7

Strategies for Dealing with Sex-role Stereotypes

IRIS FODOR AND
ESTHER D. ROTHBLUM

Sex role stereotypes refer to general beliefs about the nature of women and men. When asked to describe typical characteristics of women and men, people tend to describe women as warm and expressive, men as rational and competent (Deaux, 1976). Whereas such personality traits might accurately describe many people, they exclude a significant proportion of the population.

Mental health professionals have not been immune from the use of stereotypes to characterize their clients. In a now-classic study (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970), mental health professionals were asked to describe either a healthy man, a healthy woman, or a healthy person. The characteristics used to describe a healthy man and a healthy person were nearly identical, whereas the opposites of these characteristics were used to describe a healthy woman. Thus, it is difficult, even in the eyes of trained professionals, to regard a person as both healthy and female.

A decade later, texts on women in therapy are continuing to report sexist practices by psychologists toward female clients (Howell & Bayes,

1981; Rawlings & Carter, 1977). Themes involving sexism in the Report of the Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice conducted in 1974 (Brodsky & Holroyd, 1981) include the following: (1) the therapist fostering the traditional sex role, by advocating marriage, housework, or childrearing for women, and deferring to the husband's needs in therapy; (2) devaluation of women via sexist jokes, demeaning comments, or inaccurate labels to describe women; (3) sexist use of pyschodynamic concepts, such as "penis envy," "vaginal orgasm," or "castrating female"; and (4) responding to women as sex objects or seducing female clients.

Similarly, feminist psychopathologists (e.g., Franks & Rothblum, 1983) have stressed the interrelationship between certain types of mental disorders and the feminine sex-role stereotype. As Table 7.1 indicates, classifying DSM III disorders as "male" or "female" as a function of which sex is more prevalent provides a virtual caricature of the male and female sex-role stereotypes; whereas men prevail among the antisocial, "acting-out," "tough" disorders, women are more frequently depressed, anxious, unassertive, and passive.

As societal roles for women are changing and women are struggling to adapt their own history of socialization to the new norms, it is the authors' belief that therapists are increasingly faced with three categories of female clients. First, there are women who seek therapy because they respond to

TABLE 7.1 DSM III Disorders Grouped by Prevalent Sex

Women Predominate	Men Predominate
	Axis I Disorders
Depression	Alcoholism
Agoraphobia	Drug abuse
Sexual dysfunction	Antisocial behavior
Simple phobias	Paraphilias
Anxiety states	Transsexualism
Somatization disorder	Factitious disorder
Multiple personality	Pathological gambling
Psychogenic pain disorder	Pyromania
	Intermittent explosive disorder
	Axis II Disorders
Histrionic personality disorder	Paranoid personality disorder
Borderline personality disorder	Antisocial personality disorder
Dependent personality disorder	Compulsive personality disorder

stress with passivity and dependence, as they were socialized only too well to do. Such clients present symptoms of depression, agoraphobia, sexual dysfunction, and anxiety states. Second, clients may seek therapy because they do not fit the feminine stereotype and wish to conform to society's standards of the ideal woman. Thus, women are overrepresented among clients seeking help for being "undesirable" as a result of being "too fat," "unattractive," "too old," or "without a man." They seek help to become more like the stereotype—thinner, attractive, and marriageable. Finally, a third group of clients seeks out therapy in response to the feminist movement and to overcome their original sex-role programming. This group often desires assertion training or coping strategies for the work setting or dealing with untraditional life styles as well as stress management training.

This chapter will discuss each of these categories of female clients by focusing on one representative disorder. Thus, clients presenting symptoms of agoraphobia, obesity, and lack of assertion will be described as they reflect the overly stereotyped woman, the woman wishing to conform more to the stereotype, and the woman wishing to conform less to the stereotype, respectively. The authors are aware that therapists differ in theoretical orientation and are knowledgeable about intervention strategies to decrease the *clinical* symptoms of these disorders. Thus, we will focus only on the components of these disorders that are the result of sex-role socialization. We will similarly provide feminist therapy intervention and prevention strategies for dealing with sex-role stereotypes.

OVERLY STEREOTYPED WOMEN: AGORAPHOBIA

The Broverman et al. (1970) research portrays the healthy woman as emotional, submissive, excitable, passive, home-oriented, tearful, dependent, and not at all adventursome. These terms are equally descriptive of women who come to therapy with phobic disorders. Agoraphobia is the most prevalent phobia and is essentially a female disorder; 85 percent of agoraphobics are women (Fodor, 1982a). In fact, agoraphobics score at the most stereotypically feminine end of the sex-role stereotyping questionnaires (Jassin, 1980). Agoraphobia has often been referred to as the "housebound housewives disorder" due to the high incidence of young married females reporting the syndrome (Brehony, 1983). From clinical discussions several patterns become apparent. The first pattern can be termed the "fear of fear" (Goldstein & Chambless, 1978). This involves worry about the

physical symptoms breaking through and leading to panic attacks. The second pattern consists of avoidance behaviors. What agoraphobics fear most are not the feared objects themselves (closed spaces, tunnels), but the trappedness in these situations which relates to anxiety about losing control (becoming hysterical). Agoraphobics similarly fear manifesting the physical symptoms (dizziness, hyperventilation, nausea) with no help or escape possible. A third feature is the lack of development of self-sufficiency. Agoraphobics appear to lack the skills to control themselves when they panic or to function competently in society in an independent way (Fodor, 1974; Goldstein & Chambless, 1978; Marks, 1969, 1970).

Research suggests that a multifaceted feminist approach is the most effective for agoraphobics (Brehony, 1983; Fodor, 1982a; Goldstein & Chambless, 1980). First the socially isolated agoraphobic needs to understand how common agoraphobia is and how many females under pressure feel dependent and helpless. Further, in therapy she can compare aspects of her agoraphobia with the way she was conditioned as a female in our society. Furthermore, the particular pressure in the life of the woman can be explored. She needs validation for how stressful it is to be at home with small children, to be married, and to do the housework; she needs reassurance that it is understandable for her to feel trapped or wish to flee. Finally, we give permission to change. What is the client not doing with her life that she would like to do? In addition to the exposure to the feared situations, she is encouraged to envision other changes, perhaps working outside the home. We also teach self-maintenance strategies so she learns to be less dependent, particularly on her husband. Through all of this the therapist is available as coach, teacher, and role-model. The therapist tries to help the client to view herself as a person in the act of changing.

The two other categories we will discuss are more problematic, since the client needs to work not only on herself, but on the societal appraisal of her behavior.

ATTEMPTING TO CONFORM MORE TO THE STEREOTYPE: OBESITY

Stereotypes about weight in our culture involve the belief that there is an ideal standard of weight for each woman. Hence, according to the Metropolitan Life Insurance Tables, 40 percent of females are classified as more than 20 percent overweight. It is further assumed that obesity is the result

of overeating and lack of self-control. Overweight women are considered unattractive and are therefore unlikely to be successful in their pursuit of the societal goals of marriage and material happiness (Fodor, 1982b). Women can be influenced by these stereotypes to the degree that the desire to lose weight becomes a chronic focus of effort and worry with adverse effects on well-being and overall functioning. Wooley and Wooley (1980, p. 137) state:

> The dieting effects . . . may number in the dozens, over spans of 10–40 years and include repeated hospitalizations, stays at reducing spas, multiple forms of hypnotherapies and self-help groups. In its most extreme form, the effort to be slender becomes so central to self-acceptance that all other life activities are relegated to relative unimportance. If weight is too high, the patient will avoid seeing friends, refuse to attend social events, avoid sex and postpone or drop out of training or careers. The plan is always to begin or resume these activities once weight is lost, but for many that day never comes or is short lived.

Women represent over 90 percent of clients at weight-reduction clinics and over 98 percent of clients presenting with bulimia and anorexia. In these disorders, mostly prevalent in adolescents, young women have extremely distorted body images, and some anorexics may starve themselves to emaciation and even death in the belief that they are obese (Fodor, 1982b; Fodor & Thal, 1983).

Feminist therapy for the overweight woman must go beyond assuming that weight reduction is the desired goal. While this past decade has seen a mushrooming of weight-control programs (mostly behavioral), such therapy at best can offer only short-term, minimal weight loss. Typically, a client after repeated battles in weight-reduction programs believes she has two problems: one, that she is overweight and therefore unattractive, and two, that she is a failure because she lacks the necessary self-control to lose weight. Feminist therapy with such clients involves questioning the societally conditioned view of one's body weight.

Clients are given a choice as to whether they wish to focus on weight loss at all or instead to increase self-acceptance of their body. In studying the messages about thin being attractive and fat being unattractive, one needs to point out the recent origins of such messages. In Victorian times, for example, lean was considered repulsive and it was quite desirable for a woman to be voluptuous. Even today, obesity is more medically hazardous for men and more socially hazardous for women (Zegman, 1983). Extreme

thinness and physical attractiveness are the norm in the media for successful women. Thus, given a lack of overweight role models, clients need to construct their own view of what is desirable and reeducate their social supports. Some women may want to reeducate the media to present normal weight and large women in a multitude of roles.

Finally, in working with weight-reduction clients, the therapist must also get in touch with her own prejudices about body weight and attractiveness. Fodor and Thal (1983) have reviewed the literature suggesting that helping professionals (particularly physicians) are likely to hold negative attitudes about the obese and to regard them as unattractive and weak-willed. Such stereotypes about obese clients impede clients' self-acceptance and motivation to change. As Linehan and Egan (1979) have put it, "When half the population is targeted as needing to change their behavior in order to gain fair treatment by the system, we have to ask what system are these individuals trying to fit into." Hopefully, therapy will allow obese women to "fit into" a larger-size society.

ATTEMPTING TO CONFORM LESS TO THE STEREOTYPE: ASSERTION

Nonassertion has been conceptualized as a socially conditioned feminine trait associated with passive, submissive, helpless, and altruistic behaviors in women (Butler, 1976). Assertiveness techniques were developed from work with women in groups to provide an antidote to the traditional feminine nonassertive social programming. Further, feminist therapists hypothesized that women would use assertiveness training to develop their own personal power base in order to confront the male establishment and redress societal inequities (Fodor & Epstein, 1983).

Assertiveness training for women has been immensely popular and has spawned numerous courses, self-help groups, and books. Some of the pioneering integration of feminist therapy with more traditional assertiveness techniques was done on female assertiveness problems (Jakobowski-Spector, 1973; Wolfe & Fodor, 1975).

Feminist therapy of assertion involves helping women become aware of sex-role socialization messages that contribute to unassertive behavior ("She's such a lovely quiet girl," "Always put other people's feelings first."). Wolfe and Fodor state (1975, p. 45), "It is largely through following out the nurturant, docile programming of the female role . . . denying their own

needs, and devoting themselves to winning others' love and approval . . . that women in particular seem to wind up with such severe deficits in assertive behavior." Women are thus encouraged to challenge these beliefs or replace them with more adaptive, assertive, enhancing belief systems that contribute to assertiveness. The therapists and other women in the group serve as models for assertive behavior; thus it is important for the therapist to have appropriate assertive skills.

While the majority of women who have gone through assertiveness training report satisfaction with such training, there exists little research documentation of long-term maintenance (Fodor & Epstein, 1983; Stringer-Moore & Jack, 1981). Further, it is in assertiveness training that we are actually demonstrating the conflict over femininity: To be nonassertive is often equated with being feminine and to be assertive is often equated with being masculine. Thus it is difficult to be assertive and still to be perceived as appropriately feminine.

As a consequence, beliefs inhibiting assertive responding may not be so irrational or maladaptive (Fodor, 1980; Linehan & Egan, 1979; Wolfe & Fodor, 1975). Schwartz and Gottman (1976) speak of the deficit in nonassertive persons as the inability to accurately estimate the consequences of their assertions. In women, it may be the *accuracy* of their perception of the consequences that truly inhibits their behavior.

There is now a growing body of research to suggest that there is bias against assertive women (see Solomon and Rothblum, in press, for a review of this literature). It may not be possible for female assertive behaviors to be judged independently of the sex of the participant and observer. Research by Bellack, Hersen, and Turner (1979), among others, suggests that expert judges are influenced by sex of the clients and, in particular, are biased against assertive behavior by women. Rich and Schroeder (1976) report that expert and peer male and female judges both identified comparable noncoercible behaviors when enacted by men as assertive but aggressive when performed by women.

Not only is there bias, but Fiedler and Beach (1978) suggest that behaviors encouraged by assertiveness training often are not rewarded but rather punished. A woman who is learning to be assertive may find that she was more highly valued by her spouse or employer when she was accommodating, self-denying, and passive. Her assertiveness may increase her self-respect, but she may be unwilling to live with the negative reactions of others to her behavior and therefore may cease to use her skills. Thus, to maintain assertive responding and to continue developing an independent

stance as a woman in a society that still values female accommodation presents some dilemmas for feminist therapists. We are training our clients to tackle a lonely and difficult path, and we must begin to do research on how to effect change at the societal level, so that the burden of change is not solely on our individual clients. Assertiveness trainers need to work together to develop appropriate techniques to deal with the media and devise programs to effect attitudinal change. We will fail more women unless we can build a better societal reinforcement system.

CONCLUSION

It is evident from the descriptions of disorders affecting women that there are numerous levels of effective intervention. Women need to know that they are not alone in their struggles to cope with changing societal roles. Thus, therapists can serve as role-models or expose clients to similar others as avenues of social support.

Feminist therapists may wish to anticipate clients' needs by serving as educators to society at large. Consulting to schools and advising parents on nonsexist childrearing methods are ways of preventing helpless, passive disorders in girls early on. Feminist therapists can similarly inform colleagues about the influence of stereotypes. Appearances in the media by informed mental health professionals are an excellent way to counter traditional media images of women. Thus, strategies for dealing with sex-role stereotypes need to incorporate prevention as well as intervention methods. Rather than treating the individual client as an isolated case, it is far more cost-effective for feminist therapists to become advocates of a changing society.

REFERENCES

Bellack, A. S., Hersen, M., & Turner, S. Relationship of role playing and knowledge of appropriate behavior to assertion in the natural environment. *Journal of Consulting and Clinical Psychology*, 1979, 47, 670–678.

Brehony, K. A. Women and agoraphobia: A case for the etiological significance of the feminine sex role stereotype. In V. Franks & E. D. Rothblum (Eds.), *The stereotyping of women: The effects on mental health*. New York: Springer, 1983.

Brodsky, A., & Holroyd, J. Report of the task force on sex bias and sex-role

stereotyping in psychotherapeutic practice. In E. Howell & M. Bayes (Eds.), *Women and mental health*. New York: Basic Books, 1981.

Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosenkrantz, P. S., & Vogel, S. R. Sex-role stereotypes and clinical judgments of mental health. *Journal of Consulting and Clinical Psychology*, 1970, *34*, 107.

Butler, P. Assertive training: Teaching women not to discriminate against themselves. *Psychotherapy: Theory, Research and Practice*, 1976, *13*(1), 56–60.

Deaux, K. *The behavior of men and women*. Monterey, Calif.: Brooks/Cole, 1976.

Fiedler, D., & Beach, L. R. On the decision to be assertive. *Journal of Consulting Psychology*, 1978, *46*, 537–546.

Fodor, I. G. The phobic syndrome in women: Implications for treatment. In V. Franks & V. Burtle (Eds.), *Women in therapy*. New York: Brunner/Mazel, 1974.

Fodor, I. G. The treatment of communication problems with assertiveness training. In A. Goldstein & E. Foa (Eds.), *Handbook of behavioral interventions*. New York: Wiley, 1980, 501–603.

Fodor, I. G. Gender and phobia. In Al-Issa Ihsan (Ed.), *Gender and psychopathology*. San Diego, Calif.: Academic Press, 1982. (a)

Fodor, I. G. Behavior therapy for the overweight woman: A time for re-appraisal. In M. Rosenbaum & C. Franks, (Eds.), *Perspectives on behavior therapy in the eighties: Selected and updated proceedings from the First World Congress on Behavior Therapy*. New York: Springer, 1982. (b)

Fodor, I. G., & Epstein, R. Assertiveness training for women: Where are we failing? In P. Emmelkamp & E. Foa (Eds.), *Failures in behavior therapy*. New York: Wiley, 1983.

Fodor, I. G., & Thal, J. The weight disorders—overweight and anorexia: The case for expanded treatment options. In E. Belchman (Ed.), *Behavior modification for women*. New York: Guilford Press, 1983.

Franks, V., & Rothblum, E. D. (Eds.), *The Stereotyping of Women: Its effects on mental health*. New York: Springer Publishing Co., 1983.

Goldstein, A. J., & Chambless, D. L. A reanalysis of agoraphobia. *Behavior Therapy*, 1978, *9*, 47–59.

Goldstein, A. J., & Chambless, D. L. The treatment of agoraphobia. In A. J. Goldstein & E. Foa (Eds.), *Handbook of behavioral interventions*. New York: Wiley, 1980.

Howell, E., & Bayes, M. (Eds.), *Women and mental health*. New York: Basic Books, 1981.

Jakobowski-Spector, P. Facilitating the growth of women through assertive training. *The Counseling Psychologist*, 1973, *4*, 76–86.

Jassin, S. A comparison of agoraphobics, anxiety neurotics, and depressive neurotics using the MMPI and the Beck Depression Inventory. Unpublished dissertation, Temple University, Philadelphia, Penn., 1980.

Linehan, M., & Egan, E. Assertion training for women: Square peg in a round hole? Paper presented at Symposium on Behavior Therapy for Women. Association for the Advancement of Behavior Therapy Annual Meeting, San Francisco, Calif., 1979.

Marks, I. *Fears and phobias*. London: Heinemann, 1969.

Marks, I. Agoraphobic syndrome: Phobic anxiety state. *Archives of General Psychiatry*, 1970, *23*, 538–553.

Rawlings, E. I., & Carter, D. K. *Psychotherapy for women: Treatment toward equality*. Springfield, Ill.: Charles C. Thomas, 1977.

Rich, A. R., & Schroeder, H. E. Research issues in assertiveness training. *Psychological Bulletin*, 1976, *83*, 1081–1096.

Schwartz, R. M., & Gottman, J. M. Toward a task analysis of assertive behavior. *Journal of Consulting and Clinical Psychology*, 1976, *44*, 910–920.

Solomon, L. J., & Rothblum, E. D. Social skills problems experienced by women. In L. L'Abate & M. P. Milan (Eds.), *Handbook of social skills training and research*. New York: Wiley, in press.

Stringer-Moore, D., & Jack, G. B. *Assertive behavior training: A cross-referenced annotated bibliography*. San Luis Obispo: Impact, 1981.

Wolfe, J. L., & Fodor, I. G. A cognitive behavioral approach to modifying assertive behavior in women. *The Counseling Psychologist*, 1975, *5*, 45–52.

Wooley, S. C., & Wooley, O. W. Women and weight: Toward a redefinition of the therapeutic task. In A. Brodsky & R. Hare-Mustin (Eds.), *Women and psychotherapy: An assessment of research and practice*. New York: Guilford Press, 1980.

Zegman, M. A. Women, weight, and health. In V. Franks & E. D. Rothblum (Eds.), *The stereotyping of women: Its effects on mental health*. New York: Springer, 1983.