentiated internal picture of others might allow a schizophrenic individual to maintain important relationships with significant others. Alternately, a capacity to relate to others might be displayed only internally but might still have a powerful effect on an individual’s capacity to relate to the world, even if it is not evident in the number of friendships or level of social activity. Findings such as these might also have important treatment implications.

An appraisal technique derived from the Thematic Apperception Test (TAT; Murray, 1943) has been developed to study personality factors related to interpersonal functioning in the normal population. McAdams and his colleagues (1979, 1980, 1982, 1984) have conceptualized empirically studied intimacy motivation, a construct defined as the extent to which an individual experiences the need for close, warm, interpersonal relationships. Intimacy motivation (IM; McAdams et al., 1987) is thought to reflect a “relatively stable personality disposition that energizes, directs and selects behavior in certain situations” (p. 397). For example, McAdams and his colleagues have demonstrated that individuals high in intimacy motivation tend to value warm and reciprocal human interaction more than those who score lower (1980, 1982); high intimacy motivation has been associated with spending considerable time over the course of the week thinking about other people and one’s relationships with them, engaging in a large number of conversations with others, and experiencing considerable positive affect in the presence of others (McAdams & Constantin, 1983). When interacting with friends, high intimacy individuals share more personal information and elicit more self-disclosure from others than do low intimacy individuals (McAdams, Healy, & Krause, 1984). McAdams et al. (1987) suggests that “high intimacy individuals may be better able to obtain more support and solace from others, perhaps drawing upon a relatively rich reservoir of social supports during times of personal stress” (p. 398). This appraisal technique was used in the present study to examine intimacy motivation and gender differences for males and females with schizophrenia.

In sum, some important questions related to premorbid adjustment and social functioning have yet to be addressed empirically, namely: Why does premorbid functioning predict outcome for males, but not for females? What are the gender-related characteristics which contribute to these differences? Is intimacy motivation a factor related to gender and premorbid adjustment which may mediate outcome in interpersonal functioning? This study investigated the relationship between premorbid adjustment and intimacy motivation for male and female schizophrenics, asking the following specific research questions: Are there differences in intimacy motivation for male and female schizophrenics? Is a history of good premorbid adjustment associated with higher levels of intimacy motivation? Are there gender differences in this relationship? What is the relationship between current levels of social withdrawal and intimacy motivation? Are there gender differences in this relationship?

**METHOD**

**Subjects**

The sample of 34 adult schizophrenic inpatients (20 females and 14 males) were selected from a group of patients who had consented to participate in a broader psychological and biological study of the cognitive and social aspects of schizophrenia. Admission criteria included (a) diagnosis of schizophrenia, or schizoaffective disorder by DSM-III-R criteria (Spitzer, Williams, Gibbon, & First, 1992) assessed by the Structured Clinical Interview for Psychotic Disorders (SCID-PD), (b) age between 18 and 54, (c) a significant other with whom patient is in contact with at least 4 hours per week, (d) no neurological or physical complications, and (e) no history...
of serious substance abuse. Table 1 presents the demographic characteristics of the sample. The females were significantly older than the males ($t(32) = 3.27; p < .01$). The males were single, and they were significantly less likely to be either married or divorced ($t(32) = 4.0; p < .01$). In addition, the male subjects tended to have a significantly higher verbal WAIS-R IQ than the females ($t(32) = 2.56; p < .01$). No other differences in chronicity, ethnicity, or socioeconomic status were revealed.

**Procedure**

During the first 2 weeks of hospitalization, a variety of neurocognitive and psychological tests including the Thematic Apperception Test (TAT; Murray, 1943) were administered by one of four (two male and two female) clinical psychologists or interns in clinical psychology to determine diagnosis and clinical assessment of current status which included negative symptom ratings, and finally, were interviewed by a female social worker to gather information about premorbid functioning. See the subsequent Measures and Scoring sections for further details. All the psychological testing took place at the time when the subject was clinically judged to have begun to stabilize (within two weeks from admission), so that acute psychosis was not present and the individual could tolerate the testing session.

The TAT was administered using standard Murray procedures (1943). The tester recorded the verbatim responses and prompted only with the allowed cues (e.g., What happened before?, etc). Six of the 10 TAT cards administered (2, 5, 10, 12M, 13MF, 18GF; Murray, 1943) were scored for IM. The six pictures used were (Card 2) a young woman carrying books in the foreground and a male and female in a farm scene behind her; (Card 5) an older woman looking into a room; (Card 10) two figures embracing (Card 12); a figure lying down and another figure standing above; (Card 13) a woman lying in bed and a man standing in the foreground with his arm over his face; (Card 18) two figures standing close to one another at the foot of the stairs.

### Table 1. Subject Characteristics

<table>
<thead>
<tr>
<th>Descriptives</th>
<th>Males ($n = 14$)</th>
<th>Females ($n = 20$)</th>
<th>Total ($n = 34$)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
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<tr>
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<td>10.7</td>
<td>10.8</td>
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<td>$n$</td>
<td>$n$</td>
</tr>
<tr>
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</tr>
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<td>White</td>
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<td>13</td>
<td>27</td>
</tr>
<tr>
<td>Black</td>
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<td>7</td>
<td>7</td>
</tr>
<tr>
<td><strong>Marital</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
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<td>11</td>
<td>25</td>
</tr>
<tr>
<td>Married/Divorced</td>
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<td>9</td>
<td>9</td>
</tr>
<tr>
<td><strong>Chronicity</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>First-Break</td>
<td>9</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>$&lt; 5$ Yrs</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>$*&gt; 5$ Yrs</td>
<td>2</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td><strong>IQ</strong></td>
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<td></td>
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<tr>
<td>$M$</td>
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<td>89</td>
<td>95</td>
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<tr>
<td>$SD$</td>
<td>17.99</td>
<td>11.6</td>
<td>16.0</td>
</tr>
</tbody>
</table>

*Indicates significant differences at the .01 level between males and females on $t$ tests.
The pictures were chosen based on presence of ambiguous scenes which elicit more communally oriented, intimate responses rather than achievement-oriented ones, and have been validated by McAdams and his colleagues (McAdams, 1980, 1982; McAdams et al., 1983, 1984, 1987).

**Measures and Scoring**

*Intimacy Motivation.* IM was coded from the TAT stories according to the McAdams (1984) standard scoring manual (IMSS). In scoring a TAT story for intimacy motivation, the coder determines the presence (score 1) or absence (score 0) of each of 10 explicitly defined content categories. See McAdams (1979) for description of these categories. The total IM score for a given story is the sum of the 10 different categories found to be present in the story, ranging from 0 to 10, and the total score for each subject is the sum of the six different stories, ranging from 0 to 60. Each of the 10 thematic scoring categories identifies a particular quality of the interpersonal interaction demonstrated by the characters in the story.

A female clinical psychology doctoral student coded all the TAT stories for IM, blind to subjects’ gender and demographic characteristics. The coder was trained according to the scoring manual (McAdams, 1984) and demonstrated high reliability in scoring the 210 practice stories in the manual. Category agreement for scoring of the first two intimacy motive categories, which are considered to be the “prime tests” of intimacy imagery, was 90%. The correlation between the coders’ scores and expert scores in the scoring manual on practice stories was consistently greater than $r > .85$. Category agreement greater than 85% for prime tests and $r$ greater than .85 are considered adequate reliability figures for research purposes. These conventions for scoring reliability in the TAT are adopted from Winter (1973).

For the present study, the TAT records were coded from previously collected data, some of the subjects’ protocols had missing responses from one or more of the six selected TAT pictures. The missing data were handled by substituting a subject’s response to a comparable card. These substitute cards were chosen on the basis of similarity between the missing and substitution card (for example, 3BM, 4, or 7GF). Since missing data represent a potential threat to the validity of the measure, a comparison between correlations of the complete and substitution groups with IM, PA, and ASOC scores was conducted. Differences between these groups in correlations with the other major variables were found to be negligible and failed to reach statistical significance using a Fisher’s $z$ transformation to compare the correlation coefficients. Thus, the entire sample was used in subsequent analyses with confidence that the validity of the data set remained uncompromised.

*Premorbid Adjustment.* The Premorbid Adjustment Scale (PAS) (Cannon–Spoor, Potkins, & Wyatt, 1982) is a semistructured interview and rating scale designed to evaluate the level of functioning prior to onset of illness in four major areas at each of several periods of the subject’s life: social accessibility–isolation, peer relationships, ability to function outside the nuclear family, and capacity to form intimate sociosexual ties. Age-appropriate functioning in these four areas are evaluated for each of four periods: childhood (birth to age 11), early adolescence (age 12 to 15), late adolescence (age 16 to 18), and adulthood (age 19+). Only the periods up to 6 months prior to onset of illness are evaluated, so that if a 35-year-old who first became ill at age 17 were interviewed, the adulthood section would not be rated. Each section of the scale contains a number of items, each item being rated 0–6, with 0 indicating greatest health. Anchors with behavioral descriptives (e.g., many close friends, or some close friends and casual friends, etc.) are presented to aid the rater in scoring.

The reliability and validity of the PAS has been demonstrated in several studies (Alvarez, Garcia-Ribera, & Torrens, 1987). In comparison with both a normal population and outpatient
controls, chronically hospitalized patients, (known to have pathological premorbid functioning) scored significantly higher on the scale. The PAS has also been compared with other scales of premorbid functioning (e.g., the Phillips Prognostic Rating Scale; Phillips, 1953) and discriminated as well or better than these scales on a variety of different predictors of outcome such as age of onset, length of hospital stay, CT scan abnormalities, etc. (Cannon–Spoor et al., 1982).

The PAS was designed primarily to measure degree of success in attainment of certain developmental goals at each phase of the subject’s life, with emphasis placed on exploring social isolation, capacity to make intimate attachments, and asocial characteristics of social functioning. However, there are also items that evaluate antisocial behavior and school performance. Since the focus of the present study was on the interpersonal aspects of functioning, rather than more community aspects, antisocial and school performance items were not included in the total score. Thus the scaled scores consisted only of social functioning items. Protocols were scored following standard scoring procedures (Cannon–Spoor et al., 1982). The ratings in each section for each item were summed and expressed as a ratio: the actual sum divided by the highest possible sum (a constant for each item). An overall total score was calculated by averaging the subscale scores for all the subscales rated for each patient.

Asociality. The Modified Scale for the Assessment of Negative Symptoms (SANS; Andreasen, 1984), is based on the rating of a 30-item semi-structured interview. The rating consisted of five global symptom scales (allogia, affective flattening, avolition-apathy, anhedonia-asociality, and intentional impairment). Reliability and validity of the scale have been demonstrated by Andreasen (1982), with reported intraclass correlations = .70 to .93. Individual items under each global heading were used to determine the quality and severity of the negative symptom; whereas the global scores, the summary of the individual items, reflect the overall negative symptom syndrome. The asociality subscale is considered a measure of the individual’s loss of ability to feel closeness with others, including spouses, family members and friends, and the person’s active engagement of others (e.g., forming friendships).

RESULTS

The results are organized around the data analyses relevant to the following questions: Are there differences in intimacy motivation for male and female schizophrenics? Is a history of good premorbid adjustment associated with higher levels of intimacy motivation? Are there gender differences in this relationship? What is the relationship between current levels of social withdrawal and intimacy motivation? Are there gender differences in this relationship? To answer the first question, separate $t$-tests were conducted between males and females on IM scores. To answer the second and third question one between-subject, $2 \times 2$ analyses of variance were performed with gender (male or female) and premorbid adjustment (good or poor) as the two independent factors. In this analysis, the IM score was used as the dependent measure of intimacy motivation. To answer the fourth and fifth questions, Pearson’s product moment correlations were conducted between the IM and ASOC scores for the overall group and by gender. Fisher’s $z$-comparisons were conducted between male and female correlations.

Gender Differences in Intimacy Motivation

No significant differences were obtained between males and females in intimacy motivation. Additionally, there were no overall differences between males and females in premorbid adjustment or asociality. All $t$-test comparisons between genders were nonsignificant ($p > .10$).
Gender, Premorbid Adjustment and Intimacy Motivation

Table 2 presents the summary of the ANOVA. The $2 \times 2$ between-subjects ANOVA was performed using the IM score as the dependent variable. The factors were gender (male, female) and premorbid adjustment (good, poor). A median split (median = .46) of the overall distribution of male and female subjects’ premorbid scores was calculated to form the two levels, (good and poor premorbid adjustment). A score below .46 was categorized as good PA, and a score equal to or above .46 was categorized as poor PA. The results failed to reveal a main effect for gender or PA. However, a statistically significant gender by PA interaction ($F(1,33) = 3.9; p < .01$) was obtained. Table 3 presents the means and standard deviations for IM by gender and PA. Males with good PA had higher IM ($M = 5.2$) than males with poor PA ($M = 2.8$), whereas females with good PA had lower IM ($M = 2.9$) than the females with poor PA ($M = 5.7$).

To test for simple effects of the interaction, post-hoc t tests were performed. In the good PA group, the males’ IM ($M = 5.2; SD = 4.1$) was significantly higher ($p < .01$) than the females’ IM ($M = 2.9; SD = 1.5$) ($t(14) = 2.7$). In the poor PA group, the females’ IM ($M = 5.7; SD = 4.7$) was significantly higher ($p < .01$) than the males’ IM ($M = 2.8; SD = 1.9$) ($t(15) = 2.7$). Within gender, the males and females also statistically differed from one another. In the female group, the poor PA females revealed statistically higher ($p < .01$) IM scores ($M = 5.7; SD = 4.7$) than the good PA females ($M = 2.9; SD = 1.5$) ($t(18) = 3.3$). In the male group, the poor PA males revealed statistically lower ($p < .05$) IM scores ($M = 2.8; SD = 1.9$) than the good PA males ($M = 5.2; SD = 4.1$) ($t(12) = 2.4$).

Intimacy Motivation and Asociality

Pearson product-moment correlations failed to reveal a statistically significant relationship between IM and ASOC overall, or within gender, although for women the association was positive in direction ($r = .31$; the higher ASOC, the higher the IM), and for men, the association was negative in direction ($r = -.03$; the higher ASOC, the lower the IM). However, when tested with a Fisher’s $z$-transformation, the difference between these correlations was not significant.

Supplementary Analyses

Because age of onset has been reported to differ for men and women, and can be a confounding variable, a supplementary check was performed to determine its relationship to the variables of

Table 2. Summary of $2 \times 2$ ANOVA for Intimacy Motivation by Gender and Premorbid Adjustment

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>$d_f$</th>
<th>$F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
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<td>2</td>
<td>.15</td>
</tr>
<tr>
<td>Gender</td>
<td>.00</td>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>PAS</td>
<td>3.93</td>
<td>1</td>
<td>.29</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender PAS</td>
<td>52.33</td>
<td>1</td>
<td>3.86**</td>
</tr>
<tr>
<td>Explained</td>
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</tr>
<tr>
<td>Residual</td>
<td>405.89</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>462.47</td>
<td>33</td>
<td></td>
</tr>
</tbody>
</table>

**significant at the level of $p < .01$.**
interest. A t test on age of onset for males and females revealed a statistically significant difference ($t(33) = 2.3; p < .025$), such that males became ill younger ($M = 23$) than females ($M = 30$). In addition, Pearson product moment correlations were performed to determine whether age of onset had a relationship to other variables of interest (PA, IM, and ASOC). All correlations, both with the overall group and separately for gender, were nonsignificant.

Although there were no significant correlations between verbal IQ and IM, the directionality of correlations differed between males and females, such that for males the higher the IQ score, the higher the IM, whereas for females, the higher the IQ, the lower the IM. A $2 \times 2$ (gender $\times$ PA) analysis of covariance was performed with IM as the dependent variable and IQ as the covariate to insure that the interaction effect described above was not the result of an association with IQ. Results revealed the same pattern for the interaction ($F(1,33) = 3.7; p < .06$), as obtained previously.

**DISCUSSION**

The main findings of interest involved the difference for male and female schizophrenics in the relationships between level of premorbid adjustment, and intimacy motivation. The link between higher levels of premorbid adjustment and better social outcome can be understood from a developmental point of view. An individual who has achieved a higher level of social competence prior to onset of illness would likely be at an advantage through the course of illness, presumably having attained a higher level of development prior to becoming ill (McGlashan, 1986). Considering the motivation for intimacy as one important aspect of “social competence,” one might predict that a person with a better premorbid history would also have a higher motivation for intimacy. In fact, the present findings did support this notion, revealing a positive association between intimacy motivation and premorbid adjustment, but only for the male subjects. Some (e.g., Castle & Murray, 1991; Flaum, Arndt, & Andreasen, 1990; Flor–Henry, 1990; Foerster et al., 1991; Haas, Sweeney, Hien, Waked, & Weiden, 1989) have suggested that for men a history of poor premorbid adjustment is a marker for a subtype of schizophrenia characterized by poor prognosis with associated features such as negative symptoms, neuroanatomic abnormalities, and cognitive impairments. The low intimacy motivation of the males with poor premorbid adjustment in the present study can be considered consistent with the other associated features of the proposed subtype.
Our findings have implications for treatment, suggesting that men and women should be considered differently, and that men with good and poor premorbid adjustment should also be considered differently. For the males with poor premorbid adjustment and low intimacy motivation, attempting psychotherapeutic intervention which involves establishing an interpersonal relationship would not be indicated, as these men may not be able to benefit from the personal contact offered by psychotherapy. The lowered intimacy motivation of the poorly adjusted men might also explain why some treatment studies have reported that men have worsened in response to therapeutic intervention (e.g., Glick et al., 1991; Spencer et al., 1988). For these men, situations which demand some capacity to interact with others could be experienced as highly stressful, and psychotherapy may actually act as a stressor to impede recovery. In contrast, for men with good premorbid adjustment with higher motivation for intimacy, some kind of supportive psychotherapy might help to engage them in the treatment process. Taking into account the differences between men with good and poor premorbid adjustment may be particularly important in treatment outcome studies, given the general findings that overall, men tend to exhibit poor treatment compliance.

As has been reviewed, Farina et al. (1963), Glick et al. (1991), Pogue–Geile and Harrow (1985) and Salokangas and Stengard (1990), have reported that the positive relationship between premorbid adjustment and outcome only holds true for males and not for females. The present findings help to explain these consistently reported gender differences. The fact that women with poor premorbid adjustment revealed higher intimacy motivation than those with good premorbid adjustment was an unexpected and counterintuitive finding.

One of the most frequently cited explanations for better social outcome in women is a developmental model focusing on gender differences in age of onset. Gender differences in levels of social functioning have been linked to the fact that women have significantly later onset of illness than men, tending to begin manifesting symptoms during their early to late twenties, where men develop schizophrenia frequently in early to late adolescence. It has been suggested (Anderson & Holder, 1989; Haas et al., 1990; Lewine, 1982) that in the developmental life cycle, this difference in onset would place women in the position of being more likely to have completed higher levels of education, more likely to have attained a position in the workplace, more likely to have entered into a significant relationship and/or to have married and had a child. Having achieved these developmental milestones would place women at an “advantage” once ill.

Yet in the present study, the women who had attained higher levels of social adjustment prior to onset of illness were specifically those women who evidenced the lowest level of internal social interest, in spite of being the group with the latest age of onset (e.g., the mean age was 32 vs. 27 for females with poor premorbid adjustment). This suggests that in spite of apparent higher levels of premorbid adjustment, for these women an internal withdrawal process may be operating. In fact, in our study, the women with the highest levels of PA were the subjects who appeared on behavioral observation the least socially withdrawn, significantly less withdrawn than the women with poor premorbid adjustment.

One possible explanation for the lowered intimacy motivation in the women with better premorbid adjustment is that becoming ill and being hospitalized may have a differential effect upon women, if one takes into account their level of premorbid adjustment. For females who have had a relatively positive background in terms of their prior social adjustment, being ill and hospitalized can represent such a dramatic change for the worse. They may feel more deprived, and the hospitalization itself could be considered as a negative life event. On the other hand, for the women with a poor previous history of social adjustment, the hospital may be experienced as an important change for the better. For the women with poor premorbid adjustment, the hospitalization itself provides the opportunity for social interaction that was previously lacking. Several studies of institutionalized children support this notion, suggesting that children
with differentially deprived backgrounds (deprived, not-deprived) either experience hospitalization as beneficial, or as detrimental, respectively.

Further support for the idea that for women the experience of illness can have a deleterious effect specifically in the area of social relations and adjustment, are a number of studies which focus on women’s experience of illness in general. Women tend to perceive themselves as mentally ill more than men, revealing more insight, less denial and a greater willingness to respond to the perception of illness (Cafferta & Meyer, 1990; Walker & Rossiter, 1989). The fact that women in general tend to evaluate their lives and well being in terms of their relationships with others more frequently than by their achievements (McAdams et al., 1987) may be particularly significant for the women who have achieved higher levels of social adjustment prior to illness, and/or hospitalization. For them, developing schizophrenia, an illness which inherently affects one’s ability to function socially and otherwise, would certainly have a more devastating impact than for a woman who never attained normal social relatedness, or even for a man, who would be less likely to define himself by his abilities to relate to others. This is further supported by Hogarty (1985) who reported that women were more vulnerable to negative life events than men, and for whom relapse was more likely precipitated by interpersonal stressors than for men, who were more impacted by an assault on self-esteem or achievement-oriented role functioning.

Sociocultural factors and gender differential expectations for role functioning may also explain the lowered IM for women with good PA. It has been suggested (e.g., Anderson & Holder, 1989) that social expectations for achievement for women overall are lower than for men. Thus, perhaps families are more able to respond positively to a disturbed female family member than a male one, making the environment less stressful for the female and relapse less frequent. Having lower expectations, they may be able to tolerate the symptoms (both positive and negative) secondary to illness in women to a greater extent, as well as being able to view women in the dependent role more easily. Alternately, the male patient may experience more difficulty being in the dependent role, as men in particular are expected to be self-sufficient and separated, and thus may not be able to tolerate any intervention from family or therapists, making it more difficult to treat the male patient and less likely that he will comply with treatments offered (Haas et al., 1990).

Along these lines, it may be important to consider women with good premorbid adjustment and those with poor differently. Whereas the family may be more tolerant of a woman who has always been dependent and has never separated from her family of origin (the woman with poor premorbid adjustment), the same expectations may not apply to the woman who has been able to attain a higher level of adjustment, and perhaps is even the person in the family who has been relied upon to manage the home, and care for the dependents. For the woman with better premorbid histories, becoming ill may have quite a different effect, particularly to the extent that she is no longer able to manage up to her previous capacities. Findings from the Haas et al. (1990) study reported that families of the women with better premorbid adjustment expressed more patient rejection than those of women with poor, providing further support for the notion that socio/familial expectations would differ for these two groups of women. The lower intimacy motivation in the women with better histories may serve as an indication of internal withdrawal (akin to depression) related to stress arising from their own feelings of role loss, as well as in response to their families’ sense of disappointment and/or rejection.

The present findings of differences between women with good and poor premorbid histories in intimacy motivation suggest differential treatment needs for women depending upon social functioning level prior to illness onset. The fact that women with good premorbid adjustment demonstrate less overt social withdrawal than poor premorbid women and good premorbid men might lead a clinician to believe that these women are in less need of treatment apart from psychopharmacologic intervention. However, the low intimacy motivation in these women
suggests that helping them to cope with role loss, possible family stresses because of higher expectations, and their own internal feelings of withdrawal may be a necessary effort toward helping prevent relapse. The vulnerability of these women to depression might also be investigated, as the evidence suggests that they may be more severely impacted by illness than the other subject groups.

In order to develop social abilities, some concurrent internal investment or interest in intimacy is required. Social abilities may be a support or “buffer” for a person through the course of illness. Consider the women with poor premorbid histories. Their interest in intimacy may be an internal resource upon which to capitalize in the process of treatment. For a woman who is internally motivated to make a connection with others, in spite of the fact that she may appear to be socially withdrawn and uninterested, an individual psychotherapeutic intervention might aid in engaging her in treatment leading to better compliance. Teaching communication and social problem solving skills may particularly help to mediate the course of illness for these women who are so interested in relationships, in spite of their apparent difficulties.

Some attention to methodological considerations vis a vis sampling bias will be given, primarily for two reasons: It may add to understanding the present findings, especially for the lower intimacy motivation of female group with good premorbid adjustment; and it is a problem inherent to gender research in schizophrenia that should be addressed when designing studies of gender and social functioning. The present study failed to confirm a number of overall gender differences that have been reported in premorbid adjustment (Farina et al., 1962; Goldstein, 1988; Pogue–Geile & Harrow, 1985; Zigler & Levine, 1981) and social withdrawal (Dworkin, 1990). Goldstein (1988) has suggested that females have a better course of illness than males, particularly marked by fewer hospitalizations. Whether due to a sociocultural phenomenon where deviant behavior in women is tolerated more easily than men’s, or because women’s symptoms in actuality are less severe or of a type which do not require hospitalization (e.g., fewer aggressive behaviors), in order to be hospitalized, women have to be quite ill. Thus, researchers who study populations of inpatients face the likelihood of sampling an atypical and nonrepresentative subject pool, as women in the hospital, or who are hospitalized as frequently as men, may represent a more severely ill sample of patients. Findings from the present study (e.g., chronicity) suggest the possibility that the females in this sample might be a more severely ill group than those in a community sample. Thus, it is possible that the present failure to obtain the expected differences between males and females on overall premorbid adjustment, intimacy motivation, and asociality may have been partially due to a sampling bias. However, on other indices of prognosis, such as age of onset and marital status, the expected gender differences for schizophrenic patients were present, weighing against rejecting the findings due to the issue of sampling bias. Nonetheless, sample bias is an important methodological point to consider in study design with this population.

Finally, the fact that the level of overt social withdrawal did not correlate with internal motivation for intimacy strongly supports our view that the comparison of behavioral measures of social functioning and social withdrawal, in combination with assessment of a psychological dimension of social relatedness, provides a promising means to further the discussion of gender differences in aspects of social functioning and outcomes. Further research in applying an integration of cognitive and dynamic approaches to empirical study of gender and interpersonal functioning in schizophrenia should be conducted. Specific avenues to pursue would include adding a psychological dimension to the study of interpersonal problem solving and social skills, in addition to further work in the area of premorbid functioning. Another fruitful area to explore would be family relations and expectations and the degree to which a person’s intimacy motivation may impact on how he or she is perceived by significant others.

It has become abundantly clear that although gender is a vital factor to consider in the investigation of interpersonal functioning, particular attention should also be given to the rela-
tionship between gender and premorbid history. Failure to attend to these nuances will result in interpretations with uncertain validity, as it is clear that gender-differential social expectations and experiences of illness will have differing meanings for individuals with better or worse histories of social functioning prior to the onset of illness.

REFERENCES


