Sex-role stereotyping

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A recent study conducted at the University of Minnesota indicates that students may be adopting a new definition of mental health—one in which traditional sex-role stereotypes are abandoned in favor of more human and flexible standards.

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THROUGHOUT recorded history two persistent themes regarding human personality have emerged: (1) the male is the prototype for humanity, the female being understood in relation to him; and (2) males represent the cognitive world, which is positively valued in this culture, and females represent the affective domain, which has less positive value overall. Out of these two themes have emerged the current concern about the existence and possible detrimental effects of sex-role stereotyping, which is abundantly present in both general news media and professional literature.[1] As defined by Kagan, sex-role stereotyping refers to the holding of "publicly shared beliefs regarding the appropriate characteristics for males and females."[2]

Various studies in this decade have indicated that mental health professionals engage in such stereotyping.[3] What happens when they accept, even implicitly, the sex-role stereotypes prevalent in the society? Are they helping to perpetuate the existence of these prevalent beliefs and thereby potentially reinforcing social and intrapsychic conflict in their clients? Are they inadvertently encouraging mutually exclusive goals: mental health as defined by prevailing sex-stereotypes versus self-actualization, sex unspecified? Are they supporting a phenomenon that seriously inhibits the self-actualization of both men and women by confining both sexes to preconceived roles, preventing them from exploring a wide range of behaviors, and prohibiting self-definition?

Broverman et al. conducted a landmark study in the late 1960s that addressed the possible effects of sex-role stereotyping by mental health professionals.[4] They surveyed seventy-nine actively functioning, clinically trained psychologists, psychiatrists, and social workers and found conclusive evidence there was a double standard for mental health that discriminated against women. Their research confirmed the following hypotheses:

- that clinical judgments about the characteristics of healthy individuals would differ as a function of sex of person judged, and furthermore, that these differences in clinical judgments would parallel stereotypic sex-role differences.
- that behaviors and characteristics judged healthy for an adult, sex unspecified, which are presumed to reflect an ideal standard of health, will resemble behaviors judged healthy for men, but differ from behaviors judged healthy for women.[5]

The study found no significant difference in the views of male and female clinicians; both subscribed to a double standard of mental health. This attitude results in a kind of "Catch-22" double bind for women. As Broverman et al. noted in a later study,

> If women adopt the behaviors specified as desirable for adults, they risk censure for their failure to be appropriately feminine; but if they adopt the behaviors that are designated as feminine, they are necessarily deficient with respect to the general standards for adult behavior.[6]

With the view that sex-role stereotyping by mental health professionals has critical ramifications, the authors undertook the study of potential professionals in the field of mental health —students in the social work curriculum at the University of Minnesota. One objective was to determine whether the study could justify possible curriculum revisions in the school. In designing the present research, the authors hypothesized that both undergraduate and graduate students of social work at the university would subscribe to a double standard of mental health for men and women as did the mental health professionals in the 1970 Broverman study.[7] As noted above, behaviors and characteristics judged healthy for an adult, sex unspecified —which are presumed to reflect an ideal standard of mental health—were expected to resemble behaviors judged healthy for men and differ from those judged healthy for women.

It was further hypothesized that, contrary to the findings of the Broverman team, male and female students would differ in their concept of mental health for a woman. The authors expected that the impact of the feminist movement would have

caused significant attitude changes in female students during the past five years.

METHOD

At the start of fall 1974 classes, 345 social work students at the university completed the research instrument. Forty-six percent were undergraduates (juniors and seniors) majoring in social work; the others were graduate students in the MSW program. Reflecting the proportion of men in the social work program, 26 percent were male. Approximately six out of ten students were from 20 to 25 years of age, three out of ten from 25 to 35, and one out of ten over 35. More than a third of both the fathers and the mothers of the subjects had completed college or graduate school.

The instrument was like that used by the Broverman team.[8] It consisted of 82 bipolar items, each describing with a short phrase a particular behavior, trait, or characteristic, such as the following: "Not at all independent —Very independent."

Item selection was based on a series of studies.[9] First a list of 122 characteristics and behaviors different for men and women was compiled from items suggested by 100 college students. In a follow-up study, 160 students analyzed the list, and it was reduced to the 41 stereotypic items they considered items on which 75 percent of the subjects agreed as to which pole was characteristic of men or women. Three items were later discarded as applying to adolescents. A further survey of students determined which pole of each of the 38 items represented the more socially desirable trait. Other research confirmed a high degree of correlation among items that college students considered socially desirable and those that clinicians judged to be indicative of mental health. Of the 38 stereotypic items, 27 that were considered more socially desirable and healthy were at the masculine pole (male-valued items); 11 considered socially desirable and healthy were at the feminine pole (female-valued items). In addition to the 38 stereotypic items, 44 other items found to be significant, but lacking 75 percent agreement, were included in the questionnaire for masking purposes.

TABLE 1. THIRTY-EIGHT BIPOLAR QUESTIONNAIRE ITEMS SELECTED FROM THOSE RATED BY BROVERMAN ET AL. (1970) AS HAVING HIGH MASCULINE OR FEMININE STEREOTYPIC ASSOCIATIONS

Items in Which Masculine Pole Was Considered More Socially Desirable	
Feminine Pole	Masculine Pole
Not at all aggressive	Very aggressive
Not at all independent	*Very independent
Very emotional	*Not at all emotional
Does not hide emotions at all	Almost always hides emotions
Very subjective	*Very objective
Very easily influenced	Not at all easily influenced
Very submissive	Very dominant
Dislikes math and science very much	Likes math and science very much
Very excitable in a minor crisis	*Not at all excitable in a minor crisis
Very passive	Very active
Not at all competitive	Very competitive
Very illogical	*Very logical
Very home oriented	Very worldly
Not at all skilled in business	Very skilled in business
Very sneaky	Very direct
Does not know the way of the world	*Knows the way of the world
Feelings easily hurt	*Feelings not easily hurt
Not at all adventurous	Very adventurous
Has difficulty making decisions	Can make decisions easily
Cries very easily	Never cries
Almost never acts as a leader	Almost always acts as a leader
Not at all self-confident	Very self-confident
Very uncomfortable about being aggressive	Not at all uncomfortable about being aggressive
Not at all ambitious	Very ambitious
Unable to separate feelings from ideas	*Easily able to separate feelings from ideas
Very dependent	Not at all dependent
Very conceited about appearance	Never conceited about appearance
Items in Which Feminine Pole Was Considered More Socially Desirable	
Feminine Pole	Masculine Pole
Very talkative	Not at all talkative
Very tactful	*Very blunt
Very gentle	Very rough
Very aware of feelings of others	Not at all aware of feelings of others
Very religious	Not at all religious
Very interested in own appearance	Not at all interested in own appearance
Very neat in habits	Very sloppy in habits
Very quiet	Very loud
Very strong need for security	Very little need for security
Enjoys art and literature very much	Does not enjoy art and literature at all
Easily expresses tender feelings	Does not express tender feelings at all

* Items with an asterisk are those in which there was a significant difference in the ratings for a healthy woman by male and female students in current study.

The authors randomly divided the volunteer student subjects into three groups. One-third were asked to rate each item by placing a slash mark on the continuum where, according to their perception, "a mature, healthy, socially competent adult person" would fit. One-third were asked to rate each item in the same way with respect to a "mature, healthy, socially competent adult male," and the other third, with respect to a "mature, healthy, socially competent adult woman."

Although the subjects responded to all 82 items on the questionnaire, only the 38 stereotypic items listed in Table 1 were scored. All comparisons were made via T tests. Scores for a healthy man and for a healthy woman were compared with the scores for a healthy adult person, sex unspecified. Students

TABLE 2. RATINGS ON STEREOTYPIC ITEMS BY TOTAL POPULATION OF STUDENTS FOR A HEALTHY MAN, A HEALTHY PERSON OF UNSPECIFIED SEX, AND A HEALTHY WOMAN

	Healthy Man (n=113)	Healthy Person (n=117)	Healthy Woman (n=111)
Mean score	4.286	4.332	4.324
Variance	.102	.152	.269

scoring the adult persons served as the control group. Because much current research in sex-role stereotyping does not use a control group standard, but rather compares ratings for women and men directly with one another, this study also compared the scores for a healthy man with those for a healthy woman.

RESULTS

When analyzing and comparing the scores of the total subjects, there was no significant statistical difference among the ratings for the three groups. As indicated in Table 2, no statistical difference existed between scores for a healthy man and a healthy woman, scores for a healthy man and a healthy person, or scores for a healthy woman and a healthy person. Consequently, these scores do not confirm the hypothesis that a double standard of mental health exists in the social work student population studied.

Male and Female Subjects In the scores of male subjects, which are summarized in Table 3, there was no significant difference between ratings for a healthy man and a healthy person or between a healthy woman and a healthy person. However, when comparing male ratings for a healthy man and a healthy woman, a significant difference was found ($p \geqq .05$). It paralleled stereotypic lines, with a healthy man rated closer to the masculine pole than was a healthy woman.

Similarly, total scores of female subjects for a healthy man and a healthy person—and for a healthy woman and a healthy person—were the same. But, when comparing female ratings for a healthy man and a healthy woman, a significant difference was revealed ($p \geqq .10$). It was the inverse of stereotypic lines, with females rating a healthy woman closer to the masculine pole than they rated a healthy man.

The second hypothesis of this design—that female subjects would respond differently from male subjects, at least with respect to their concept of mental health for a woman—was confirmed, especially in the latter respect. Analyzing total scores of male and female subjects for a healthy man alone, no significant difference was seen in the concept of a healthy man. Furthermore, an item analysis did not show a difference in any individual items between male and female ratings for a healthy man.

A significant discrepancy was revealed between male and female judgments of a healthy woman ($p \geqq .01$). Although males and females reached a consensus on every item regarding characteristics for a healthy man, 25 percent of the scored items showed a highly significant difference between male and female ratings for a healthy woman. These items are indicated by an asterisk in Table 1. Females viewed a healthy woman as closer to the masculine pole than males did. In other words, females judged healthy women as more independent, less emotional, more objective, less excitable in minor crises, more logical, more sophisticated, less easily hurt in their feelings, more readily able to separate feelings from ideas, and more blunt. All these items except the final one are associated with the socially desirable, healthy pole. Since they are also masculine stereotypic items, it might seem on the surface that females were rejecting their femininity and adopting a masculine stance. However, in the authors' view, the female students' incorporation of male-valued stereotypic traits into the self-concepts of women cannot be interpreted as a shift away from the positively valued characteristics of the female stereotype, since these students still judged women to be at the feminine pole on items in which the feminine pole was more socially desirable and healthy. Female subjects judged healthy women as very aware of the feelings of others, very neat in habits, very tactful, as enjoying art and literature very much, and as easily expressing tender feelings.

Male and female subjects disagreed in their concept of a healthy person ($p \geqq .05$). Females rated a healthy person closer to the masculine pole than did males.

Undergraduate and Graduate Students Scores of undergraduate and graduate students were analyzed and compared. As Table 4 demonstrates, the total scores of undergraduates were the same for a healthy man and a healthy person, for a healthy woman and a healthy person, and for a healthy man and a healthy woman. This indicates that, as a total population, juniors and seniors in the social work curriculum did not hold a double standard of mental health.

Graduate students rated a healthy woman the same as a healthy person; however, they rated a healthy man differently from a healthy person ($p \geqq .025$) and from a healthy woman ($p \geqq .025$). This suggests that graduate students subscribe to a double standard of health which, on the previously established index of social desirability, tends to discriminate against men. This

TABLE 3. RATINGS ON STEREOTYPIC ITEMS BY MALE AND FEMALE SUBJECTS FOR A HEALTHY MAN, A HEALTHY ADULT PERSON OF UNSPECIFIED SEX, AND A HEALTHY WOMAN

	Healthy Man	Healthy Person	Healthy Woman
Male subjects	(n=32)	(n=29)	(n=29)
Mean score	4.251	4.188	4.049
Variance	.064	.047	.237
Female subjects	(n=81)	(n=88)	(n=82)
Mean score	4.299	4.379	4.421
Variance	.117	.178	.246

TABLE 4. RATINGS ON STEREOTYPIC ITEMS BY GRADUATE AND UNDERGRADUATE SUBJECTS FOR A HEALTHY MAN, A HEALTHY ADULT PERSON OF UNSPECIFIED SEX, AND A HEALTHY WOMAN

	Healthy Man	Healthy Person	Healthy Woman
Undergraduate students	(n=48)	(n=54)	(n=51)
Mean score	4.346	4.279	4.221
Variance	.151	.146	.225
Graduate students	(n=62)	(n=61)	(n=58)
Mean score	4.238	4.362	4.413
Variance	.065	.146	.302

finding is somewhat paradoxical in that a healthy man was viewed as less "masculine" than either a healthy woman or a healthy person.

Undergraduates and graduates differed in their concepts of a healthy man, with the undergraduate rating being closer to the masculine pole ($p \geqq .10$). The two groups also disagreed in judging healthy women, with graduate rating being closer to the masculine pole ($p \geqq .10$). They agreed in their concept of health for a person, sex unspecified. These findings suggest that undergraduates subscribe to sex-role stereotypes more than graduate students do.

IMPLICATIONS

This research suggests that sex-role stereotypes are not static but are changing among both male and female students, although females are possibly revising their views more rapidly than males are. Since masculine and feminine roles are complementary and interact, any pervasive, long-term change in one stereotype leads to revision in its counterpart. The study seems to indicate a trend toward a new definition of mental health—one that is not based on rigid sex-role boundaries but one that represents more human and flexible standards, one in which the differences for men and women are less marked. Other researchers have also documented a trend, albeit slow, toward androgyny.[10]

Several factors may have contributed to discrepancies between the results of this study and those of the Brovermans and others. The feminist movement has made a significant impact within the past five years and the rate of change in sex-role stereotypes seems to be accelerating, particularly among university students. Furthermore, the subjects studied may represent a highly significant variable. Most researchers study either practicing clinicians or undergraduate college students. As the findings of this research indicated, junior and senior undergraduates are more likely to subscribe to sex-role stereotypes than are graduate students. It seems probable that the tendency to adhere to sex-role stereotypes would be even stronger among the freshmen and sophomores most often surveyed in introductory psychology classes. Female graduate students represent a large proportion of the subjects in this research, and they are representative of that relatively small group of women who have incorporated, to a greater degree than their homemaker counterparts, the male-valued characteristics of competence and achievement. Being highly educated and career oriented, they are less likely to have incorporated traditional feminine sex-role stereotypes. In fact, graduate students may be overly sensitive and self-conscious about endorsing traditional stereotypes.

Because of generational differences, research using university students as subjects may not be generalizable to the population at large and particularly to practicing clinicians. Today's university students are more likely to have had mothers who were employed than practicing clinicians are, and a 1970 study found that daughters of employed mothers perceived women less negatively on the male-valued characteristics involving competence than did daughters of mothers who were homemakers.[11]

In judging the degree to which subjects in this research have overcome sex-role stereotypes in their concept of mental health, one should remember that the paper-and-pencil inventory used allows for a "more superficial, simple verbalized, egalitarian point-of-view than do situational, experiential tasks."[12] In addition, the authors speculate that the publicity of the feminist movement may have increased the reluctance of people, particularly university students, to acknowledge openly their belief in a sex-stereotyped notion of mental health. The results of this study indicate a definite trend toward an androgynous concept of health, but because of the possible self-consciousness of subjects, the degree of the attitude change is difficult to assess.

AREAS NEEDING EXPLORATION

The authors believe that further research in the area of sex-role stereotyping should be conducted. As Schwartz has noted,

> The social work profession has finally learned the necessity of examining the effects of class, ethnicity, and race on social work thinking. But it continues to undervalue the importance of the sex factor.[13]

Many other researchers have found that the sex of both client and worker is a highly significant factor affecting the nature of the helping relationship.[14]

Although the results of this research do not show the existence of a double standard when comparing healthy man and woman with healthy person, male and female subjects held a different concept of mental health for men and for women when the two sexes were compared directly. Thus, when the data was analyzed in this way, a double standard for mental health was substantiated. In addition, male and female subjects had a strong difference of opinion in their concepts of a healthy woman. These findings—which suggest that males and females have different expectations for a healthy, socially competent, adult woman—have important implications for potential difficulties in relationships between males and females at both personal and professional levels.

Researchers are documenting the

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many negative pressures facing women who incorporate into their self-concepts male-valued stereotypic traits, such as independence, competence, and assertiveness.[15] Likewise, men who begin to adopt female-valued stereotypic traits—such as ready expression of tender feelings, neatness, awareness of feelings of others, and gentleness—may encounter similar pressures to adjust to traditional male-valued stereotypic traits regardless of their relative merit in terms of an androgynous standard of mental health.

Ambivalence, conflict, and resistance always accompany transition. Today's woman find herself within a maelstrom of pressures and counterpressures, both ideological and situational. And to some extent this is true also for today's man. The discord between the traditional, cherished sex-role stereotypes of the past and current societal changes may be leading to serious conflicts. One potential area for further research would be Merton's concept of anomie: The period of normlessness resulting from the conflict between traditional sex-role stereotypic values and the emerging androgynous self-definition. This normlessness facilitates the termination of ties with former attitudes and behaviors until the new orientation can be defined, integrated, and operationalized.[16] During this anomie, women are likely to be groping to discover the new boundaries for constructing their revised self-concept and goals.

Since sexual identity is at the core of self-definition, the current upheaval in norms for traditional sex-role identity may have even more profound effects on adolescents who are struggling to piece together their individuality than on more mature adults. In recent years observers have quoted a dramatic increase in the rate of suicides among female adolescents out of proportion to the rate of male adolescents, an increase in the proportion of female adolescents engaging in violent delinquent acts, and an increase in the proportion of female referrals to child guidance clinics.

Professionals in the human services must redefine what it means to be a woman or a man in the 1970s and make special efforts to increase their understanding. Men and women who deviate from traditional sex-role stereotypes are likely to suffer from the internal doubts and conflicts arising because of the discrepancy between sex-role stereotypes internalized in childhood and their emerging struggle toward androgynous self-definition, and they may suffer as well from the hostile reactions of others.

Mental health professionals have been exposed to sex-role stereotyping not only in their own socialization, but also in the psychological theories they are taught, most of which are firmly rooted in a sexist notion of health.[17] Therapists and social planners should be especially concerned about the degree to which they may reinforce rather than resolve social and intrapsychic conflicts in their clients by steering them toward an adjustment model of mental health that is based on traditional sex-role stereotypes.

The trend toward androgyny is apparently under way, at least among the social work students studied. It is crucial for social workers to be aware of their own sex-role biases, and have the knowledge, attitudes, and skills needed to assist clients struggling with the clash between traditional stereotypes and a more healthy self-definition of their sex roles.

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