GENDER ROLES AND EXPECTATIONS IN CLINICAL PRACTICE

AND RESEARCH

Teresa A. Young

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This paper summarizes relevant literature on the subject of gender roles and expectations in the following six areas: clinical assessment, foundations of behavior, application to therapy, ethical and professional issues, cultural considerations and diversity, and research challenges and needs.
As gender roles evolve, expectations for behavior also change. This paper summarizes traditional and more recent conceptualizations and theoretical approaches regarding gender roles. The assessment of gender role orientation will be discussed, followed by a review of theories regarding gender role acquisition. Gender role considerations for therapy, ethical issues, and cultural considerations will follow. The paper concludes with a discussion of challenges in research and future directions.
GENDER ROLES AND EXPECTATIONS IN CLINICAL PRACTICE

AND RESEARCH

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CHAPTER I

INTRODUCTION

Gender roles and expectations have a place in modern therapeutic and counseling practices as a topic for discussion, because both men and women are socialized into stereotypical gendered behaviors and interests (Hyde, 1991). Generally, parents dress little boys in blue and give them cars to play with while little girls are dressed in pink and play with dolls. These colors and toys set children up for the roles they will be expected to fulfill as adults. The concepts of masculinity and femininity and their congruence with men and women, respectively, preceded most other psychological constructs.

Early personality theorists were accustomed to the notion that masculinity and femininity occurred naturally among men and women, respectively. As a result of the prevalent views, men were thought to be competitive and agentic by nature, and the prevalent views of women were that they were essentially maternal and nurturing (Hyde, 1991). The perspective of sex and gender congruence was not only thought of as inherent but desirable, maintaining a patriarchal status quo, which limited the roles and opportunities of men and women. These viewpoints guided early interventions of counseling in that women were directed toward family, marriage, and motherhood while men were directed toward excelling in careers, which kept women financially dependent. The initial therapeutic state of affairs was one in which more women utilized services,
and more therapists were men, who would position themselves as authority figures in the lives of clients. In fact, the common view from Freudian theory was that women were passive, narcissistic, and masochistic (Worell & Remer, 2003).

The idea that women had more psychological problems than men was pervasive well into the last century (Broverman, Broverman, Rosenkrantz, & Vogel, 1970). Theorists on personality would use the status quo as a means of describing the “true” nature of men and women, but in recent years, masculine and feminine roles have come to be viewed as socially constructed and prescribed rather than naturally occurring (Worell & Remer, 2003). Overemphasis on traditional gender role norms can be very limiting for men and women in terms of behavior and opportunities. Society during the latter part of the 20th century was more welcoming to the concept of androgyny over gender-typing (Hyde, 1991).

With help from the civil rights and feminist movements, feminists fought the devaluation of qualities associated with women and advocated for a wider range of opportunities for men and women. As researchers and clinicians move away from androcentric theories, the experience of how men and women enact their gender becomes more important. The intersection of gender roles and expectations with psychology will be discussed in terms of both traditional approaches and more recent literature. Topics that will be addressed include assessment of gender role orientation, foundations of behavior, application to therapy, ethical and professional issues, cultural considerations and diversity, and research challenges and needs.
CHAPTER II

ASSESSMENT

Several measures have been developed to assess gender role orientation. Various instruments conceptualize gender roles differently and through different aspects of psychological functioning, such as traits versus behaviors. Gender was considered a bipolar, unidimensional construct as early as 1939 when it appeared as a scale on the Minnesota Multiphasic Personality Inventory (MMPI). Gender roles started to receive considerable attention in the 1970s, which led to the development of measures examining masculinity and femininity as two orthogonal dimensions, such as the Bem Sex-Role Inventory (BSRI; Bem 1974) and the Personal Attributes Questionnaire (PAQ; Spence, Helmreich, & Stapp, 1975). Individuals are considered to have some degree of both masculine and feminine traits. The BSRI and PAQ are instruments designed to measure desirable personality traits related to gender role. The Sex-Role Behavior Scale (SRBS; Orlofsky, 1981) was designed to assess gender-specific interests and behaviors. Other measures, such as the Conformity to Masculine Norms Inventory (Mahalik et al., 2003) and the Conformity to Feminine Norms Inventory (Mahalik et al., 2005), are based on a model of gender role orientation in which masculinity and femininity are two orthogonal variables, and each variable is multidimensional. These instruments will be discussed in detail in the following paragraphs.
The Bem Sex-Role Inventory

One instrument that assesses gender role orientation in terms of two distinct categories is the Bem Sex-Role Inventory (BSRI; Bem, 1974). The scale is comprised of items that are adjectives describing personality. Respondents rate the extent to which they perceive themselves as masculine or feminine based on a seven-point Likert-type scale. The 60-item questionnaire contains three scales, 20 of which comprise a masculinity scale, 20 comprise a femininity scale, and the remaining 20 are a social desirability scale of neutral items. Depending on scores, respondents can be assigned to one of four categories: masculine, feminine, androgynous, or undifferentiated. The scales are based on sex-typed social desirability, meaning the results of the questionnaire are based on the respondents’ internalization of societal standards for sex-role behavior and their consideration of what is socially desirable among men and women. Some examples of items from the masculinity scale include “independent”, “forceful”, “has leadership abilities”, and “competitive.” Examples of femininity items are “yielding”, “loyal”, “sensitive to the needs of others”, and “loves children” (Bem, 1974). As discussed in the introduction, masculinity is marked by an emphasis on leadership, achievement, and independence; whereas, femininity is marked by passivity, providing support to others, and domesticity. High scorers on both the masculinity and femininity scales are categorized as androgynous; whereas, low scorers on both scales are classified as ‘undifferentiated’. The list of traits that comprise the BSRI are all positive traits, meaning that they are socially desirable.

The psychometric properties of the BSRI are known to be in the acceptable range as well. Bem (1974) reported internal consistency reliability ranging from .80 to .82 for
femininity and .86 for masculinity. These results have been replicated in later studies (Hyde, 1991). Test-retest reliability over a four-week interval produced high correlations ranging from .89 to .93 across the four categories (Bem, 1974). Factor analyses of the BSRI have yielded inconclusive results due to differing methods of utilization of the inventory. For example, some analyses have used only the 40 items comprising the masculinity and femininity scales while others have included the remaining 20 items as well. Those that used all 60 items found that the social desirability items actually weighed heavily on one of the two sex-typed scales (Ballard-Reisch & Elton, 1992; Moreland, Gulanick, Montague, & Harren, 1978). Bem later decided to refer to the remaining 20 items as filler items rather than as a social desirability scale (1981). Out of 23 studies examining the factor structure of the BSRI, the number of factors has ranged from 2 to 11. In most studies, there has been one femininity factor that falls under the category of expressive or communal. On the other hand, at least nine studies indicated at least two factors for masculinity. The categories of those factors fall into agentic and instrumental, representing two different variables (Choi & Fuqua, 2003).

Due to the complex factor structure and the appearance of more than just masculinity and femininity factors, Bem revised the BSRI into a short form with 20 items, known as the Short Bem Sex-Role Inventory (SBSRI; Bem, 1979). As mentioned previously, because the original BSRI was based on socially desirable traits, certain traits that were low on social desirability were omitted. For example, the feminine trait of ‘child-like’ was known to be associated with less social desirability, and thus was removed from the short form of the BSRI.
According to Hunt (1993), this change drastically improved the ability to predict well-being in association with gender role, a relationship which researchers had examined for decades. In a study of 72 males and 87 females from a college campus, both instrumental (masculine) and expressive (feminine) traits were negatively and significantly correlated to depression and positively correlated to positive affect, affect balance, and satisfaction with life. Further, women whose SBSRI scores placed them in the feminine category experienced greater intensity of positive affect, meaning that these women would describe themselves as feeling “joyful or elated than simply content” (Hunt, 1993, p. 162)

The Personal Attributes Questionnaire

Another instrument used to assess gender roles in terms of two discrete categories is the Personal Attributes Questionnaire (PAQ; Spence, Helmreich, & Stapp, 1975). The PAQ is comprised of 55 items, each of which participants rate on a 5-point Likert-type scale. The items comprising each scale are based on typical and ideal characteristics of males and females, meaning how they “are” and how they “should be”. Instrumental refers to the stereotypically masculine concept of agency or self-assertion. Expressive refers to the stereotypically feminine concept of communion or the need to be part of a group.

The three subscales of the PAQ were originally designed to measure social desirability of either instrumental, expressive, or sex-specific traits. Items that are more common in men but socially desirable in both males and females make up the M (masculine) scale. Likewise, items that are more common among women but socially
desirable traits of both sexes make up the F (female) scale. Sex-specific items were those that seemed to belong to one particular sex and were only desirable amongst that sex, such as ‘aggressive’ for males and ‘religious’ for females.

The scales on the PAQ generally have high internal consistency with the exception of the sex-specific subscale and men alpha coefficient, which is in the acceptable range. The coefficient alphas for the expressiveness scale are .79 and .84 for men and women, respectively. The coefficient alphas for the instrumental scale are .85 and .94 for men and women, respectively. Coefficient alphas for the sex-specific subscale are .53 and .85 for men and women, respectively (Spence et al., 1975). The authors proposed the use of less stereotypical, more precise terms; they reframed feminine as expressive and masculine as instrumental. Although the instrument was developed to assess dimensions of expressiveness and instrumentality, more studies use it for categorizing respondents as masculine or feminine (Whitley, 1988). An extended version of the PAQ was developed in 1979 (Spence, Helmreich, & Holahan) and is known to have acceptable internal consistency ranging from .70 to .83 (Trudeau, Danoff-Burg, Revenson, & Paget, 2003).

The Sex-Role Behavior Scale

The Sex-Role Behavior Scale (SRBS; Orlofsky, 1981) is designed to assess male, female, and sex-specific interests and behaviors much in the same way the PAQ and BSRI measure personality traits. The questionnaire is comprised of 240 items which respondents rate on a 5-point Likert-type scale. There are four categories of behaviors: Recreational Activities, Vocational Interests, Social and Dating Behavior, and Marital
Behavior. Each category is comprised of male-valued, female-valued, and sex-specific items. Male-valued means that the behavior is valued in both men and women but occurs mostly with men. An example of a male-valued item would be “Sailing.” Female-valued items would be items that men and women value but are more common among women, such as “Gardening.” Sex-specific items means the behavior occurs most often in one sex and is not valued by both, such as “Football.”

Internal consistency ranges from acceptable to satisfactory with coefficient alphas of .81 for the men and .82 for women on the male-typed subscale, .79 for men and .59 for women on the female-typed subscale, and .88 for men and .87 for women on the sex-specific subscale. There is also a short form version of the SRBS (Orlofsky & O’Heron, 1987) containing 96 items. The internal consistency is somewhat lower than that of the original form, and the authors of the short version suggest that the long form be used for more specific assessments while the short form could be used for more global assessments.

The Conformity to Masculine Norms and Conformity to Feminine Norms Inventories

Recently two scales, known as the Conformity to Masculine Norms Inventory (CMNI; Mahalik et al., 2003) and the Conformity to Feminine Norms Inventory (CFNI; Mahalik et al., 2005), were developed to examine masculinity and femininity as multidimensional constructs. Both the CMNI and CFNI are designed to assess affective, behavioral, and cognitive aspects of gender role conformity. They can be used to provide an overall masculinity and femininity score, respectively, as well as individual
scores on each of the subscales. The inventories were both designed first through a series of focus groups that dealt with differing norms between men and women in the dominant U.S. culture. The focus groups were comprised of male and female masters and doctoral level counseling psychology majors. There were 12 initial subscales for the CMNI (Mahalik et al., 2003) and also 12 initial subscales for the CFNI (Mahalik et al., 2005).

Mahalik et al. (2003) defined conformity to masculine norms as “the extent that an individual male conforms or does not conform to the actions, thoughts, and feelings that reflect masculinity norms in the dominant culture in U.S. society” (p. 5). The CMNI is comprised of 94 items on 4-point Likert-type scale. The 11-factor structure of the CMNI includes subscales of Winning, Emotional Control, Risk-Taking, Violence, Power over Women, Dominance, Playboy, Self-Reliance, Primacy of Work, Disdain for Homosexuals, and Pursuit of Status. The Physical Toughness subscale was removed from the inventory following factor analysis. The inventory has very good internal reliability with a Cronbach’s alpha of .94. For subscales, coefficient alphas ranged from .72 for Pursuit of Status to .91 for Emotional Control. Men also scored significantly higher on the Total Score as well as 9 of the 11 subscales, excluding Primacy of Work and Pursuit of Status. Test-retest reliability over a 2- to 3-week period was also very good with a Pearson correlation of .95 with subscale Pearson coefficients ranging from .51 for Pursuit of Status to .96 for Disdain for Homosexuals.

Mahalik et al. (2005) defined conformity to feminine norms as “adhering to societal rules and standards about how to be feminine and is demonstrated in the individual woman’s behaviors, feelings, and thoughts” (p.418). Using focus groups, an eight-factor structure of feminine norms that emerged from the analysis of the data
includes the following subscales: Nice in Relationships, Thinness, Modesty, Domestic, Care for Children, Romantic Relationships, Sexual Fidelity, and Invest in Appearance. The subscales of Sweet and Nice, Put others First, Sexy, and Look Young were omitted following factor analysis. Cronbach’s alpha for internal consistency reliability of the total score was .88. Internal consistency for subscales ranged from .77 for Romantic Relationships to .92 for Caring for Children. Women scored significantly higher than men on the Total Score and six of the eight subscales, excluding Modesty and Romantic Relationships. Test-retest reliability over a 2- to 3-week period revealed a Pearson correlation coefficient of .94 for the Total Score, and coefficients ranging from .83 to .95 for the subscales. The CMNI and CFNI as well as their subscales have been used several times since their conception to assess for a wide variety of research topics related to gender role orientation.

Although the scales discussed are very common means of assessing gender role orientation, other questionnaires and inventories exist related to gender roles. Thus, the BSRI (Bem, 1974), PAQ (Spence & Helmreich, 1978), SRBS (Orlofsky, 1981), CMNI (Mahalik et al., 2003), and CFNI (Mahalik et al., 2005) are considered here and are the most commonly used measures in research that involves the assessment of gender role orientation.
CHAPTER III

FOUNDATIONS OF BEHAVIOR

Theories regarding gender and gender role orientation have emanated from the subfields of the social sciences. However, there is no single theory available that serves as an all-encompassing theory of gender differences. In fact, many theories simply underscore aspects of gender differences pertinent to the author’s field of study, such as sociology or developmental psychology (Eagly, 1997). Hyde (1991) summarized the evolution of the way in which gender is conceptualized. Historically, gender orientation fell into two distinct categories, masculine and feminine. During the mid-1900s, gender was considered a unidimensional, bipolar construct with masculinity on one end and femininity on the other. Then, during the 1970s, a two-dimensional scheme was developed introducing the concepts of androgyny and undifferentiated types of gender role orientation. The most recent conceptualization of masculinity and femininity is multidimensional and includes intellect, personality characteristics, agency-communion dimension, and several undefined constructs. In the subsequent paragraphs, several common theories regarding gender and gender role differences will be discussed and evaluated.

Freud and Psychoanalysis

Freudian psychoanalytic theory postulated that people make meaning out of internal conflicts. Thus, to achieve adulthood, boys and girls supposedly undergo
specific processes or conflicts related to gender role (Freud, 1905). The transition from boy to man is marked by the story of Oedipus. During the first few years of life, boys focus on and cling to their mothers, desiring affection from them. Thus, competition arises between boys and their fathers, and realizing that fathers are stronger and a potential source of castration, boys relinquish the lust for their mothers. They begin to identify with their fathers, leading to the acquisition of their gender roles (Bell, 2004).

Girls also spend their early years attached to their mother. However, girls begin to feel contempt toward their mothers for not having penises and for not giving girls penises. In such a way, mothers are seen as inferior. This envy of penises eventually is redirected as a focus toward wanting children (Bell, 2004). Women turn toward the fact that they can become mothers as a replacement for not having a penis. Thus, males enter into their gender roles out of desire to identify with their fathers. However, the adherence to gender roles is more complicated for females, as they supposedly feel envy toward their fathers and anger toward their mothers, and then they miraculously abandon those conflicts in exchange for motherhood.

Although the male version of Freudian gender acquisition has been commonly accepted, there is no strong support for the female version. In fact, many arguments have been made about the theory in terms of both the female view and the theory as a whole. First, Karen Horney (1926) and other psychoanalytically-oriented psychologists proposed other methods of female gender role development. These other methods evolved through direct clinical experiences, which seemed to contradict Freud’s assertions that women simply trade penis envy for motherhood (Flax, 2002). It would appear through Freud’s theory that men and women devalue femininity and female roles.
Feminist psychoanalysts posited that the male devaluation of women begins with the mother, as maturing boys attempt to identify with their fathers. The female devaluation of women begins as an attempt at individuation from their mothers, who seem to be at the bottom of the proverbial totem pole devalued by their husbands and sons (Flax, 2002). This notion of girls’ individuation from the mother and attraction toward the father is thought to be the internal conflict that girls undergo, also called the Electra complex (Hyde, 1991). Also, researchers and clinicians have challenged the famous quote, “Anatomy is destiny” (Hyde, 1991, p. 29), a hallmark of Freudian theory in that Freud conjured his theory based on anatomical parts and completely ignored cultural influences of behavior between men and women. Freud also considered women to have “immature superegos” compared to men, reinforcing sexist ideas that women are inferior and childish (1931). Many of these themes have been rejected, particularly by feminist psychologists.

Second, aside from an insufficiently defined path for female gender role development, another downfall of Freudian theory regarding male gender role development was that it assumed mature development occurred in a heterosexual way. For men, failure to mature during the third psychosexual stage of development, the phallic stage, was said to lead to homosexuality and perversion (Maddi, 1989). Homosexuality has been pathologized; therapists rooted in this belief have made a change in sexual preference the goal of therapy, and the view overall has stigmatized any sexual orientation aside from heterosexuality (Friedman, 1986).

Finally, perhaps the most significant criticism of psychoanalytic theory is that much of its tenets are unable to be measured empirically. Because many of the internal
conflicts that people experience are unconscious, they cannot be tapped into usual typical scientific procedures (Hyde, 1991). Although modern psychology utilizes some of Freud’s concepts, his approach to gender role development has been disputed.

**Jungian Theory**

Early on in the study of personality psychology, Carl Jung and Sigmund Freud worked together as colleagues. Differences arose between the two men in the 1910s, and they parted ways (Maddi, 1989). Like Freudian theory, Jungian theory used the concept of conflicting forces. However, Jung focused less on sex and more on spirituality. Although it may sound simplistic, Jung’s overall theoretical emphasis was on achieving selfhood (Jung, 1953). This process is not one of simple means, however. There are many conflicts, conscious and unconscious, that people experience. In Jung’s mind, resolving these conflicts was a step toward becoming whole.

Jung’s approach to gender was in some ways ahead of its time in that it was not male-normative (Young-Eisendrath, 2004). His theory regarding gender had to do with what he called contrasexualituy. According to contrasexualituy, people project unconscious, other-gendered parts of themselves onto others. Jung is famous for introducing the concept of archetypes into psychology. His two archetypes for masculinity and femininity were animus and anima, respectively. Theoretically, within each woman, there is a male sub-personality known as animus, and within every man, there is a female sub-personality known as anima. It is almost as if there is an ‘other’ within everyone that is of the other gender. This ‘other’ is separate from the self, because it is either undesirable or glorified. For example, a man may view himself as masculine
in the sense that he is more rational and able to exert more emotional control than women. He projects the emotional (anima) part of himself onto women by saying that he is always more rational, causing women to get irritated or upset with this statement and proving his own point by using his anima to yield otherness. Thus the man’s emotionality is undesirable, and he projects it onto women, keeping it separate from himself. The animus/anima may be projected on to others as a means of creating a dichotomy between masculinity and femininity and separating one from the other in interactions. Self-reliance can be considered a male trait, but it may also be part of a woman’s animus. The woman may look for self-reliance more when she is among men than when she is among women, facilitating this difference between males and females.

However, to achieve a whole sense of self, the anima within men and the animus within women need to be balanced. Jung encouraged his patients to get in touch with their other gendered sides (Maddi, 1989). In bringing these archetypes into consciousness, patients could integrate the archetypes into their personality, experiencing the complexity of their personalities. Also, patients who got in touch with their anima/animus were essentially achieving androgyny, which has historically been associated with higher self-esteem and mental health (Hyde, 1991). This theory is revolutionary for the first half of the twentieth century, because the focus of gender is redirected inward. Of course, Jung’s archetypes of animus and anima are based on the subjective cultural norms of his time and location (Young-Eisendrath, 2004). Also, in the development of his theory, he facilitated some use of male-female stereotypes; however, his theory has been endorsed by feminists with minor adjustments to avoid stereotyping.

**Evolutionary Psychology**
Another popular theory of gender role differences stems from evolutionary psychology, also known as sociobiology. This viewpoint suggests that men and women are biologically different in terms of temperament and cognitive ability (Browne, 2006). Males and females are said to differ in the areas of competitiveness, dominance, risk-taking, nurturance and interest in children, spatial ability, mathematical ability, mechanical ability, and verbal ability. Further, the roles of men and women revolve around reproductive success. For men, aggression and risk-taking may make them more attractive mates. Women invest more time in parenting due to the limitations in their ability to reproduce (Archer, 1996). Thus, choices that men and women make regarding their gender roles are a function of their inherent, biological differences. In particular, when it comes to reproduction, these differences are considered paramount to the survival of the species. For men, sperm is constantly available throughout the lifespan; thus, there is a payoff for not being monogamous. For women, eggs are only available for a restricted period of time through the lifespan, providing more of an incentive for monogamy. The sociological and biological components of this notion are the underpinnings of sociobiology (Hyde, 1991).

Mate selection is one area where researchers have found support for evolutionary psychology. Males of all sorts of species have bright feathers, large horns, etc. to both compete with other males and to be considered the best possible choice of sexual partner by females (Kenrick, Trost, & Sundie, 2004). Human males are no exception, and from an evolutionary perspective, they must prove that other men are lesser choices while also presenting themselves as desirable potential sexual partners to women. Hence, there is a lot of pressure to stand out as perhaps the strongest, for example. But, it becomes
difficult to tell the difference between what is actually an evolutionary outcome versus a stereotype. For instance, that pressure to be an optimal sexual partner by looking strong is broadcasted in popular culture as evolution. Such perspectives play into stereotypes that men are aggressive, competitive, and playboys. Women, on the other hand, have a limited time in which reproduction is possible, which usually peaks during the mid-20s (Kenrick et al., 2004). Thus, there is a focus on youth and physical health in women due to the time constraints of fertility. Once again, each sex theoretically has their own interests, which motivate behavior.

Out of the evolutionary perspective and its vast emphasis on mate selection came the Parental Investment Theory developed by A.J. Bateman, based on observations of other species (1948). According to this theory, males are more eager to mate and less selective, thus they are easily prone to aggression toward other males out of the prospect of mating with females. Men want sex, and if another man gets in the way, men are more willing to fight. Females thus have a greater investment in a mating encounter given the burdens of pregnancy and passively select the more outspoken, aggressive male, because he will be a protector for her and the children. This theory has been widely accepted over the past several decades; however, newer research contradicts this approach. Gowaty (2003) asserted that male sea horses spend more time parenting than female sea horses, but male sea horses are still more competitive with other male sea horses for the opportunity to mate. Also, female chimpanzees and langurs, biologically close to humans, solicit sex eagerly but continue to invest more as parents. Thus, the notion that males are more driven by sexual intercourse and invest little in parenting while women are less competitive sexually due to the investment in parenting does not hold up across
species. Further, human males are expected to invest more in parenting in U.S. culture and compared to other animals, and being choosy is an advantage. Despite some of the conflicting evidence of PAI, there is some evidence that supports the evolutionary perspective of gender role orientation. For example, despite within-group differences, males do tend to be more socially dominant than women (Kenrick et al., 2004). Still, human beings are complex creatures with the ability to socially construct cultures that influence biology. It is important to consider the interaction of culture with biology.

**Cognitive Developmental Theory**

Other theories of gender and gender role acquisition focus on cognitive aspects of development. Kohlberg’s Cognitive Developmental Theory contends that children realize in childhood that their gender is fixed and irreversible, thus ascertaining gender constancy (1966). Further, children adopt a healthy gender identity by behaving in ways that are consistent with their gender, and adults and peers reinforce those gender-consistent actions. This cognitive development of gender happens very early. In fact, children as young as two years old can categorize toys on the basis of gender (Levy, 1999). Also, boys begin to imitate masculine activities around 30-32 months of age (Poulin-Dubois, Serbin, Eichstedt, Sen, & Biessel, 2002). Thus children begin to develop ideas about the differences in gender and act accordingly upon recognition of their own genders. However, once gender constancy is attained, people realize that their sex does not change, leading to less of an emphasis on prototypical behaviors of men and women. Men may wear their hair long and women may play sports knowing their sexes will not change as a result.
Gender constancy occurs in three stages. First, boys and girls learn to identify themselves as such, leading to gender identity. Second, people achieve recognition of gender stability, that one’s gender at birth will be the same gender in adulthood. Third, gender consistency is acknowledgement that no matter what people do, dress like, or look like, their gender remains the same (Slaby & Frey, 1975). By the end of the third stage, females learn that there can be police officers who are women, for example, and who still maintain their gender. Likewise, males may be more interested in household chores relative to other men and can still identify as a male.

Unfortunately, the main tenets of Cognitive Developmental Theory (Kohlberg, 1966) do not have much empirical support. Bussy and Bandura (1999) cited research that does not support the association between the process of acquiring gender constancy and gender-typed behaviors. Further, the ability to discern gender role behavior occurs around ages three and four, rather than around age six as Kohlberg hypothesized. Last, gender constancy is difficult to assess, especially among children.

**Gender Schema Theory**

The Gender Schema Theory of Bem (1981) suggested that gender roles and sex typing occur through gender-schematic processing. Schema is a term used to describe an organized cluster of ideas that center around a common theme (Bartlett, 1932). According to Schema Theory (Neisser, 1976), people process incoming information as either part of an existing schema or as part of a different schema. The combination of incoming information and the schema it pertains to influences peoples’ perception. Cognitive availability is a term used to describe how quickly incoming information is
categorized into one schema versus another (Nisbett & Ross, 1980). Gender is considered a paramount societal influence, and people who are sex-typed as either masculine or feminine show more sex-typed cognitive availability than androgynous or undifferentiated people (Bem, 1981). Bem used the term gender salience to describe this phenomenon, akin to cognitive availability. Thus, behaviors, traits, and emotions may be categorized along gender lines for sex-typed individuals while gender- or sex-typing schemata is less salient for androgynous and undifferentiated people. The influence of gender salience also varies by context in that gender identity or sex-typing may be more important in some situations than others.

Gender schemata originate from the early childhood years in which children have a difficult time with abstraction and focus more on concrete, rigid boundaries (Brown, 2010). Typically, children become more open and flexible as they develop. However, due to trauma, cultural norms, and other factors, gender schemata seem to prevail to the extent that they become internalized as part of an individual’s self-concept. Bem (1981) also considered self-concept to be affected by gender-schematic processing. For example, people are more likely to comment on a boy’s strength or a girl’s nurturance, even though a girl may be very strong and a boy very nurturing.

In The Lenses of Gender, Bem (1993) argued that “…because American culture is so gender polarizing in its discourse and its social institutions, children come to be gender schematic (or gender polarizing) themselves without even realizing it” (p. 125). Bem emphasized that masculinity and femininity are culturally constructed and then imposed on children to maintain strict boundaries of roles and expectations between girls and boys. She went on to say that the focus on biological and psychological differences
between men and women is unproductive and called for transcendence of such a focus toward addressing the uses of gender differences as a means to disempower one gender over the other.

**Social Cognitive Theory**

In more recent decades, attempts have been made to synthesize evolutionary and cultural perspectives of gender roles. Social Cognitive Theory is rooted in the notion that there are evolutionarily-based traits that influence social conditions, which in turn influence evolution. People possess certain behavioral potential for things that may be rooted in biology, but culture has an effect on whether or not those behavioral potentials are realized in action (Bussey & Bandura, 1999). Social cognitive theory suggests that gender role conceptualization and behavior are transmitted through both the family and other social systems with which people come into contact throughout the lifespan (Bussey & Bandura, 2004).

Social cognitive theory is a triadic lifespan perspective of gender role acquisition involving the three domains of personal, behavioral, and environmental factors (Bussey & Bandura, 2004). In the personal realm lie biological forces, personal values, standards, and beliefs. The behavioral component consists of gender-typed behavior. The environmental factors are social and institutional influences, which contribute to how people make sense of their gender. Factors in each domain vary in strength and causality at any given time.

According to this theory, gender role orientation develops in three main ways. First, modeling occurs when individuals of a particular gender engage in gender-typed
behavior that younger generations observe and perpetuate. Second, enactive experience involves differential societal reactions to gender-typed activities. For example, girls who play with dolls will be reinforced for such behavior, whereas, boys who play with dolls may be punished and/or perhaps steered toward a different, more masculine-type toy.

Third, direct tutelage is the precise teaching of gender appropriate behavior. Because adults may not practice what they preach, young children may get confused by what is modeled versus what is taught, adding to the complexity of gender role development (Bussey & Bandura, 2004). Overall, Social Cognitive Theory provides a complex framework for gender development, and the authors assert that gender behavior has much to do with the interplay of the individual and the other forces acting on him or her. Because the theory is so complex, however, it is difficult to determine all of the different pathways leading to gender itself and its behavior and cognitions.
APPLICATION TO THERAPY

Historically, women experienced oppression and marginalization in therapeutic settings (Hyde, 1991). More recently, some therapeutic approaches, such as family systems theory, have been identified in feminist critiques as perpetuating male norms that may be adverse to effective work with in counseling (Deinhart & Avis, 1994). In the early days of therapy, the therapist, usually a man, would foster female clients’ dependency on the therapist, keeping authority over women and maintaining the status quo that women belong at home (Hyde, 1991). Male therapists were often seen as father-or husband-figures who regarded female clients’ distress surrounding the conflict of achieving personal goals and making a home to be dangerous and disturbing (Brown, 2010). Early psychoanalysts went as far as to consider women experiencing the work-family conflict to have unresolved penis envy (Bell, 2004). In fact, one study found that therapists generally considered a healthy person to be one that corresponds to normative male traits (Broverman et al., 1970). Chesler (1972) made a comparison between heterosexual marriage relationships and therapist-client relationships. The feminist critique of both relationships was that “…women’s subordinate, inferior position, especially in marriage produces a vulnerability to psychopathology” (pp. 12; Weiner & Boss, 1985). At the time of Chesler’s (1972) work, there were more male therapists than female. Also, women were more likely to seek counseling services and to be diagnosed with depression, as is the case today (Nutt, 2005).

In contrast to this picture of a therapy ridden with unconscious male norms, some have contended the opposite, at least for therapy as conceived in recent decades. R.M. Bergner (personal communication, November 2011) notes that a review of the stated
desirable qualities in the therapeutic relationship shows overwhelming agreement on such qualities as warmth, empathy, unconditional acceptance, and genuineness, all of which date back to the work of Carl Rogers over half a century ago (1957). Turning to the process of therapy itself, Bergner notes further, stress is very frequently placed on things such as the importance of being in touch with one's emotions, on expressing these emotions to others (even when they might be considered "weak" or "vulnerable" ones such as fear), and on being able and willing to engage in intimate verbal communication with important others in one's life. While not questioning the desirability of any of these, he asserts, all of them aside from genuineness (which seems gender neutral) are consistent with values historically more associated with the female than the male gender role.

In response to the disparity between these two views, I would say that while the nature of therapy may be considered feminine in the sense that the desirable traits of therapists and the focus of treatment on emotional expression and building close bonds with others are commonly associated with femininity, it does not mean that gender roles between client and therapist are not in operation. That is to say, even if those qualities are present, one school of thought is that the therapeutic relationship is necessary but not sufficient for change (Beck, Rush, Shaw, & Emery, 1979). Further, therapists may possess all of these qualities and still diagnose more women with depression. The importance of therapist self-awareness and examination of gender role socialization is discussed in the next chapter. In the service of clients, it is truly important for providers to be aware of their gender role socialization and how that may contribute to their conceptualizations of male and female clients (Steigerwald & Forrest, 2004). For
example, and this may be the case among more novice therapists, therapists may use circumlocution to talk about sex with opposite-gendered clients as a result of social norms. By not addressing certain issues directly, clients may be getting a watered-down version of treatment. Further, misconceptualizations of women led and continue to lead to the overdiagnosis of borderline personality disorder, histrionic personality disorder, depression, and agoraphobia (Nutt, 2005).

**Gender Role Orientation and Mental Health**

Androgyny has been found to be associated with higher self-esteem than masculinity and femininity (Hyde, 1991). Whitley (1985) conducted three meta-analyses of 32 studies pertaining to models of gender role orientation in relation to psychological well-being. The androgyny model posited that high degrees of both masculinity and femininity correlate to better life adjustment and lack of depression. Another model, referred to as the masculinity model, posited that a high degree of masculinity and low levels of femininity correlate with better life adjustment and lack of depression. Last, the congruence model posited that adherence to the gender role congruent with one’s gender correlates with better life adjustment and absence of depression. The total number of participants across studies was 4551 women and 2909 men from college settings. The effect size for Adjustment was .109 for masculinity and .030 for femininity. The effect size for Depression was .072 for masculinity and .006 for femininity, with higher scores reflecting less depression. Although no support was found for the congruence model, the results showed support for the androgyny and masculinity models. Interestingly, femininity was not related to depression at all, but femininity was positively and significantly related to life adjustment. Thus, there was partial support for an association
between femininity and well-being, and it would appear that androgynous and masculine
gender role orientations were historically associated with psychological well-being.

Sanfilipo (1994) examined the relationship between masculinity, femininity, and
subjective experiences of depression. The sample was comprised of 63 men and 77
women in college. The results of the study indicated that gender alone was not related to
depression. In fact, greater masculinity and greater femininity were both associated with
lower levels of depression. The two factors associated with less depression were self-
efficacy, more commonly associated with men, and strong interpersonal relationships,
more commonly associated with women. This study highlights the importance of
masculine and feminine qualities as contributors to psychological well-being.

Feminist Therapy

Given the historical framework of the therapeutic setting, a plethora of changes
began in the mid-20th century. Feminist theory began in the 1960s with the ideology that
marginalized groups have more to offer society than mainstream psychology had
believed (Brown, 2010). The transition from theory to practice began with the advent of
consciousness raising (CR) groups in which women would gather and share information
about their oppression and ideas for empowerment. The concept of CR continues to be a
strong component of feminist therapy.

Brown (1994) defined feminist theory as one that came from a political
philosophy and multicultural approach to women and gender. The therapist and client
used gender role consciousness-raising for clients’ personal growth and relationship
growth in and out of the therapy setting. Feminist therapy mainly focuses on the balance
of power with two key concepts, though the concepts are not exclusive to this approach. First, feminist therapists operate in a manner that diminishes any unnecessary imbalance of power. Although the establishment of an egalitarian relationship may not be entirely possible, a focus on egalitarian values in therapy is considered necessary to bring about change. The relationship is one of collaboration, and the therapist and client are encouraged to acknowledge any imbalance of power within their relationship that may result from the therapist’s professional status and the client’s needs. Second, feminist therapists conceptualize presenting concerns in the form of distress or dysfunction rather than psychopathology. In this way, issues that men and women bring into counseling are destigmatized and normalized (Brown, 2010).

In feminist therapy, presenting complaints about clients’ social environments are viewed in the context of a dominant culture in which sexism has not been fully eradicated. Thus, feminist therapists assess and address on an ongoing basis the impact of gender inequality on clients’ lives as related to presenting and emerging concerns assessment phase. Brown (2008) considers feminist therapy as a form of existential therapy, citing that the awareness of social injustice brings clients into the moment of their experiences and helps them regain lost power. Indeed, a main tenet of existential therapy is that existential awareness results in some level of distress, a level that motivates clients to make meaning out of their past, present, and future experiences (Yalom, 1980). Therapeutic work using feminist therapy involves an examination of social hierarchies and power imbalances in addition to problem-solving techniques that can be used to empower (Brown, 1994). The empowerment model of power-sharing in therapy sessions has been empirically validated as distinct from other therapeutic
techniques (Rader & Gilbert, 2005). Feminist therapy also focuses on factors that are commonly associated with healthy outcomes, such as the therapist-client relationship and cultural competence. Furthermore, feminist therapy has been shown to be effective for a wide variety of clientele and power imbalances, such as male feminist therapists working with men or women’s groups in prison settings. One group for which feminist therapy is not recommended is people who lack empathy and derive enjoyment from others’ suffering. The ideas of empowerment and focus on relationships would be an exercise in futility. Still, a feminist therapist can be alert and informed of how the dominant culture may reinforce some of those clients’ behaviors (Brown, 2010).

Although feminist therapy shows promise in its effectiveness, additional empirical research is required for validation. Also, research on diverse populations is also very sparse when it comes to feminist therapy (Worell & Johnson, 2001). Measuring the effectiveness of therapeutic techniques’ effectiveness can be cumbersome, but without empirical validation feminist and gender-sensitive approaches to counseling do not receive recognition and thus do not receive coverage. Thus, there is a both a sociocultural and economic incentive to conduct research on outcomes of feminist therapy patients. In addition, most of the research on feminist therapy has been conducted on female therapists who identify as feminists. However, male feminist therapists do exist and have not received adequate representation in empirical studies (Brown, 2010). The challenge now is to justify the use of a feminist or gender-sensitive perspective by both male and female therapists through research.
Assertion Training

Assertion training is a therapeutic technique that addresses underlying gender stereotypes and gender role socialization in terms of how people relate to one another. The concept of assertiveness came from the civil rights movement and women’s movement in the 1960s and 1970s (Willis & Daisley, 1995). Thomas Harris (1967) identified four ‘life positions’ of how people related to one another. Those positions were: I’m not ok – you’re ok, I’m not ok – you’re not ok, I’m ok – you’re not ok, and I’m ok – you’re ok. He later identified each position as passive, depressive, aggressive, and assertive, respectively. The passive relational style is one in which the passive person allows others to take charge, does not express emotions or desires directly, and shows more respect to the other person than the person has for him- or herself. The depressive style conveys a sense that no one, including oneself, is deserving of respect or has a right to express wants or desires. Aggressive relational styles convey a lack of respect for others as well as a thought process that the aggressive person’s rights and desires prevail over anyone else’s. Finally, assertive styles of relating to others are those in which people maintain respect for themselves as well as the dignity of others, freely expressing rights and desires in a collaborative way, allowing others to do the same (Willis & Daisley, 1995).

Gender role socialization impacts people’s relational styles. Men have been stereotyped to be more aggressive communicators, and women have been stereotyped to be more passive (Brovermen et al., 1970). The goals of assertion training include developing a belief system involving high regard of one’s self and others, recognizing and changing irrational beliefs and self-statements that enhance anxiety or anger,
reducing excessive anxiety or anger, developing a wide repertoire of assertive responses in social situations, and enhancing self-regard (Whiteley & Flowers, 1978). Once appropriate goals are outlined, trainers and clients engage in an assessment and intervention of nonverbal behavior and thought processes that contribute to relational patterns. This type of training contains abundant use of modeling and role-plays to guide clients toward assertion. Role-plays may include, but are not limited to starting and maintaining conversations, saying “no” and expressing emotions appropriately (Alberti & Emmons, 2008).

Assertion training has been used in a wide variety of settings and is even becoming a normal part of professional training in businesses. Therapists can conduct assertion training with clients, but it is more commonplace for clients to receive this intervention in a group or workshop format. Still, trainers should make modality decisions based on the needs of the client (Alberti & Emmons, 2008). Some groups are single-gender while others are mixed, and there are benefits and limitations to both types. One concern is that due to gender role socialization, men in mixed-gender groups may dominate conversation, offering fewer opportunities for women to practice assertion (Willis & Daisley, 1995). On the other hand, some practitioners have stated that mixed-gender groups offer a more accurate reflection of real life. And group members can be helpful in providing critical feedback, which may be damaging to rapport in individual sessions (Alberti & Emmons, 2008).

This type of intervention has been effective for a number of populations as well. Assertion training groups have been shown to be an effective component in the treatment of substance abuse, domestic violence issues for victims and perpetrators, gender role
conflict, and business management (Dupree & Schonfeld, 1996; Kidder, Boell, & Moyer, 1983; Saunders, 1984; Brecklin & Ullman, 2005; Wheelan, 1978). The effects of assertion training have been discussed in terms of an enhanced ability to resolve conflicts openly, an increase in confidence and self-esteem, enhanced competency to handle highly emotional situations, and retention of dignity for all parties (Willis & Daisley, 1995).

**Gender-Sensitive Approaches**

Feminist therapy and assertion training are not theoretical orientations or techniques geared toward women only. Effective therapeutic work with women and men in therapy involves a blending of approaches and techniques. Because women tend to communicate as a means of connection and men as a means of imparting information, therapy for women may focus on reporting feelings and needs, and therapy for men may focus on behaviors and verbal communication that enhance intimacy (Forrest & Steigerwald, 2004). Also, a thorough understanding of masculinity and societal expectations are necessary components for therapeutic work with men. Kierski and Blazina (2009) identified the term Fear of the Feminine (FOF) to explain the fear and defensive reactions that males tend to have about femininity. The authors attributed FOF to the perceived loss of power that is associated with femininity. This concept is also associated with a term called normative alexithymia, the inability to describe or stifling of emotions as a defense mechanism against appearing feminine. Stoicism and alexithymia can happen in therapy, which is feminine in concept given the focus on relationships and sharing of feelings, as means of gaining back lost power. Kierski and Blazina suggested that gender-sensitive therapy work with men should take an existential approach with respect for these types of defenses. They identified many complex concerns that men
have related to their gender role expectations, including isolation, pain, real or perceived lack of success as defined by culture, and lack of control. Additional techniques for working with men are discussed below in the context of couples and family counseling.

**Gender in Different Treatment Modalities**

Gender can also be addressed in therapy modalities other than individual therapy, such as couples and family therapy. For many heterosexual couples, the two people enter into a relationship with preconceived and mostly unconscious ideas about the roles each will play in a romantic relationship. Indeed couples that show flexibility with gender roles tend to fare better than those who rigidly adhere to them (Knudson-Martin & Laughlin, 2005). Without bringing these ideas into awareness, many issues go unacknowledged and thus create conflict.

Early forms of couples and family therapy contained several myths between men and women. Knudson-Martin and Laughlin (2005) identified those myths as (1) an assumption that individuals can make choices regardless of social forces, (2) both parties are equal in a relationship, (3) male and female roles are normative standards, and (4) therapists can be neutral. New multicultural models were then compared to white male models, creating “otherness” between different theoretical approaches to couples and family counseling. Recently, however, traditional approaches have moved to models of inclusion that add gender sensitivity and power imbalance consideration into the therapy atmosphere.

According to Nutt (2005), the couples therapist should facilitate an environment free from blame and also model empathy and flexibility. She suggested that therapy
begin with an examination of gendered experiences in the past and steer clear of emotional hot spots early on in counseling. Careful examination of messages from family, peers, and media in early childhood experiences creates a context for dealing with the presenting problems. For women, presenting problems may appear as depression, anxiety, eating disorders, and somatic complaints. Men may present with problems related to violence or self-destruction, because anger appears to be the only socially acceptable emotion for men (Knudson-Martin & Laughlin, 2005). The therapist acts as a supporter of both women’s empowerment and men’s expression of emotion. Nutt also encouraged couples therapists to do an activity in therapy in which couples learn to interview one another to open a dialogue that builds empathy and acceptance of their experiences.

Bowenian therapy was criticized for a long time by some but not all interpreters due to the concept of differentiation, placing a seemingly androcentric emphasis on individuality as the standard for mental health, possibly at the expense of relationships (Silverstein, 2005). However, Silverstein integrated Bowenian techniques into feminist therapy, arguing that differentiation means a balance of interpersonal connectedness and individuality. Because couples are not immune to societal influences about gender roles, their problems can be seen as systemic rather than personal. The unspoken expectations about gender behavior can create an atmosphere of criticism and blame, toxic to most relationships.

For women, Bowenian therapy has several benefits. In working alone with a therapist, as is the case in most uses of this approach, women are free from any pressure to focus on their partner’s needs in therapy. Thus they can turn the focus onto themselves
by devising a plan of action and anticipating possible negative responses to the change in behavior (Silverstein, 2005). For example, a woman may voice a feeling of frustration because her partner leaves items scattered about, leaving her to clean up after him. After discussing the implications of having a messy home, the woman can prepare herself to not pick up after him and see where that behavior change leads. For men, often the focus of therapy is the conflict between being a provider and being a good partner in the present (Silverstein, 2005). A word of caution for this type of approach to couples counseling is that the goal is not to change someone else by working with their partner. The person in therapy must decide to make those changes with awareness, preparation, and acceptance that nothing may change on the part of the other person.

Within the realm of working with families, Hampton and Gottlieb (1997) asserted that, “Gendered behavior is learned within the context of family interaction through clear role expectations and proscriptions that may encourage or inhibit individual growth and development” (p. 50). Within a family systems approach, gender role expectations play an important role in a family’s response to stressful situations. Because of its focus on power imbalances as a fundamental attribute of family dysfunction, structural family therapy may be appropriate. One basic assumption with this type of therapy is that both men and women suffer as a result of their gender role socialization. By identifying how gender role expectations affect every member, entire families can be treated effectively with gender-sensitive structural family therapy. One way to address power in familial relationships is to reframe being powerful in terms of the power to care for others and the power to connect (Deinhart & Avis, 1994). When working with men, it may also help to
broaden and include work life into addressing family problems as a means of engagement for fathers in therapy.

Overall, the literature on addressing gender role expectations in therapy show several themes that can serve as guidelines for practice. First and foremost, therapists should always be aware of their own gender socialization and the impact it has on treatment (Deinhart & Avis, 1994; Knudson-Martin & Laughlin, 2005). Knudson-Martin and Laughlin also suggested that therapists consider the interpersonal context of clients as well as how clients construct themselves. Nutt (2005) also emphasized the traditional empathy, unconditional positive regard, and genuineness as essential for addressing gender in therapy.
ETHICAL AND PROFESSIONAL ISSUES

When working with clients and considering gender, ethical and professional issues are abundant. Historically, the origins of therapy was such that there were more male therapists than females, and women were more likely to seek therapy due to the tendency toward expressiveness that was discussed in the assessment section (Weiner & Boss, 1985). Although the former is not the case today, in the past therapists were more authoritative in practice. This imbalance of power has been recognized as a contributor to the over diagnosis of certain disorders among women that was discussed in the application to therapy section (Nutt, 2005). Weiner and Boss identified several myths about gender in individual and family therapy. First, staying in a marriage was thought to be the best outcome of early couples therapy. Now, couples enter into therapy with the disclaimer that staying together may not be the end goal. Second, in both individual and couples therapy, women’s careers received less attention. Third, issues with children were considered the mother’s responsibility. Fourth, extramarital affairs were handled in manner that created a double standard; men were forgiven for their indiscretions while women were castigated for them. And last, the needs of the husband tended to outweigh those of the wife. Of course, with time these myths have dissipated, but vestiges of them do appear sometimes in therapy sessions. Ethical and professional considerations will be discussed in the following paragraphs in terms of explicit principles, self-examination, specific issues that come up in counseling, and how to overcome ethical obstacles.

**Ethical Principles Pertinent to Gender**
Despite the long list of ethical principles that apply to the therapist-client relationship, Steigerwald and Forrest (2004) outlined five basic principles stemming from multiple professional organizations for mental health professionals. First, therapists should work to maintain client’s autonomy. Therapists have a responsibility to clients to ensure that clients have the freedom to choose and act in any way they please (Weiner & Boss, 1985). Second, and perhaps the most important, is that therapists have a duty toward non-maleficence or to cause no harm (Steigerwald & Forrest, 2004). This particular principle becomes even more complex when working with couples and families. In some states, therapists are legally responsible for reporting abuse of any person (Weiner & Boss, 1985). In addition, some theoretical approaches suggest a strategic position of neutrality while working with couples. In terms of social responsibility, the stance of neutrality may be tacit approval or maintenance of a status quo of abuse. That is not to say that a neutral stance promotes abuse, but in the case of clinicians who are new to the field or the concept, inaction may be mistaken for neutrality (Hampton & Gottlieb, 1997). Third, aside from the agreement to do no harm, there is the principle of beneficence, promoting the growth and well-being of the client (Steigerwald & Forrest, 2004). When considering again the concept of neutrality, it is pertinent to ask the question of whether or not it is in the best interest of the client to take sides on the issue of abuse (Hampton & Gottlieb, 1997). Fourth is the principle of justice and fairness. This principle goes beyond how much to charge clients and into the realm of power and how power imbalances play out in therapy. Last, therapists have a responsibility to maintain fidelity by means of keeping promises (Steigerwald & Forrest,
Maintaining promises to clients, aside from being a question of ethics, shows that the therapist has a certain level of integrity and competence (Weiner & Boss, 1985).

Worell and Remer (2003) stated that although most therapists attempt a collaborative egalitarian relationship, therapists still hold some power over clients resulting from the services provided. Clients are dependent on therapists for counseling itself. Power differentials continue to exist and affect gender discrimination in therapy. The authors contended that effective treatment in a male therapist-female client dyad is the most difficult due to power inequality related to gender. Therapists have an obligation to clients to be aware of and work to fix discriminatory practices within the counseling relationship. Smith (1980) asserted that clinicians promoted sex-role stereotypes by using a framework of acceptance and adjustment rather than addressing gender stereotypes. As a result, clinicians are responsible for learning about societal stereotypes and understanding how stereotypes infiltrate clinical practice. Therapists should be aware of their clients’ needs, without fostering dependence and family orientation in female clients.

**Self-Examination**

Perhaps one of the most important and most mentioned ethical tasks is self-examination. Steigerwald and Forrest (2004) assert that ethical behavior in working with gender role expectations in counseling begins with knowledge and self-examination. Therapists are not immune to gender socialization while growing up. Experiences with gender mold their expectations and affect how they react to clients, mostly in terms of how power is perceived and in the ability to engage in meaningful therapeutic
relationships (Hampton & Gottlieb, 1997). Usually, biases regarding women, men, and relationships appear in the form of countertransference, which are feelings and behaviors evoked in the therapists as a reaction to the client, though the client may not have been the exact catalyst for such a reaction (Erickson, 1996). An example of this type of countertransference could be a feminist therapist who has not sufficiently dealt with her own feelings about men acting overly-confrontational and dismissive of a male client’s concerns. When this happens, it is a good time for self-examination on the part of the therapist.

Several self-examination remedies to countertransference and gender role expectations in counseling settings are offered. Erickson (1996) suggested monitoring physiological arousal during sessions. Perhaps there are times when the therapist experiences an increase in heart rate or begins to sweat, reactions that are not clearly warranted by the interaction. Also suggested is the use of a journal following therapy sessions. Therapists should write about the experience with the client and any issues that arise as a result. In the same vein, tape-recording sessions is also a valuable self-examination tool when sessions get off track.

Regardless of whether or not countertransference has occurred yet or not, there are still special considerations to which therapists should attend. The gender of the therapist should be considered, especially when working with families. Likewise, the impact that therapy has on reinforcing destructive social norms and expectations should be met with awareness on the part of the clinician. In terms of diverse populations, sexual orientation, culture, and level of development should also be contemplative tasks undertaken by therapists (Forrest & Steigerwald, 2004). Because gender roles and
awareness change with the times, clinicians need to ensure they have received appropriate and continuous training. Education about gender sensitivity goes beyond effectiveness; clinicians need to be able to explain their position to clients.

**Professional Practice Considerations**

There are a few other aspects of professional and ethical practice pertinent to gender roles. First, the education and theoretical orientation of the therapist plays a role in therapy. As clinicians, it is our duty to know how gender roles are constructed and to choose the most appropriate form of treatment for clients (Steigerwald & Forrest, 2004; Hampton & Gottlieb, 1997). Clinicians working with couples and families also need to be aware of the additional ethical demands of working with multiple clients at one time. Indeed, certain theoretical approaches involve a stance of neutrality on the part of the therapist, which may put clinicians in an ethical dilemma when abuse is present in relationships. Of course these theoretical approaches do not condone abuse, but abusive scenarios certainly put demands on treatment that need to be met with a level of theoretical flexibility (Hampton & Gottlieb, 1997). Last, Erickson (1996) provides some tools and considerations for working with men in therapy. Some feminist therapists run the risk of marginalizing and devaluing men in the same way women were in the past. This behavior only perpetuates male stereotypes and blames men for what they are taught to do rather than challenges norms and expectations. Clinicians need to be conscientious about choosing the most effective gender-sensitive approach without enabling abuse to continue and devaluing male clients.
With all of the ethical and professional demands put on therapists to ensure that the ethical principles outlined above are met, therapists need to know what to do to address and resolve gender role issues. Aside from self-monitoring, clinicians should obtain information by consulting with colleagues, either informally or in supervision, and read current literature on the topic at hand (Steigerwald & Forrest, 2004). If problems continue to arise in sessions or in supervision, therapists should seek personal therapy for themselves (Erickson, 1996).

**Ethical and Professional Obstacles**

Knudson-Martin and Laughlin (2005) identified eight major obstacles to maintaining ethically and professionally sound practice. A lack of flexibility in viewing gender and sexual orientation has the potential to cause harm to clients, as these concepts are in some instances damaging to persons. Also, personalizing sociocultural issues creates a therapeutic “blind spot” for therapists. If these issues cannot be dealt with through self-monitoring and supervision, personal counseling is recommended. Even the most gender sensitive clinician runs the risk of reinforcing old constructions of gender, which is why continual education is a necessary component of ethical practice. Another obstacle to addressing gender in counseling is minimizing within-group differences and failing to see between-group similarities. Also, a stance of neutrality, as is the case with some forms of family therapy, does not mean therapists should take a stance of inaction by not addressing power imbalances in family relationships. Likewise, ignoring the differences in power that operate between men and women may maintain a status quo of inequality. Though it will be discussed in detail in subsequent sections, therapists should not assume that lesbian and gay couples do not experience complications when it comes
to gender role expectations. The final major obstacle to overcome for adequate ethical and professional practice is to acknowledge that issues of gender roles are not old issues. With these concepts in mind, therapists will be on the path to handling any ethical or professional issues in an effective manner.
CHAPTER VI

CULTURAL CONSIDERATIONS AND DIVERSITY

Most research over the decades has focused on traditional white middle-class American women and heterosexual gender role norms and expectations. There are several cultural considerations to take into account when addressing gender in research and practice. First, there are racial and ethnic differences in regard to gender and research points to holes in both empirical study and treatment of psychological illness with these populations. In addition, there is also a complex interaction of gender and sexual orientation that plays out in role expectations. Other forms of diversity, including religion, physical disability, and multiple minority status are rarely addressed but will be highlighted here as well.

Ethnic Minorities

Ethnic minorities are only one example of the ways cultural differences interact with gender. Many ethnic groups work to balance their cultural heritage and combat racial oppression simultaneously. The gender role norms of African American women stand out from those of white culture for two reasons. First, African American women play a greater economic role than white women within families. Second, African American culture is well known for the strong bond between mother and child (Hyde, 1991). Family and economic independence are marked features of this group. In
addition, African American heterosexual families tend to be more egalitarian than white families. African American men face higher rates of unemployment than white and Hispanic men, putting a gender role strain on African American men due to the emphasis on being a breadwinner the dominant U.S. culture. Studies have shown that middle-class African American men participate more in parenting than white men (Hyde, 1991). These are just a few general examples of cultural considerations to reflect upon in therapy sessions with this population.

For African Americans and their families, the experience of discrimination is also impacted by gender and gender role expectations. Riina and McHale (2010) studied the effects of racial discrimination on family relationships by gender among 156 African American families. Mothers, more so than fathers, tended to view familial relationships as supportive in the face of discriminatory experiences. The authors of the study attributed this difference to the notion that mothers, as caretakers, have a more scripted role; thus, their family lives are less disturbed by racial discrimination. On the other hand, Hyde (1991) said that family plays an important role among African American women. Thus, in the face of discrimination, it is possible that African American women redirect their energy into family. Interestingly, for fathers there was also a positive relationship between the experience of discrimination and building bonds with children. Perhaps fathers who experience prejudice reach out to their children with warmth and use the experience as a teaching and bonding moment (Riina & McHale, 2010). Further, men who exhibited more instrumental traits were more likely to use problem-focused coping skills. However, because discrimination is out of the realm of things one can control,
instrumental traits were negatively associated with positive familial relationships (Riina & McHale, 2010).

African American women show both unique and similar conceptualizations of femininity and feminine roles relative to White, European American women. In a telephone survey of 1130 African American and European American women, both groups identified the same three dimensions of femininity as the dominant cultural characteristics of femininity: feminine appearance, feminine behaviors, and traditional gender role ideology (Cole & Zucker, 2007). Differences were found, however, in that African American women were more likely to identify as feminists and to be more assertive while European American women were not. In contrast to what one might expect given that information, African American women also indicated feminine appearance as being more important to them than European American women did. These results provide support for consistent research reporting African American women as more androgynous than white women in that they report higher levels of assertiveness, traditionally associated with masculinity, and value certain aspects of femininity, such as beauty (Hyde, 1991). Thus, a major ethnic difference between the two groups lies in the enactment of traditional gender roles and beliefs behind them. Another study examined 380 African American and European American mothers’ experience of psychological distress in relation to multiple roles. The roles examined were those of worker, wife, and mother. There were few differences in terms of the intersecting roles. Both groups experienced significant psychological distress if they were unable to balance working with parenting (Davis, Sloan, & Tang, 2011).
Wester, Vogel, Wei, and McLean (2006) examined the relationships between racial identity, gender role conflict, and psychological distress among 130 African American males. Racial identity partially mediated the relationship between gender role conflict and psychological distress. African American males who exhibited more internalized racism were more likely to experience symptoms of anxiety and depression when attempting to navigate situations in which gender roles were called into question.

On the other hand, men who acknowledged and were involved in the preservation of their cultural heritage experienced less distress in defining their particular gender roles. For African American men and women, the dominant U.S. culture may seem oppressive in that some of the social prescriptions for men and women do not align with African American cultural norms.

Traditionally, Latin American men and women have had rigidly defined gender roles and expectations (Hyde, 1991). Although there are within-group differences, generally speaking, there are two main concepts paramount to the enactment of gender in Latino/Hispanic culture. Machismo is a term used to describe masculinity of Latino men. This concept was historically a negative stereotype, indicating aggression and chauvinism, but there is a more recent push culturally and in research to emphasize that machismo is more about honor and family (Cruz et al., 2011). Men are expected to bring honor to the family, serving as the breadwinner. Marianismo is the female role prescription, stemming from the Catholic worship of the Virgin Mary. Women are expected to be self-sacrificing and to focus on motherhood (Hyde, 1991). Machismo and marianismo can be found in extreme forms, but they are usually more subtle and complex.
Ojeda, Rosales, and Good (2008) examined gender role attitudes among 130 Mexican American men. The majority of the participants held traditional gender role beliefs that men should pursue status, act tough, and be anti-feminine. Interestingly, this study also examined the role that socioeconomic status played in gender role attitudes. In particular, socioeconomic status was positively correlated with beliefs that men should be physically strong and should not behave in characteristically feminine ways. Also, adherence to traditional Mexican cultural values was also positively associated with more rigid gender beliefs.

Given the cultural push to not seem weak, it makes sense that some men may not pursue counseling (Ojeda et al., 2008). Shattell, Hamilton, Starr, Jenkins, and Hinderliter (2008) used focus groups to address the disparity of Latino men and women who seek counseling compared to other ethnic groups. The focus groups were comprised of seven members who were both providers and consumers of mental health treatment all from different Latin American countries. The group highlighted that because Latino men were reluctant to talk about emotional distress and considered themselves to be breadwinners over parents, they experienced very little social support. Group members attributed higher rates of alcoholism, substance abuse, and violence to this cultural norm. Latina women also seemed to have lower rates of going to counseling. Group members explained that more Latinas in the U.S. are working outside the home than in previous generations but tasks within the home have changed very little. Despite being overwhelmed, Latina women seemed to feel guilty about seeking help, seeing counseling as a distraction from their obligations.
The intersection of culture and gender has been difficult to navigate for men and women. Because there has been a shift in focus from research on the harms of hyperfemininity to the harms of hypermasculinity, there is more literature available on how culture and gender interact for men. Pompper (2010) found that pride is a major contributing factor in masculinity for men of color. Still, men of different ethnicities define their masculinity in diverse ways. For example, Asian American men said that masculinity has less to do with physical toughness and more to do with pride. Another study found that Asian American men who adhere to Asian values experience more gender role conflict and psychological distress in U.S. culture (Liu & Iwamoto, 2006). Also in Pompper’s study, Hispanic men indicated that they considered masculinity to be more about taking responsibility for the community and morality than being the breadwinner. This result provides some explanation for Shattell et al.’s (2008) explanation that Hispanic men focus on earning money over other roles; they conceptualize their role as one of responsibility for the community.

Another important area to examine within the realms of ethnicity and gender is that of emotional expression. Durik, Hyde, Marks, Roy, Anaya, and Schultz (2006) compared gender stereotypes regarding expectations of emotions across four ethnic groups. Each group of participants consisted of roughly 50 to 100 people and was comprised of European Americans, African Americans, Hispanic Americans, and Asian Americans. The largest gap between men and women in terms of gender stereotyped emotions was among European Americans. There were not many other differences across cultures except for a few. African American women were expected to express more interest in others than men. Also, Hispanic American women were expected to
experience more shame, while men were expected to experience more pride. Across all ethnic groups, women were expected to experience and express more fear, guilt, love, sadness, shame, surprise, and sympathy than men.

**Sexual Orientation**

Aside from ethnicity, sexual orientation is another valuable consideration when evaluating gender roles. This area is becoming even more salient given the increased focus on bullying in elementary, junior high, and high schools, much of which is directed at lesbian, gay, bisexual, transgender (LGBT) children or children perceived as LGBT. Parrott (2009) suggested that hate crimes against LGBT individuals were motivated by a desire on the part of perpetrators to enforce gender roles. Indeed, it does seem that the dominant U.S. culture does not know what to make of LGBT people in the context of traditional gender roles. A study of 287 men and women was conducted by having participants evaluate a domestic violence vignette that takes place between a lesbian couple (Little & Terrance, 2010). Women tended to consider the incident more dangerous than participants who were men. In addition, women tended to assign more blame surrounding the situation to feminine-looking perpetrators than to the victims, regardless of masculinity or femininity. The authors attributed this result to the idea that acting out violently is in direct contrast to traditional feminine norms; thus, female participants tended to place more blame on the feminine-looking aggressor. Further, masculine-looking victims were assigned more blame than feminine-looking victims, playing into the notion that masculine people should have more power and be more aggressive. Certainly the results of this study highlight the heightened ambiguity of
gender roles and domestic violence among LGBT people as compared to a traditional male perpetrator-female victim scenario.

People who are lesbian, gay, bisexual, and transgender often experience an invisible prejudice. Many clinicians lack the competency to work with LGBT clients because the field lacks appropriate research behind effective practices with this population (Scrivner, 1997). Researchers and clinicians should take these results into consideration when working with LGBT individuals. Martinez, Barsky, and Singleton (2011) asserted that there is an increase in positive attitudes among clinicians working with LGBT clients, but clinicians continue to struggle with sexual orientation and traditional gender roles with clients.

Additional Considerations

Although ethnicity and sexual orientation are two main components to consider when working with diverse populations, it is important to remember that there is something different about everyone. As psychological science shifts to more diverse and multicultural approaches to research and applications, the status quo is also redefined. Funk and Werhun (2011) have conducted research on men’s experiences of gender role harassment. Particularly, they studied the reactions of men following a statement such as “like a girl” directed to them to gauge the effect of those statements on subsequent behavior. Although their study did establish that men who experience this type of harassment tend to engage in ultra-masculine behavior immediately following the incident, additional research is necessary to address the experience of the loss face and the effect that has on stereotypically masculine behaviors of aggression and risk-taking.
Men are not the only population in need of attention from gender role researchers. Disability status is a rather neglected area of research in the context of gender role expectations. Beigi and Cheng (2010) underscored the impact that disability has on the pressure to adhere to traditional gender roles. For example, men with physical disabilities often experience psychological distress as a result of not being able to be the breadwinner of the family. Another cultural consideration is that of religion, because even among the dominant Protestant religions there is a wide array of gender role disparities depending on the denomination and type of congregation (Edgell & Docka, 2007).

Gender affects everyone and should not be considered a white, heterosexual, female issue. The information provided here represents an overview of just some of the respects in which individuals differ, and the goal is to use this research to inform treatment practices. Gender role expectations are a salient issue among all cultures and backgrounds. Along with people at different developmental stages and genders, sexual minorities also need to be included in research on gender role socialization. In addition, ethnic minorities, a range of socioeconomic statuses, and disability status are not well represented in the literature on gender role expectations (Worell & Johnson, 2001).
CHAPTER VII

RESEARCH CHALLENGES AND NEEDS

Despite decades of research and attention, gender role expectations and conflicts continue to require attention as they evolve with the culture and times. The theoretical backing of research has also been called into question. Oftentimes theories of either a person-centered or situation-centered approach have been the backbone of certain research methodology. Currently, there is a calling for an interactionist model of person and situation to serve as the theoretical driving force behind research and to control for bias in methodology (Russo & Tartaro, 2008). Even though the challenges and needs in this area are many, a few more pressing ones will be outlined in the following paragraphs. One of the most pressing challenges in gender role research today has to do with methodology. Within the study of epidemiology, there are biases in the reporting of rates of certain mental illness that are affected by gender (Russo & Tartaro, 2008). Mainly, the gender rates for different disorders are confounded by societal norms that promote help-seeking behavior in women but not among men. Thus, one large barrier to a true understanding of epidemiological analyses stems from not taking that variable into account.

In addition to epidemiological research, there is a need for different types of data. At present, most data regarding gender roles comes in the form of self-report. Zosuls,
Miller, Ruble, Martin, and Fabes (2011) reported that survey data is most commonly used followed by experimental, observational, content analysis, qualitative, and transcription designs. However, even with all of these other data collection options available, researchers still turn to self-report, because it is less time-consuming, labor-intensive, and cost-effective. The problem is that the data afforded by surveys and questionnaires cannot be used to establish causality. Also, self-report data is subject to greater demand characteristics during collection. Participants’ answers are more likely to change as a function of whether they can tell what is being measured. Thus, it becomes more difficult to attribute results to the theoretical background of the measurements versus confounding variables. Zosuls et al. (2011) called for additional longitudinal and causal data, despite the higher cost and labor involved. One way to address issues of methodology is by using a research design that incorporates quantitative and qualitative designs. Such an approach would account for the limitations that are associated with both kinds of designs (Kierski & Blazina, 2009). In addition, more complex forms of self-report data could be used. Zosuls et al. (2011) suggested development and use of measurements that tap into deeper processes of gender, relying less on stereotypes.

Zosuls et al. (2011) summarized the history of research on gender and gender role development. Aside from a need for more reliable methodology, the researchers noticed an age group gap. Although research with young children is becoming more popular, the amount of data on this population is smaller than the amount for older people. One reason for the age gap is that university students tend to be the most accessible population for academic research, and populations of children require more safety precautions (Zosuls et al., 2011). However, it is important to study young children, because they are
able to discern differences between faces of men and women and categorize items based on gender (Levy, 1999). Their conceptualizations about gender seem to begin very early and serve as the foundation for their gender role expectations. Yet, research has mostly focused on adults with a slight shift into adolescence. Much of the research on adolescents has dealt with family and media influences (Zosuls et al., 2011). There is a need for additional research regarding the influence of peers on gender role socialization, as most children begin to spend more time with friends around mid-adolescence.

To train therapists in awareness to the ways in which gender issues present themselves in therapy, the Gender Discourse in Therapy Questionnaire (GDTQ; Keeling, Butler, Green, Kraus, & Palit, 2010) was created. The GDTQ is a 13-item open-ended questionnaire designed to tap into specific processes related to gender, such as open discourse about gender, use of language in sessions, and the shifts of power in sessions. The questionnaire was devised out of an acknowledgement that many therapists’ opinions about what goes on in sessions diverges considerably from what clients believe happened. In terms of gender, this questionnaire prompts therapists to think about nuances of gender. It is designed to be used as a training tool but requires additional follow-up studies to be established as a legitimate tool in training programs.

As Russo and Tartaro (2008) pointed out, popular culture often dictates popular research. In setting an agenda that brings gender roles into awareness within the culture, there will be a greater demand for more accurate research on gender roles.
CHAPTER VIII

CONCLUSION

In this paper, I have reviewed several aspects of gender roles and expectations that influence both research and clinical practice. In the Assessment Section, I discussed the changes in conceptualizations of masculinity and femininity, highlighting different self-report measures. Then, I summarized different theoretical approaches to gender, including psychoanalytic theories of Freud and Jung, evolutionary psychology, Cognitive Developmental Theory, Gender Schema Theory, and Social Cognitive Theory. In the Application to Therapy section, I discussed the evolving nature of therapy from an activity that was once sexist to one that is female normative. Approaches to therapy were also addressed and include feminist therapy, assertion training, gender-sensitive techniques, and couples and family therapy. In the Ethical and Professional Issues section, I highlighted ethical issues and obstacles to consider related to gender. In the Cultural Considerations and Diversity section, I discussed the intersection of gender and ethnic diversity as well as sexual orientation. Finally, I addressed some of the challenges in research and future directions.

As clinicians and researchers, we should continue studying the psychology behind gender as a concept that evolves and changes. Historically, femininity has been devalued in the dominant U.S. culture. But, in the past decade, the focus of research has changed
toward studying masculinity in relation to mental health. With the knowledge that psychological androgyny, which involves high levels of masculinity and femininity, is associated with higher self-esteem (Hyde, 1991), it is fair to say that there are adaptive and healthy qualities of both gender orientations. Future research should focus on finding empirical support by using methods other than self-report, as there is an imbalance in data using this type of assessment. It should also examine gender roles in terms of mental health and well-being. Also, therapist training and theoretical approaches may consider adopting interactionist perspectives of biology and culture. There is still a long way to go both empirically and professionally to comprehend fully the impact of gender roles and expectations on micro- and macro-levels.
References


