All Performances

Theses, Dissertations and Capstones

2003

Gender Bias Among Mental Health Professionals

Joan B. Schroering

Follow this and additional works at: http://mds.marshall.edu/etd

 Part of the Counseling Psychology Commons, and the Gender and Sexuality Commons

Recommended Citation

Schroering, Joan B., "Gender Bias Among Mental Health Professionals" (2003). *Theses, Dissertations and Capstones*. Paper 845.

This Thesis is brought to you for free and open access by All Performances. It has been accepted for inclusion in Theses, Dissertations and Capstones by an authorized administrator of All Performances. For more information, please contact zhangj@marshall.edu.

Gender Bias Among Mental Health Professionals

Thesis submitted to
The Graduate College of
Marshall University

In partial fulfillment of the
Requirements for the degree of
Master of Arts
Psychology
by

Joan B. Schroering

Tony Goudy, Ph.D., Committee Chairperson
Mark Clingan, Ed. D.
Stephen O'Keefe, Ph.D.

Marshall University

2003

Abstract

Gender Bias Among Mental Health Professionals

by Joan B. Schroering

The frequently cited Broverman study (Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel, 1970) has motivated a great deal research in the area of gender bias, particularly investigations into the attitudes of mental health professionals. After a review of the literature referencing the Broverman study, the current study, utilizing the research patterns set forth in that research, examines if and to what degree gender bias affects mental health professionals in the state of West Virginia. The results of this study indicate that mental health professionals across the state hold fairly equitable and balanced views of the male and female gender, with one exception. Female mental health professionals tended to place great emphasis on masculine characteristics for females, an outcome encountered in other studies. While speculations abound, there appears to be no definitive reason for this result.

Dedication

The author wishes to dedicate this body of work to her husband, Michael S. Schroering, without whose help, encouragement and support this study would not have been possible.

Acknowledgments

The author wishes to thank and acknowledge the help and support offered by the thesis committee, Dr. Tony Goudy, Dr. Mark Clingan, and Dr. Stephen O'Keefe. Their comments, and encouragement helped to keep the project moving forward. The author would also like to thank and acknowledge Dr. Enrique Moreno with whose help and patience the data for this project was analyzed and understood.

TABLE OF CONTENTS

CHAPTER I

Introduction

Gender Bias Among Mental Health Professionals

Thirty-three years ago, researchers (Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel, 1970) polled 79 mental health professionals in the state of Massachusetts for their descriptions of "a healthy, mature, socially competent (a) adult, sex unspecified, (b) a man, or (c) a woman" (Broverman et al., 1970, p. 1) using a series of sex-stereotypic adjectives. Comparisons of their ratings of traits and characteristics for the healthy adult, sex unspecified, with ratings for males showed a near match of characteristics. Comparisons of the adult, sex unspecified, with the traits and characteristics ascribed to females, however, showed very few characteristics listed in common, with some traits in direct opposition to those given for the adult, sex unspecified. The hypothesis of the study, which received strong support from their findings, was that clinical judgments about the characteristics of healthy individuals would differ depending upon the gender of the person being evaluated. A second theory, that behaviors judged healthy for men would not be judged healthy for women, was also given confirmatory evidence (p.1). By analyzing the differences in descriptions, Broverman et al. concluded that a "double standard of health exists for men and women, that is, the general standard of health is actually applied only to men, while healthy women are perceived as less healthy by adult standards" (p.5). An essentially simple study derived from a surprisingly small sample population, it has since become one of the most frequently cited studies on gender bias ever published (Sankis, Corbitt, & Widiger, 1999). It also created a storm of debate, defense and research within the professional mental health community.

This paper will first review chronologically some of the seminal research generated by or referenced to the Broverman study. Then it will present original research that roughly parallels that of the Broverman study. Using data collected from mental health professionals across the state of West Virginia and divided into the same three categories, adult, sex unspecified, male, and female, comparisons of gender attitudes will be made. While the Broverman study has generated a tremendous amount of anger, anguish, energy and argument, it has also served to motivate a great deal of valuable research in the area of gender differences.

CHAPTER II

Review of Literature

Sometimes the impact of an event only becomes clear over time. The initial response to the furor produced by the Broverman study can be seen as early as 1974. At that time a task force was formed by the American Psychological Association's Board of Professional Affairs in response to requests by the APA Committee on Women in Psychology. Their purpose was to examine sex bias in psychotherapeutic practice, to recommend actions that might reduce sex bias and to develop materials to do this and ways to distribute these materials to APA members and other professionals. Their report begins with what the task force perceived as the two central difficulties with sexism in psychotherapeutic practice with women: "(a) the question of values in psychotherapy and (b) the therapist's knowledge of psychological processes in women" (American Psychological Association- Board of Professional Affairs, 1975, p. 1169). Stating that at the least, therapists must maintain an awareness of their own values and not impose them on the patient, the report acknowledges the recent impact of the Broverman study. "That psychologists expect women to be more passive and dependent than men while acknowledging that these traits are not ideal for mental health has been empirically demonstrated (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972)" (American Psychological Association- Board of Professional Affairs, 1975, p. 1169). The task force recommendations included educational efforts at the graduate school level as well as postgraduate workshops and lectures for working professionals, the development of guidelines for nonsexist psychotherapeutic practice and sensitization through group processes to affect attitudinal change, and, finally, sanctions with and without the profession to force

psychotherapists to modify their existing sexist behaviors (American Psychological Association, 1975, p. 1174). This report indicates the seriousness with which allegations of possible therapeutic gender bias on the part of mental health professionals were met and reflects favorably on the mental health profession generally and on the American Psychological Association in particular.

Another excellent example of the impact of the Broverman's study on later research is to be found in Carol Gilligan's work concerning the moral development of women (Gilligan, 1977). Gilligan introduced her research efforts by stating that the men whose theories have informed and defined our understanding of moral growth and development have always been plagued by "the problem of women, whose sexuality remains more diffuse, whose perception of self is so much more tenaciously embedded in relationships with others and whose moral dilemmas hold them in a mode of judgment that is consistently contextual. The solution has been to consider women as either deviant or deficient in their development " (Gilligan, p. 482) Gilligan went on to cite the discrepancy between concepts of womanhood and adulthood that were "nowhere more clearly evident than in the studies on sex-role stereotypes reported by Broverman, Vogel, Clarkson, and Rosenkrantz (1972)" (p. 482). Her research examined and subsequently challenged a distinctive construction on moral problems, seeing moral dilemmas in terms of conflicting responsibilities"(p. 515). She maintains that the development of women's moral judgment "appears to proceed Kohlberg's Stage Theory of Moral Development (Kosslyn and Rosenberg, 2001), citing the fact that he had standardized his entire construction using men exclusively. When women were finally included and rated using Kohlberg's standards, they were consistently found to be morally deficient or lacking in their development (Gilligan, 1977, p. 481- 484). Her research findings suggested that "women impose from an initial concern with

survival, to a focus on goodness and finally to a principled understanding of nonviolence as the most adequate guide to the just resolution of moral conflicts" (Gilligan, p. 515). Her contributions examined and clarified some of the developmental differences that were contributing factors in the perceived bias against women.

In the mid 1970s, Bem developed the Bem Sex-Role Inventory (BSRI) in a concerted effort to construct a better instrument with which to examine gender distinctions (Bem, 1974). In her introduction to the BSRI, Bem asserts that both psychology and the larger society have long conceptualized femininity and masculinity as opposite ends of a single bipolar dimension. Unlike other types of rating systems, which forced a dichotomy between male and female traits, the BSRI allowed individuals to rate themselves by choosing freely from both male and female valued items in their descriptions. She offered the concept of psychological androgeny, a term that denotes the integration of femininity and masculinity within a single individual. Androgeny implies that it is possible for an individual to be " both compassionate and assertive, both expressive and instrumental, both masculine and feminine, depending upon the situational appropriateness of these various modalities." (Bem, 1978,1981, p. 4) The Bem Sex-Role Inventory was developed to encompass the concept of androgeny by creating an inventory format that circumvents the automatic opposition of masculinity and femininity. According to Bem, the original form contained sixty empirically defined personality characteristics. Twenty of these characteristics are stereotypically feminine (e.g., affectionate, gentle, understanding), and twenty are stereotypically masculine (e.g., ambitious, self-reliant, assertive) along with twenty "filler" items that are considered to be gender neutral (e.g., truthful, happy, conceited). These characteristics were chosen from a list of 200 personality characteristics that appeared to the author and several of her students as positive in value and either feminine or masculine in tone.

A personality characteristic was defined as masculine or feminine if it was judged to be significantly more desirable in American society for one sex than the other. Individuals rate on a seven point scale how well each of these characteristics describes her or him or others (Bem, 19748/1981, p. 4).

Her 1982 book, In a Different Voice: Women's conception of the self and morality, allowed Gilligan to reach a larger audience. Once again, she pointed to the discrepancy between womanhood and adulthood reported by Broverman et. al. in 1970. “The repeated finding of these studies is that the qualities deemed necessary for adulthood - the capacity for autonomous thinking, clear decision-making, and responsible action - are those associated with masculinity and considered undesirable as attributes of the feminine self” (Gilligan, 1982, p. 17). Her goal was to expand the understanding of human moral development by using the group (females) left out in the construction of Kohlberg's developmental theory to call attention to what is missing in its account. “Seen in this light, the discrepant data on women’s experience provide a basis upon which to generate new theory, potentially yielding a more encompassing view of the lives of both of the sexes” (p. 4).

In 1987, Widiger and Settle contended that, while the Broverman study (1970) had long been widely recognized as one the most influential and important studies on sex bias, their research results demonstrated that the biased findings of Broverman et al. were the result of the Broverman instrument having more male-valued than female-valued items. “The sex bias was in the inventory, not the subjects” (Widiger & Settle, 1987, p. 466). The Brovermans et.al. had freely admitted (Rosenkrantz, 1968) (Broverman et.al., 1970) that their data gathering tool was constructed from the responses of undergraduate psychology students. Nevertheless, this was the first real challenge to the credibility of the Broverman study.

However, at this same point in time, a Canadian researcher (Page, 1987) published results of a research project that examined the diagnostic expectations of mental health professionals in clinical in-house situations. These findings strongly supported the male-biased findings of the Broverman study (1970) and seemed to contradict Widiger's study, serving to confuse the issue once again.

At the end of the 80s, the Broverman study was still serving as a thought-provoking reference for feminists, with all the issues it had raised still unanswered, or else answered in too many confusing and conflicting ways. On the other hand, it continued to provoke an amazing amount of research; certainly it can be said to have served as a catalyst.

Stivers, (1991) explained that in her experience as a psychologist, women tended to be more readily victimized by psychiatric labeling. Once again, as a case in point, she referenced the dramatic results obtained by the Brovermans: "Broverman's study demonstrated a double standard of mental health, since clinicians set standards for healthy men and adults different from those set for healthy women" (p. 253). Her article also discussed the contributions of Gilligan and others in directing attention to the ways in which women are judged as lacking and defective when they are evaluated by masculine models of development.

Tackling the political aspects of research comparing the sexes Eagly, 1995, took note of the feminists who were working to preserve the earlier scientific consensus that sex-related differences were in fact quite small. "The fear is often expressed in feminist writing that differences become deficiencies for women because women are an oppressed group" (Eagly, 1995, p. 155). Eagly asserted that not only has contemporary research shown that, in actual fact, the stereotype of women is even more positively regarded than the stereotype of men, but that learning about these specific differences may prove helpful to women in improving their overall

status in society. For example, she suggested that women who possess an understanding of male dominance behaviors may find points in the behavioral sequence where they could intervene to produce a more equal sharing of power, but her article failed to include any specific recommendations for this. Her overriding concern, however, appeared to be that research in this area might be misused, "Never before in the history of psychology has such a formidable body of scientific information encountered such a powerful political agenda. The results of this encounter should be instructive to all psychologists who believe that psychology should serve human welfare as it advances scientific understanding" (Eagly, p.156).

In the first half of the 1990's, psychologists Kaplan and Free (1995) conducted a study examining the attitudes of male and female psychiatrists and non-physician male and female psychotherapists. Utilizing the BSRI as the tool in their efforts to map attitudinal changes since the Broverman study (1970). Their research results suggested that neither psychiatrists or non-physician psychotherapists endorsed stereotypical gender roles for their male or female patients. However, the significant differences that were found between the optimal categories chosen by male and female therapists were linked to the gender of the therapist rather than the gender of the hypothetical patient. Women therapists were more likely to choose as optimal the androgynous (equally high levels of both feminine and masculine characteristics) category for patients of both sexes, while male therapists were more likely to choose as optimal the undifferentiated (low levels of both masculine and feminine traits) category. In other words, women therapists tended to give high end numbers to traits like "forceful, affectionate, sympathetic, assertive, has leadership abilities, and loves children," a combined mixture of masculine and feminine traits, while male therapists tended to use lower numbers to rate these same traits as optimal. Among therapists who selected stereotyped categories (categories that rated either feminine or masculine

characteristics with high end numbers) women therapists were more likely to choose the masculine traits to describe optimal functioning for their hypothetical patients and men were more likely to choose feminine traits as optimal for patients of both genders (Kaplan & Free, 1995, p. 64). Results also suggested that among those participants with more stereotypical perceptions, women tended to value masculine traits more highly and men tended to value feminine traits more highly.

Sankis, Corbitt, and Widiger (1999) proceeded to scrutinize the whole of the English language for gender bias. This ambitious undertaking drew on previous efforts by Allport and Odbert in 1936, by Norman in 1967 and by Goldberg in 1982. After culling for obscurity, temporary moods or activities, or simply physical aspects of appearance, behavior or dress, Sankis et al.(1999) whittled the compilation down to 1,710 personality trait terms. These were rated by participants for either masculinity, femininity, or social desirability. More than 460 students responded to each of these three areas of assessment. Results of the study suggested that within the English language, there were more desirable feminine trait terms than masculine trait terms, more undesirable masculine trait terms than undesirable feminine trait terms and more undesirable masculine trait terms than desirable masculine trait terms. Sankis et.al., professed that the results validated their claim that the English language itself is biased as it contains more female-valued terms than male-valued terms. “Even unbiased, gender-neutral clinicians would have difficulty in describing a normal, healthy adult in a manner that did not appear to be biased against men (or biased in favor of women) if their descriptions were confined to a representative set of trait terms” (Sankis, Corbitt, & Widiger, 1999, p. 1293). The results of these extensive labors were used to explain how and why the data-gathering tool used by the original Broverman study was necessarily flawed. They asserted that Broverman et. al. (1970) justified their use of a

measuring instrument that favored males in the belief that the imbalance was an accurate representation of the language. "Asking students to cite from memory as many traits as they can is unlikely to produce a comprehensive list of traits and would be, at best, only representative of the terms that they could spontaneously recall." (Sankis et.al.,1999, p. 1289-1290). Sankis concluded that the traits utilized in the Broverman 1970 study to describe men and women were not representative of the language, "71% of the adjectives generated by Rosenkrantz's college students favored men" (Sankis et. al., 1999, p. 1293). Continuing with this speculative train of thought, Sankis observed that "If Broverman et.al. had used a more representative sample of socially desirable (or undesirable) terms, they would probably (have) reported that clinicians were biased in favor of women" (p. 1293).

A chronological review of the better than thirty years of literature focusing on gender differences and the perceptions of these differences by mental health professionals has shown a gradual evolution in terminology; the more emotionally loaded term, “sex-role stereotyping” has gradually been replaced by the more neutrally descriptive “gender differences,” a difference that is apparently only that of adopting a more politically correct word choice. Interestingly, in their presentation of actions calculated to reduce sex bias, the task force formed by the APA's Board of Professional Affairs introduced neuter gender pronouns that were substituted for the generic *he* throughout their task force report, "tey = he/she; and tem = him/her" (American Psychological Association - Board of Professional Affairs, 1975, p. 1169). Much research has also indicated that both women’s need for connection and men’s need for status are social and cultural realities we cannot ignore (Gilligan, 1982; Tannen, 1990; Kaplan, 1995). Still, no human being is capable of being totally defined by gender and there seems to be a growing social and political awareness of this concept throughout the literature (Brody, 1997; Eagly, 1995; Stivers, 1991; Gilligan,

1982; Bem 1978/1981). The Broverman study (1970) has played a pivotal role throughout the last thirty years of research and development. It will be utilized once again in this study as the pattern for conducting research. This study was conducted to examine the possibility of gender bias on the part of mental health professionals practicing in the state of West Virginia. It will contribute to the ongoing body of literature and research begun by the Broverman study through an investigation of the possibility of prejudicial attitudes toward males and females.

CHAPTER III

Methods

The purpose of the present study is to survey mental health professionals in the state of West Virginia in order to determine their perceptions of male and females patients and the way in which their perceptions characterize their patient's respective gender roles. The results should prove to be of interest to the mental health professionals, graduate and undergraduate students in these fields, as well as individuals utilizing or considering the services of mental health clinicians throughout the state of West Virginia.

Gender bias as examined in this study is defined as a significant difference in the perceptions of metal health professionals between the characteristics attributed to an adult, sex unspecified, and an adult male, or the characteristics attributed to an adult, sex unspecified and an adult female.

The hypotheses for this study are:

Null Hypothesis (H0): There is no significant degree of gender bias in the perceptions of male or female patients and their gender roles by male and female mental health professionals in the state of West Virginia.

Alternative Hypothesis (H1): There is a significant degree of gender bias in the perceptions of male or female patients and their gender roles by male and female mental health professionals in the state of West Virginia.

Participants.

Three hundred subjects were selected from a listing of practicing mental health professionals across the state of West Virginia. The main list, from which 250 names and addresses were obtained, was provided by the West Virginia Board of Examiners in Psychology.

The listing of all licensed psychologists in the state of West Virginia included 556 names in total. Those practicing or living out of the state were eliminated from the mailing list, leaving 487 names. Starting from the top of the alphabetized list, two individuals were selected and one was skipped. This procedure was followed until there were 127 names on the compiled list. Then the selection process began at the end of the list and one was selected while two were skipped from the list. When 200 names were gathered in this way, a register of psychiatrists and social workers from the surrounding hospitals and clinics was used to augment the list. Counting the names and genders collected, it was determined that 34 more names were needed to complete a mailing list of 300. These names were chosen from those not marked off from the list of licensed psychologists in the middle section of the list. The final mailing included clinically trained, licensed psychologists, psychiatrists and social workers across the state, all of whom were actively functioning in clinical settings.

The total list was then divided into three further groups of 100 individuals, with 50 males and 50 females in each grouping. This selection was achieved by shuffling the addressed envelopes garnered from the various lists. The first group was asked to use the modified version of the BSRI to describe a healthy, mature, socially competent adult, sex unspecified. The second group was asked, using the same version of the BSRI, to describe a healthy, mature, socially-competent adult male. The third group was asked, using this version of the BSRI, to describe a healthy, mature, socially competent adult female. Participants were also asked to report their gender, but not their names, following the procedure utilized in the Broverman study. Those interested in the results of the study were invited to submit a self-addressed stamped envelop to be mailed back to them with results when the study was completed. Fifteen of the respondents enclosed a stamped, self-addressed envelop and requested a copy of the research results.

Instrument

A slightly modified version of the Bem Sex-Role Inventory - Short Form (Bem, 1978,1981) was the data-gathering tool utilized for assessing the sex-role perceptions of each group (Appendix C). The modification consisted of asking participants to rate one of three hypothetical others (a healthy, mature, socially competent adult, sex unspecified; a healthy, mature, socially-competent adult male; or a healthy, mature, socially competent adult female) instead of rating only themselves as stipulated in the original, unmodified version of the short form. As in the original short form, the modified version consisted of the same thirty adjectives and phrases and included a list of ten feminine characteristics, ten masculine characteristics, and ten neutral characteristics. Raters were asked to use each of these characteristics to rate the hypothetical adult male, or female, or generic adult on a scale from one to seven, including never or almost never true to always or almost always true. It is possible to score highly on both masculine and feminine traits because they are treated as independent dimensions and scored separately. The median score on the Bem Sex-Role Inventory (BSRI) is 4.5. Scores higher than this indicate the possession of masculine or feminine traits. When this happens, the scores indicate that the rater has an androgynous perspective (high masculinity-high femininity scores). When scores are below the median of 4.5 on both the masculine and the feminine scales, they suggest that the raters view of males and females is undifferentiated (low masculinity-low femininity scores). Scores that pass the median on masculine characteristics only or on feminine characteristics only indicate that the rater's overall perception of gender tends to be stereotypically masculine or feminine (1978,1981).

In the standardization of Bem's instrument, psychometric analyses were performed on two samples of subjects consisting of undergraduate students at Stanford University. The first sample

included 279 females and 444 males who filled out the BSRI in 1973. The second sample included 340 females and 476 males who took the BSRI in 1978. In order to estimate the internal consistency of the BSRI, coefficient alpha was computed separately for females and males in both samples for the Femininity score, the Masculinity score, and the Femininity-minus-Masculinity Difference score.

The following scores are for the Original version of the BSRI containing 60 responses as well as the Short form that contains 30. It reflects internal consistency as computed by coefficient alpha, showing all three scores to be highly reliable (Bem, 1978/1981, p. 26-27).

	FEMININITY		MASCULINITY		F-M DIFFERENCE	
	F	M	F	M	F	M
Original BSRI						
Stanford, 1973	.75	.78	.87	.86	.78	.84
Stanford, 1978	.78	.78	.86	.87	.82	.82
Short BSRI						
Stanford, 1973	.84	.87	.84	.85	.85	.90
Stanford, 1978	.84	.87	.86	.85	.89	.88

The BSRI was administered for a second time to twenty-eight females and twenty-eight males from the 1973 Stanford sample four weeks after the first administration. Product-moment correlations were computed between the first and second administrations for both the Original and Short BSRI. All three scores proved highly reliable, with the lowest test-retest reliability (.76) occurring for males describing themselves on the masculine items (Bem, 1978, 1981).

A modified version of the 30 item short form of the BSRI is being used in this study for several reasons. It was felt that the short form was more user-friendly in terms of a time-commitment from participants and therefore more likely to garner responses from busy professionals. Research has also indicated that the short form may actually be more reliable than the longer version, particularly the feminine scale (Campbell, James & Thompson, 1997).

Procedure

Following the pattern set by the Broverman study (1970), one-third of the participants were asked to describe a healthy adult (gender unspecified), one-third were asked to describe a healthy adult male, and one-third were asked to describe a healthy adult female. Participants were also asked to indicate their gender. They each received instructions for rating the optimal characteristics for one of the three choices (Appendix B). A personal cover letter explaining that this was a graduate thesis project and inviting their interest and cooperation served as an introduction (Appendix A). Participants were also invited to include a stamped, self-addressed envelop if they were interested in receiving a copy of the results of the study. Fifteen stamped, self-addressed envelopes were received.

CHAPTER IV

Results

In this study, the dependent variable was gender bias on the part of mental health professionals in the state of West Virginia as measured by the Bem Sex-Role Inventory. The first set of independent variables is the three hypothetical adults being rated: male, female and generic adult (gender unspecified). The second set of independent variables is the gender of the raters. Scores used in the analysis are achieved by grading the questionnaires as instructed by the Ben Sex-Role Inventory Manual. This generated three *t* scores for each returned questionnaire, a masculinity score, a femininity score, and a score for the difference between the individual raters degree of difference between femininity and masculinity scores. Six groups for analysis, males rating males, males rating females, males rating adults, females rating males, females rating females, and females rating adults were then analyzed for variance in terms of the masculinity scores. There was no significant difference between the masculinity means of the six groups. The mean was 48.9244 with a standard deviation of 6.7694. There was a significant difference between the femininity means of some groups. The mean was 48.8605 with a standard deviation of 8.1616. In analyzing the masculinity and femininity scores, an ANOVA showed that the masculinity scores approached significance at .084. The femininity scores achieved significance with .0496. Multiple comparisons of femininity scores showed that female mental health professionals achieved a significance difference when they were evaluating other females.

Of the 300 questionnaires that were sent out to practicing mental health professionals in the state of West Virginia, 150 were addressed to males and 150 were addressed to females. There were 50 male addressed questionnaires and 50 female addressed questionnaires asking for ratings on each of the three categories, adults, sex unspecified, males, and females. 172 (57%) of

the questionnaires were properly completed and returned; the respondents were 78 males (45%) and 94 (55%) females. Within the three categories being assessed, 57 or 33% responded to the survey on adults, sex unspecified, 57 (33%) responded to the survey on males, and 58 (33%) responded to the survey on females.

In rating the adult (sex unspecified), of the 57 respondents for this group, 32 (56%) were females and 25 (44%) were males. The 57 responses rating males were provided by 29 females (51%) and 28 males (49%). Female ratings totaled 58 (33%) with 33 female responders (57%) and 25 male responders (43%). This means that females provided 94 responses or 55% and males provided 78 responses or 45%.

Responses were scored according to the Bem Sex-Role Inventory instruction manual, achieving three *t* scores on each returned questionnaire; masculinity, femininity, and the difference between the masculinity and femininity scores. Analysis of variance tests were run for each of the six groups, males rating males, males rating females, males rating adults, females rating males, females rating females, and females rating adults. In comparing the means of the six groups on masculinity, femininity, and difference, an analysis of the masculinity factor showed that there was no significant difference between the masculinity means of the six groups (see Appendix C). An analysis of the femininity factor, however, showed a significant difference between the femininity means of some groups. Further analysis utilizing paired t tests showed that the mean of group 4, females rating females, was significantly less than the mean of any other group.

An analysis of the difference factor, the score obtained by subtracting the masculinity *t* score from the femininity *t* score of each rater, showed there was a significant difference between the means of the variable difference of some groups. Further analysis using paired *t* tests

showed that the mean of group 4, females rating females, was significantly less than the means of any other group, except group 1, males rating females (see Appendix C).

Tests were then run to see if the mean values of masculinity and femininity were equal in the six groups. This analysis showed that the mean of the ratings for masculinity was significantly greater than the mean of the ratings for femininity in the group 4, females rating females. In all other cases there were no significant differences (see Appendix C).

Data analysis, with one significant exception, is compatible with the null hypothesis, i.e., there is no significant degree of gender bias in the perceptions of males or females by male and female mental health professionals in the state of West Virginia. The exception appeared when female mental health professionals rated optimal characteristics for females. Analysis pointed to the rejection of the null hypothesis and acceptance of the alternative hypothesis in this instance, suggesting that when female mental health professionals evaluate females, there is a significant degree of gender bias. The direction of the gender bias, however, was in a direction opposite the findings of the Broverman study. Female mental health professionals tended to highly rate far fewer feminine characteristics for females than masculine ones and to rate masculine traits for females more highly than feminine ones.

CHAPTER V

Summary and Conclusion

The Broverman study (Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel, 1970), which served both as the motivating factor for this study as well as providing the general framework for this investigation, has had an amazing amount of longevity and influence for what was basically such a small study. Over the past thirty-three years, a number of researchers have challenged the results with studies of their own. Some have urged a reorganization of therapist's psychotherapeutic knowledge and values (American Psychological Association, 1975); some have been driven to challenge the work of those who seem not to have been taking women into consideration when constructing moral hierarchies (Gilligan, 1977); some have set out to develop an improved tool for evaluating gender bias (Bem, 1978/1981); some attacked the Broverman instrument directly by challenging the data-gathering tool as inherently flawed (Widiger, 1987); some have used the Broverman study as a springboard toward developing new possibilities for therapeutic development for women (Stivers, 1991); some have explored the political implications involved in gender differences research (Eagly, 1995); some have gone on to provide their own research efforts on determining gender bias (Kaplan and Free, 1995); and some have been motivated to examine the entire English language for gender bias (Sankis, Corbitt, and Widiger, 1999). Not a bad track record for one research project.

The organized efforts of the task force formed by the APA in 1974 illustrated the concern with which that organization viewed prejudiced perspectives on the part of its members and remains a commendable and noteworthy effort. It underlines the impact that the allegations of bias in the field of mental health stemming from the Broverman study had on the mental health community of the time.

Gilligan's work still lacks the recognition it deserves in the field of psychology. It was important that the skewed sample used in Kohlberg's hierarchy of moral development be publicized and corrected. Historically women were routinely excluded from studies in both mental and physical health due to perceived fluctuating moods and hormones that researchers feared would affect the outcome of their research. Of course, excluding 50% of the population could have that effect, too. Gilligan's work on the moral reasoning and moral development of women remains a landmark in the developmental field, but direct comparisons to Kohlberg's studies are necessarily flawed. Kohlberg used quite different moral dilemmas with his male subjects than Gilligan used with her female subjects. The male subjects were dealing with totally hypothetical situations; Gilligan's females were reflecting on their own decisions about abortion during and after their pregnancies.

Bem's desire to impart the social desirability of androgeny (defined by the BSRI as above the mean ratings of both male and female characteristics; high male-high female) has possibly distorted her research as well as her instrument. While her instrument was an improvement over the unvalidated instrument utilized by the Brovermans and over the last 25 years has been utilized in a number of studies quite similar to the present one, it suffers from personal bias injected by the researcher. Widiger's criticism of the Broverman instrument (Widiger, 1987) also figured in the decision to use the BSRI as the data gathering tool in this study. The BSRI had the advantages of brevity, a significant factor when requesting anonymous feedback by mail from busy professionals, as well as low-cost availability. The brevity is, in part, the reason for such a high rate of response on the part of mental health professionals across the state of West Virginia.

The response rate for all groups was quite acceptable (57%) given a mailed questionnaire format, there was some difference in the response rate of males and females in each of the three

hypothetical adults being rated. Perhaps those with stronger feelings about the characteristics individuals should possess were the ones who were most motivated to complete the questionnaire and return it. Another speculation is that female mental health professionals may have responded with a sense of affiliation to the female investigator's name on the cover letter, while the males felt no particular affiliation and so felt less inclined to respond. These considerations may possibly limit the generalizability of the results.

An interesting parallel of these results can be found in the 1995 study by Kaplan and Free, which also utilized the BSRI. They were comparing psychiatrists' and non-physician psychotherapists' perspectives of patients, but they also noted that females, both medically trained psychiatrists and non-physician psychotherapists, were more likely to choose the androgynous (high male, high female characteristics) category for females (Kaplan and Free, 1995, p. 66). Both the Kaplan & Free study and the one presented in this paper are based on abstractions, hypothetical males, females, or adults existing only on paper or as a mental construct. Whether female mental health professionals would actually encourage their female patients to develop more and stronger masculine traits is a speculation that is not warranted by the current data.

This present study also found a slight but not statistically significant bias when male mental health professionals were evaluating females. However, only the females evaluating females expressed a significant degree of bias by consistently downplaying the value of feminine characteristics for females.

Accessing the view mental health professionals in West Virginia have of gender roles for males and females was the stated purpose of this study. Utilizing the same general format as that used by the original Broverman study was an organizational device that proved helpful. Results

of this study would seem to indicate that the overall perspective in West Virginia is a fairly balanced one. No significant degree of gender bias in the perceptions of male or female patients and their gender roles by male and female mental health professionals in the state of West Virginia was found, with one interesting exception; female mental health professionals tend to rate masculine traits for females more highly than the norm. In other words, females apparently felt that women needed to strengthen their masculine traits like assertiveness, forcefulness, leadership, independence, and risk-taking.

It can be speculated that due to the insight and awareness of women's lives that they develop through counseling and therapy, female mental health professionals are particularly sensitized to the struggles encountered by physically and emotionally abused women. Perhaps female mental health professionals have discovered that masculine characteristics have served them well in completing graduate school requirements or in pursuing other career goals or possibly they have made a generalization that the characteristics that proved helpful on a personal level might be helpful to other women in their own lives.

We, as a society, have also been sensitized over the past decade to issues of sexual bias and gender discrimination through in-service training programs in schools and work places and much publicized lawsuits over sexual harassment, as well as books and articles and the media. Perhaps individuals responding to anonymous questionnaires present a socially sanctioned version of their personal judgments. In other words, perhaps the questionnaire garnered the responses that individuals felt were correct, rather than the ones they believed. This sensitization could, at least in part, account for the differences in results of the current study to the results presented by the Broverman study thirty-three years ago. Of course, it could also be suggested

that within a single generation, we have made remarkable social progress and are pursuing a higher form of social evolution.

Whatever other speculations might arise from these results, it is to be hoped that this study might borrow a little momentum from the Brovermans and serve to encourage others to continue to explore this fertile area of research. There is still a real need for a better tool with which to access gender bias. One logistical difficulty is the time factor. A questionnaire asking for ratings of, for example, 500 traits and characteristics could cross-check and safeguard the responses and possibly achieve a greater degree of validity. However, a questionnaire that takes only 5 minutes to complete has a much greater chance of getting completed and returned. For those with an interest in the area of gender bias, this could prove to be a productive area for further investigation.

Bibliography

American Psychological Association - Board of Professional Affairs, (1975) Report of the task force on sex-bias and sex-role stereotyping in psychotherapeutic practice. American Psychologist, December, 1169-1175.

Bem, S. L. (1974). The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology, 42(2), 55-162.

Bem, S. L. (1978,1981). Bem sex-role inventory manual, test booklet (short and original) and scoring key (short and original) Consulting Psychologists Press, Inc.

Bem, S. L. (1981). Gender schema theory: A cognitive account of sex typing. Psychological Review, 88(4), 354-364.

Brody, Leslie R. (1997). Gender and emotion: Beyond stereotypes. Journal of Social Issues, 53(2), 369-394.

Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosenkrantz, P. S., & Vogel, S. R. (1970). Sex-Role stereotypes and clinical judgments of mental health. Journal of Consulting and Clinical Psychology, 34 (1), 1-7.

Broverman, I. K., Vogel, S. R., Broverman, D. M., Clarkson, F. E., & Rosenkrantz, P. S. (1972). Sex-Role stereotypes: A current appraisal. Journal of Social Issues, 28(2), 59-78.

Campbell, T. G., Jr., James, A,, & Thompson, B. (1997). The factor structure of the Bem sex-role inventory (BSRI): Confirmatory analysis of long and short forms. Educational and Psychological Measurement, 57, 118-124.

Eagly, A. H. (1995). The science and politics of comparing men and women. American Psychologist, 50 (3), 145-158.

Gilligan, C. (1982). In a different voice: Women's conception of the self and of morality. Harvard University Press, Cambridge, Massachusetts.

Gilligan, C. (1977). In a different voice: Women's conception of the self and of morality. Harvard Educational Review, 47(4), 481-517.

Kaplan, M. J., & Free, N. (1995). Psychiatrists' and non-physician psychotherapists' beliefs about gender-appropriate behavior: a comparison. American Journal of Psychotherapy, 49, 59-67.

Kosslyn, Stephen M., and Rosenberg, Robin S. (2001) Moral development: The right stuff. Psychology: the Brain, the Person, the World. Allyn and Bacon, Boston, London, Toronto, Sydney, Tokyo, Singapore (p. 409-410).

Page, Stewart (1987). On gender roles and perception of maladjustment. Canadian Psychology/Psychologiee Canadienne. 28:1, 53-59.

Rosenkrantz, P., Vogel, S., Bee, H., Broverman, I., and Broverman, D. (1968). Sex-Role stereotypes and self-concepts in college students. Journal of Consulting and Clinical Psychology, 32, 287-295.

Sankis, L. M., Corbitt, E. M., & Widiger, T. A. (1995) Gender bias in the English language? Journal of Personality and Social Psychology, 77(6), 1289-1295.

Smith, M.L., (1980). Sex bias in counseling and psychotherapy. Psychological Bulletin, 87 (2), 392-407

Stivers, I. P., (1991). The meaning of care: Reframing treatment models. In Jordan, J.V., Kaplan, A. G., Miller, J. B., Stiver, I. P., & Surrey, J. L. Women's growth in connection: Writings from Stone Center, (pp. 250-267). New York: Guilford Press.

Widiger, T. A., and Settle, S. A. (1987). Broverman et al. revisited: An artifactual sex bias. Journal of Personality and Social Psychology, 53 (3), 463-469.

Appendix A

Current Date

Dear Mental Health Professional,

I am conducting research for my Master's Thesis at Marshall University Graduate College and I need your help. This involves about 5 minutes of your time and earns you my eternal gratitude. Enclosed please find a page listing 30 personality characteristics. Mark each trait with a number from 1 to 7 that best describes a healthy, socially mature adult (or a healthy, socially mature male or a healthy, socially mature female). Please mark the other information at the bottom of the page for data analysis and send it back to me using the stamped mailing envelope enclosed.

Thank you so very much for your time, effort and cooperation.

Sincerely,

Joan B. Schroering

P.S. If you are interested in receiving a copy of the research results, please include a stamped, self-addressed envelope and results will be posted to you.

JBS

Appendix B

1	2	3	4	5	6	7
Never or almost never true	Usually not true	Infrequently true	Occasionally true	Often true	Usually true	Always or almost always true

Using the scale above, rate each of the following personality characteristics to form a description of a healthy, socially competent adult. Please do not leave any characteristic unmarked.

1. Defends own beliefs _____
2. Affectionate _____
3. Conscientious _____
4. Independent _____
5. Sympathetic _____
6. Moody _____
7. Assertive _____
8. Sensitive to needs of others _____
9. Reliable _____
10. Strong personality _____
11. Understanding _____
12. Jealous _____
13. Forceful _____
14. Compassionate _____
15. Truthful _____
16. Has leadership abilities _____
17. Eager to soothe hurt feelings _____
18. Secretive _____
19. Willing to take risks _____
20. Warm _____
21. Adaptable _____
22. Dominant _____
23. Tender _____
24. Conceited _____
25. Willing to take a stand _____
26. Loves children _____
27. Tactful _____
28. Aggressive _____
29. Gentle _____
30. Conventional _____

Please provide the following information by circling the correct response.

Gender: Male Female

Age group: 20-30 30-40 40-50 50--

Appendix C
Statistical Analysis of Data

Case Summaries

	FEM	MASC	DIF
N	172	172	172
Mean	48.8605	48.9244	49.8198
Median	49.0000	50.0000	49.0000
Variance	66.612	45.825	52.663
Std. Deviation	8.1616	6.7694	7.2569

Oneway

ANOVA

MASC

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	441.427	5	88.285	1.982	.084
Within Groups	7394.590	166	44.546		
Total	7836.017	171			

Oneway

ANOVA

FEM

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	729.810	5	145.962	2.273	.0496
Within Groups	10660.841	166	64.222		
Total	11390.651	171			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: FEM
LSD

(I) GROUP	(J) GROUP	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
0	1	.188571	2.205112	.932	-4.165108	4.542251
	2	.268571	2.205112	.903	-4.085108	4.622251
	3	.842365	2.123250	.692	-3.349690	5.034419
	4	5.670996*	2.059068	.007	1.605659	9.736332
	5	1.459821	2.073783	.482	-2.634568	5.554211
1	0	-.188571	2.205112	.932	-4.542251	4.165108
	2	8.00000E-02	2.266662	.972	-4.395201	4.555201
	3	.653793	2.187105	.765	-3.664334	4.971920
	4	5.482424*	2.124852	.011	1.287206	9.677643
	5	1.271250	2.139115	.553	-2.952128	5.494628
2	0	-.268571	2.205112	.903	-4.622251	4.085108
	1	-8.0000E-02	2.266662	.972	-4.555201	4.395201
	3	.573793	2.187105	.793	-3.744334	4.891920
	4	5.402424*	2.124852	.012	1.207206	9.597643
	5	1.191250	2.139115	.578	-3.032128	5.414628
3	0	-.842365	2.123250	.692	-5.034419	3.349690
	1	-.653793	2.187105	.765	-4.971920	3.664334
	2	-.573793	2.187105	.793	-4.891920	3.744334
	4	4.828631*	2.039772	.019	.801392	8.855870
	5	.617457	2.054625	.764	-3.439108	4.674022
4	0	-5.670996*	2.059068	.007	-9.736332	-1.605659
	1	-5.482424*	2.124852	.011	-9.677643	-1.287206
	2	-5.402424*	2.124852	.012	-9.597643	-1.207206
	3	-4.828631*	2.039772	.019	-8.855870	-.801392
	5	-4.211174*	1.988229	.036	-8.136650	-.285699
5	0	-1.459821	2.073783	.482	-5.554211	2.634568
	1	-1.271250	2.139115	.553	-5.494628	2.952128
	2	-1.191250	2.139115	.578	-5.414628	3.032128
	3	-.617457	2.054625	.764	-4.674022	3.439108
	4	4.211174*	1.988229	.036	.285699	8.136650

*. The mean difference is significant at the .05 level.

Oneway

ANOVA

DIF

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	626.531	5	125.306	2.483	.034
Within Groups	8378.882	166	50.475		
Total	9005.413	171			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: DIF
LSD

(I) GROUP	(J) GROUP	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
0	1	2.0014286	1.9549151	.307	-1.8582733	5.8611304
	2	-1.3985714	1.9549151	.475	-5.2582733	2.4611304
	3	-1.5751232	1.8823414	.404	-5.2915386	2.1412923
	4	3.6850649*	1.8254415	.045	8.099031E-02	7.2891396
	5	-.1473214	1.8384872	.936	-3.7771529	3.4825101
1	0	-2.0014286	1.9549151	.307	-5.8611304	1.8582733
	2	-3.4000000	2.0094814	.093	-7.3674351	.5674351
	3	-3.5765517	1.9389511	.067	-7.4047350	.2516315
	4	1.6836364	1.8837619	.373	-2.0355836	5.4028563
	5	-2.1487500	1.8964065	.259	-5.8929348	1.5954348
2	0	1.3985714	1.9549151	.475	-2.4611304	5.2582733
	1	3.4000000	2.0094814	.093	-.5674351	7.3674351
	3	-.1765517	1.9389511	.928	-4.0047350	3.6516315
	4	5.0836364*	1.8837619	.008	1.3644164	8.8028563
	5	1.2512500	1.8964065	.510	-2.4929348	4.9954348
3	0	1.5751232	1.8823414	.404	-2.1412923	5.2915386
	1	3.5765517	1.9389511	.067	-.2516315	7.4047350
	2	.1765517	1.9389511	.928	-3.6516315	4.0047350
	4	5.2601881*	1.8083349	.004	1.6898880	8.8304882
	5	1.4278017	1.8215031	.434	-2.1684971	5.0241006
4	0	-3.6850649*	1.8254415	.045	-7.2891396	-8.09903E-02
	1	-1.6836364	1.8837619	.373	-5.4028563	2.0355836
	2	-5.0836364*	1.8837619	.008	-8.8028563	-1.3644164
	3	-5.2601881*	1.8083349	.004	-8.8304882	-1.6898880
	5	-3.8323864*	1.7626404	.031	-7.3124690	-.3523037
5	0	.1473214	1.8384872	.936	-3.4825101	3.7771529
	1	2.1487500	1.8964065	.259	-1.5954348	5.8929348
	2	-1.2512500	1.8964065	.510	-4.9954348	2.4929348
	3	-1.4278017	1.8215031	.434	-5.0241006	2.1684971
	4	3.8323864*	1.7626404	.031	.3523037	7.3124690

*. The mean difference is significant at the .05 level.

APPENDIX D

MARSHALL UNIVERSITY
www.marshall.edu

Office of Research Integrity
Institutional Review Board

MEMORANDUM

To: **Tony Goudy, Ph.D.**
Psychology - MUGC

From: **Christopher W. LeGrow, Ph.D.** *Christopher W. LeGrow*
Marshall University IRB #2 Chairperson

Date: **June 19, 2003**

Re: **IRB #2 Exempt Study No.** EX03-0104 -- Gender Bias Among Mental Health Professionals – Thesis Project of Student Joan B. Schroering

Thank you for the submission of the above non-risk study. The purpose of the study is to survey mental health professionals in the state of West Virginia in order to determine their perceptions of male and females patients and the way in which their perceptions characterize their patient's respective gender roles. The hypothesis for the study is that there is no significant degree of gender bias in the perceptions of male or female patients and their gender roles by mental health professionals in the state of West Virginia. Volunteers will complete an anonymous questionnaire.

The study as submitted would be exempt from IRB review and approval in accordance with 45 CFR 46.101b. A progress report of the study will be due prior to the anniversary date of June 29, 2004, or upon completion and/or closure of the study if prior to the anniversary date.

CWL/tjs

EX03-0104exemptschroering6-03

Curriculum Vitae

Address
1 Pinnacle Peak
Fairmont, WV 26554

Biographical Data
Birthdate: April 15, 1946
Place of Birth: Washington, D.C.

Education

Masters of Arts in Education
May 1989
West Virginia University
Morgantown, West Virginia

Certification - Elementary Education
June 1971
University of Louisville
Louisville, Kentucky

Bachelor of Arts in Speech and Drama
August 1968
Kentucky Wesleyan College
Owensboro, Kentucky

Work Experience

Taught Psychology 101
Fall Semester - 2002
Fairmont State College
Fairmont, West Virginia

Taught Psychology 210
Fall Semester - 2002
Fairmont State College
Fairmont, West Virginia

Nontraditional Student Advisor
October 1991-February 1994
Fairmont State College
Fairmont, West Virginia

Workshops in Stress Management
October 1991-February 1994
Fairmont State College
Fairmont West Virginia

Workshops in Study Skills
October 1991-February 1994
Fairmont State College
Fairmont, West Virginia

Grant Writing
October 1991- February1994
Fairmont State College
Fairmont, West Virginia

Teacher - 2nd/3rd grades
Fairmont Catholic School
September 1989 - June 1991
Fairmont, West Virginia

Teacher - 3rd/4th grades
Bayshore Private School
September 1976 - June 1977
Miami, Florida

Director of Preschool
Prince George Baptist Preschool
August 1982 - May 1983
Prince George, Virginia

Teacher - 6th Grade
Stonestreet Elementary School
August 1971- June 1973
Valley Station, Kentucky

References

Dr. Paul Edwards
Fairmont State College

Sister Stephens
St. Barbara's Nursing Home

Dr. Tony Goudy
Marshall University