AKSHARASURYA
Peer-Reviewed, Multi Lingual E-Journal
Volume – 02, Issue – 01, January 2023.

# Challenges faced by female psychologist in understanding gender stereotypes and it's impact on their clients

Dr. LAKSHMI DEVI. T
CENTER FOR WOMEN'S STUDIES,
BANGALORE UNIVERSITY
BANGALORE-560056
lakshmid42@gmail.com

ABSTRACT

The present study experimentally investigated to understand the challenges that the female psychologists face in guiding and counseling women in understanding the selfconcept in stereotyping and individual differences. Female psychologists (N=60) were been interviewed who has more than 10-yearexperience in the field of counseling. This research specifies more on what their understanding on gender stereotyping, their representation and representation of women in portrayal of gender based social roles.Research questions that extensively discussed among the psychologists are the socialization experiences that women experience while counseling, identify aspects of own socialization as a female guiding and counseling other women, did she able to help and support women in psychological need. What happened in situations when women crossed gender rules, psychological and emotional stress?Research methods used in the present study was in analyzing direct communication with the psychologists, their case reports and text analysis and unobstructive observation and case studies. The findings of the study emphasized that women had been given gender identity and self-perceptions in their childhood having an impact on their self-esteem and conflicts in their life. The female psychologists faced lots of challenges in remolding the personality traits such as removing aggression, prosocial behavior, inferentiality, emotionality and moral reasoning.

## FINDINGS AND CONCLUSIONS

### Recommendations:

The study recommended training of psychologists in understanding women issues in gender perspective because women developmental growth in Indian is mostly influenced by society, culture, parents, religious institutions. An individual to work on self concept it is most important how the memories have been gender oriented. If this gender segregation is not properly understood the psychologists cannot help women to solve their life problems.

## INTRODUCTION

Beginning in the 1960s and 1970s, psychology as a discipline was widely criticized for its biases with regard to gender, race, ethnicity, class, and sexual orientation. A number of classic studies and publications focused on these limitations. This literature challenged the extent to which existing psychological theories were androcentric and didnot adequately describe women's psychological development and behavior, including those of women of color andlesbians (APA, 1975; Barrett, Berg, Eaton, & Pomeroy,1974; Chesler, 1972; Gilligan, 1982; Rawlings & Carter,1977; Rice & Rice, 1973; Weisstein, 1968). Scrutiny of avariety of theories of psychotherapy, research on psychological development, diagnostic systems, assessment procedures, and measures found difficulties with non-inclusiveversions of mental health and problematic gender and eth-nic biases (Worell & Remer, 2003).

Diversity of women's experiences has to be discussed both with similarities and differences in the attitudes,emotions,relationships, goals and behaviors of girls and women who have a diversity of background. The role of psychologists becomes crucial because psychological understanding depends on integrated thoughts and thinking process in the rule of experiences in gender construction and power plays in the society. Although we make use of a variety of cues for the sorting process and social categorization is frequently based on stereotyping and prejudices that makes women vulnerable. In the recent study in India, we can see that stereotyping of girls and boys from the birth. The concept of marriage is inculcated in the minds of girls in their developmental process. Parents rate their girls as beautiful and their sons as big and more girls are rated in weakness and feminine. This attitude gives a psychological conflict in women's life.

The major challenges female psychologists face is making women understand to describe their social roles over rigid gender. How they can use information in addition to person's gender to form own impression and guide their interactions in their relationships. They face challenges in understanding stereotypes and discriminatory behaviors that serve to restrict women's roles and maintain male dominance. Thus stereotype such as "women are dependent and passive" or "women should be the primary caregivers and women are not competent to shape women's role to shape women's role choices". This negative treatment affects women and their self-esteem and give multiple challenges in guiding women by female psychologists.

**DefinitionsThat Needs To Be Understood By Psychologists In Guiding The Women**

**Sex and Gender**

The term sex refers to biological aspects of being male or female, and gender refers to psychological, social, and cultural experiences and characteristics associated with thebiological aspects of being female or male. Gender includes assumptions, social beliefs, expectations, and stereotypes about women, girls, men, and boys (Gilbert, 1999;Gilbert & Scher, 1999) and is an active process that can beunderstood as doing gender (West & Zimmerman, 1987). Gender-related attitudes are often embedded in complex and nonconscious cognitive beliefs that are shaped and reinforced by social interactions, institutional practices, and power structures in society (Bem, 1993). Beliefs about andexpectations regarding gender and gender identity also varywithin and between groups associated with social categories, such as ethnicity, sexual

orientation, disability, class,and race (Olkin, 1999; Worell & Remer, 2003). For example, several studies of African American women revealedthat, whereas race was identified as the most significantaspect of identity in the realm of political orientation (Gay & Tate, 1998), gender was found to be most significant with regard to domestic violence issues (Fine & Weis,1998). Although gender and sex can be seen as overlapping and fluid categories with multiple meanings (e.g., Golden, 2000; Lips, 2001; Marecek, 2002), this document uses the term gender to refer primarily to the social experiences andexpectations associated with being a girl or woman.

**Gender Bias:**

Gender bias is a construct that frequently occurs in this literature. Bias is defined as a partiality or prejudice. The term gender bias is applied to beliefs, attitudes, and/or views that involve stereotypes or preconceived ideas about the roles, abilities, and characteristics of women and men.Gender bias is often modified by and intersects with biases related to race, class, culture, age, ability, and sexual orientation.

**Social Identities:**

Social identities encompass personal and group definitionsthat are embedded in a variety of social groups and statuses. These identities are associated with but are not limited to gender, race, ability level, culture, ethnicity,geographic location, intellectual ability, sexual orientation, gender identity, class, age, body size, religious affiliation, acculturation status, SES, and other sociodemographicvariables. The complex interactions of these group identities and statuses are reflected in multidimensional conceptsof identity and gender that are influenced by visibility orthe degree to which they are easily discernable to others,situational salience or relevance, and experiences of oppression or privilege (Decaux& Stewart, 2001; Stewart &McDermott, 2004; Worrell& Remer, 2003).

**Oppression and Privilege:**

Oppression includes discrimination against and/or the systematic denial of resources to members of groups who areidentified as different, inferior, or less deserving than others. Oppression is most frequently experienced by individuals with marginalized social identities. Oppression is manifested in blatant and subtle discrimination, such as racism, ageism, sexism, and heterosexism, and it results in powerlessness or limited access to social power (T. L. Robinson& Howard-Hamilton, 2000; Worrell& Remer, 2003). Incontrast, privilege refers to sources of social status, power, and institutionalized advantage experienced by individualsby virtue of their culturally valued social identities (McIn-tosh, 1998). Privilege is most frequently experienced bythose persons whose life experiences and identities areassociated with dominant social identities, cultural traditions, and sources of power (e.g., being White, Christian, male, and middle/upper class). It should be noted that anindividual can operate from points of privilege and oppression simultaneously.

**Diversity**

diverse psychology of women reflects all women's andgirls' experiences, is based on data from a wide range ofsources, reflects openness to and a valuing of difference,and cultivates many perspectives and experiences. Thisapproach to diversity also recognizes the ineffectiveness ofconceptualizing aspects of gendered experiences in isolation (e.g., culture, race, gender, sexual orientation, ability)and emphasizes the complex interaction of social identities, oppressions, and privileges. Although diversity is oftenreflected in experiences associated with class, race, gender, ability level, ethnicity, and sexual orientation, our conceptualization of diversity also allows for "other dimensions of persons or groups that are salient to their understanding ofthe world and of themselves"

**Psychological Practice**

For the purposes of this document, psychological practiceis defined broadly to include activities related to all appliedareas of psychology. Psychological practice may includeclinical practice and supervision, pedagogy, research,scholarly writing, administration, leadership, social policy,and any of the other activities in which psychologists mayengage (Worell & Johnson, 1997).

## Review of literature

Bias in psychological Diagnosis and Treatment of girls and women issues.

In recent times, gender bias has been observed to be morecovert but is still a detectable and powerful force in psychological practice. Particular areas of concern include thepresence of gender bias—as well as bias in other social constructs, such as ethnicity, age, race, disability, and social class—within diagnostic criteria and labeling (Caplan& Cosgrove, 2004; De Barona & Dutton, 1997; Hartung &Wedgier, 1998; Marecek, 2001; Ratty& Johnson, 1997;Ross, Frances, &Wedgier, 1997). Women of color and lesbians may be especially vulnerable to misdiagnosis and other forms of bias (APA, 2000b; Hall & Greene, 2003).For example, among women and girls, gender-role socialization, economic status, ethnicity, sexual orientation, anddisability status, as well as biased criteria and perceptions,may contribute to inappropriate use and overuse of certain diagnoses, such as histrionic and borderline personality disorders, depression, dissociative disorders, somatizationdisorder, premenstrual dysphoric syndrome, and agoraphobia (Becker & Lamb, 1994; Bakker, 1996; T. L. Campbell,Byrne, & Baron, 1992; Chrisler & Johnston-Robledo,2002; Cosgrove, 2004; Garb, 1997; Hartung & Widiger,1998; Klonoff, Landrine, & Campbell, 2000; Landrine &

Klonoff, 1997; Lerman, 1996; Sperberg & Stabb, 1998).Many symptoms associated with the aforementioned disorders have been conceptualized as exaggerations or stereotyping of traditional female gender roles and behaviors(as defined by mainstream culture; e.g., overreacting emotionally, attempting to sexually attract men and to preserve romantic relationships at all costs, and placating others byinternalizing, denying, or inefficiently expressing anger).Misdiagnosis can also occur when a client's problem behaviors are inconsistent with societal expectations, such aswhen an Asian woman, assumed by stereotype to be meek,reacts to discrimination with anger. In another example, Crosby and Sprock (2004) found that when clinicians rated a case of a woman with antisocial symptoms, they were more

likely to exhibit biases that were consistent with relying on prototypes (i.e., stereotypes regarding diagnostic categories) rather than actual diagnostic criteria. There is ample evidence that poverty and economic inequality are strong predictors of depression in women (APA, 2004b;

Belle & Doucet, 2003; C. Brown, Abe-Kim, & Barrio,2003). African American women are more likely to bediagnosed with schizophrenia than White women (Mare-cek, 2001). Issues of gender identity have been viewed aspathology rather than an alternate form of gender andsexual expression (American Psychiatric Association,2000).

In addition, the specific needs and problems of girls may be overlooked and underdiagnosed because girls are more likely than boys to internalize problems or to expressproblems with less overt symptoms (Angold, Erkanli, Sil-berg, Eaves, & Costello, 2002; Fergusson, Swain-Camp-bell, & Horwood, 2002; Gershon, 2002; Hayward & San-born, 2002; Jenskins, Goodness, &Burmaster, 2002;Quinn, 2005; Seiffge-Krenke & Stemmler, 2002), a problem that may be even more serious if the girl is also froma marginalized group. For example, girls with attentiondeficit disorders exhibit fewer disruptive behavior problems than boys but have been found to suffer more severecognitive disabilities (Biederman et al., 1999). Problemsthat coexist with attention-deficit/hyperactivity disorder may also differ for girls and boys and across SES and ethnic groups, further complicating the diagnostic process. Underidentification of attention problems in girls appears.

## TRAUMA AND OTHER STRESSORS

One important diagnostic issue is found in posttraumaticstress disorder (PTSD; American Psychiatric Association, 2000). Despite the greater prevalence and chronicity of PTSD among females (Tjaden & Thoennes, 2000a), theconstruct is based on data from male combat veteran experiences, resulting in measurement problems that can affect both research and practice (Cloitre, Koenen, Gratz, &Jakupcak, 2002; Wolfe & Kimerling, 1997). For example, girls and women may be diagnosed with other Axis I and Axis II disorders when they experience trauma symptoms that do not fit the traditional PTSD profile (Cloitre et al.,2002). Further, women and girls may be misdiagnosed with more stigmatizing and chronic disorders (e.g., borderlinepersonality disorder or schizophrenia) than men with post-traumatic conditions (Fish, 2004). Women of color mayexperience additional trauma from multiple experienceswith discrimination and oppression. This trauma may lead to further misdiagnosis that does not take context into account. The experience of African American women withintergenerational trauma and the ongoing effects of a history of slavery have generally not been considered in thediagnosis of trauma (H. Vasquez & Magraw, 2005). Inaddition, men and women may experience trauma differently and may respond more effectively to different treatment approaches because of the types of traumas they arelikely to encounter, potential differences in neurobiologicalstress pathways, whether the stressor is chronic or a single-event stressor, and cultural and gender socialization experiences that influence self-concept, expectations, and meaning systems (APA, 2005; Cloitre et al., 2002; Kimerling,Ouimette, & Wolfe, 2002; Krause, DeRosa, & Roth, 2002;Root, 1992, 2001). The Resolution on Male Violence Against Women (APA, 2005) noted that more than 20% ofwomen are physically assaulted by a partner, and

approximately 12% experience sexual assault at some time in their lives. The effects of these traumatizing events are compounded by ethnicity/race, social class, physical ability, and sexual orientation because the likelihood of assaultincreases for marginalized groups (Bryant-Davis, 2005;Harway & O'Neil, 1999; Neville & Heppner, 1999). Trauma is an important area to consider in more detail because a high proportion of girls and women of all ethnic groups, SESs, sexual orientations, and ability statuses are exposed to traumatic stressors, and their mental health maybe severely affected. It should also be noted that psychologists may not be trained to work specifically with traumasurvivors (Harway & Hansen, 2004), which can reduce theeffectiveness of the treatment survivors receive. Not only are 69% of women exposed to a traumaticstressor in their lifetime (H. S. Resnick, Kilpatrick, Dan-sky, Saunders, & Best, 1993), but women are more thantwice as likely than men to develop chronic PTSD symptoms following exposure to a traumatic stressor (Kimerlinget al., 2002; M. B. Stein, Walker, & Forde, 2000; Sutherland, Bybee, & Sullivan, 1998). Rape and domestic violence seem to account for a higher prevalence of trauma in girls and women of all ethnic groups, and survivors havehigh rates of PTSD (see review by Wolfe & Kimerling, 1997). In the 1998 National Violence Against Women Survey (Tjaden & Thoennes, 1998), 25% of women and 8% of men reported being raped or physically assaulted by a spouse, partner, or date in their lifetime; men perpetrated approximately 90% of this violence. Girls are also raped. Child sexual abuse happens two to two-and-one-half times more often to girls than boys (Boney-McCoy & Finkelhor,1995). Such abuse not only results in immediate psychological symptoms (e.g., Polusny & Follette, 1995), but alsoresults in lifetime risk for self-destructive or suicidal behavior, anxiety and panic attacks, eating disorders, substance abuse, somatization disorder, and sexual adjustmentdisorders (Finkelhor, 1990). Rates of childhood sexualabuse are similar for Black, White, Hispanic, and Native American women (Arroyo, Simpson, & Aragon, 1997;Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). Although sexual assault traumas are experienced by women of diverse social identities across the lifespan, the specific issues and challenges of girls and women vary. For example, the presence of stereotyped images of Black women can exacerbate the psychological aftereffects ofrape, can contribute to the marginalization of their concerns, and may increase the likelihood of holding victimsresponsible for their own assault (Donovan & Williams,2002; Varelas & Foley, 1998).

## FINDINGS AND DISCUSSION

Female psychologists in therapeutic interventions were always unclear and challenged with issues related with personal growth and development of women client. The questions that raised in the guidance needs to examine from the purview of genuineness, empathy, positive regard and concreteness of being a women psychologist and providing treatment and guidance. How well that they can be trustworthy in supporting other women. As there is perceived emotional risks in sharing thoughts, feelings, anxiety and gears that are difficult to discuss and sometimes denied. For example, a woman abused by own father who she herself has a great respect, how can a psychologist help that woman to raise a voice against her father in a society affecting the morals of a family. Accepting an attitude without making any judgments and appreciate the client as

aperson which is a biggest challenge of the female psychologists as they themselves are victims of stereotypes as a woman.

**The self-challenges that a female psychologists face in therapeutic relationship:**

- Can I be in some way which will be perceived by the other women as trustworthy as dependable or consistent in some deep sense?
- Can I be expressive enough as a person that what I am will be communicated unambiguously
- Can I free my clients from the threat of evaluation
- Can I be supportive through the relationship offer women clients a system of support to provide the necessary stability for taking risks and changing behaviors
- Can I let myself experience positive attitudes as a psychologists towards the other person attitudes of warmth, caring , liking , interest , respect
- Can I maintain privacy to protect client self-disclosure

**Difficulty in guiding and counseling the women:**

Psychologists face difficulties to recognize that all girls andwomen are socialized into multiple culture and societal norms. girls andwomen have both shared and unique identities and developmental pathways. Psychologists try to endeavor to understandthe life issues and special challenges related to the development of girls and women, the diverse beliefs and valuesof girls and women with whom they work, and how thesefactors may have an impact on each girl's and woman's experience. Psychologists face tough time to recognize the biopsychosocial effects of unique developmental experiences, such as reproduction, on women's lives, and they work support healthy transitions, prevent problems, and remediate difficulties.

**Diversity of women's experiences :**

Difficulty in understanding diversity of women experiences, Bias and discrimination are embedded in and driven by organizational, institutional, and social structures. These dynamics legitimize and foster inequities, influence personal relationships, and affect the perception and treatment of a person's mental and behavioral problems. Discrimination has been shown to contribute more to women's perceptions of their psychiatric and physical symptoms than any other environmental stressors and power domination in the systems of the society.

**Gender differences in families:**

In family and couple relationships, women continue to assume disproportionate

responsibility for child care, elder care, household management, and partner/spouse relationships. Although it has been well documented that multiple roles and relationships may lead to increased overall mental health for women.

Power inequities within couple and family relationships, as well as within the larger social context, may create conditions under which sexual abuse, rape, sexual harassment, bullying, and other forms of relationship violence.

**Conclusion**

Need for special counseling techniques and psychological counseling for women who are underprivileged and has special needs. Special training required to understand the societal norms and gender disparities in the society so as to help women recover their psychological wellbeing. Psychologists respect the dignity and worth of the individual and strive for the preservation and protection of women rights. As women rights are called human rights.

**Recommendations:**

The study recommended training of psychologists in understanding women issues in gender perspective because women developmental growth in Indian is mostly influenced by society, culture, parents, religious institutions. An individual to work on self-concept it is most important how the memories have been gender oriented. If this gender segregation is not properly understood the psychologists cannot help women to solve their life problems. To understand girls and women more fully, psychologists are encouraged to identify the social group memberships of girls and women, the extent to which they accept or deny these memberships, their experience of oppression and/or privilege within the context of these memberships, and their abilities to resist confining or oppressive messages. In addition, psychologists strive to understand and appreciate differences in various aspects of identity formation (e.g., sexual and social identity development) in the complexities of the stages through which these various identities may emerge.

Psychologists should be encouraged to develop awareness about how their own self-perceptions and levels of identity awareness influence their psychological assessments and perceptions of girls' and women's salient identities. Thepractitioner may, for example, be cognizant of the importance of avoiding gender and racial stereotyping in practice decisions but may not be aware of the subtle interaction between gender and race for girls and women who may experience unique child-raising, socialization, and gender-role development experiences related to biracial identity.

Psychologists needs to be educated and strive to be aware of socialization processes, to recognize stereotyping, and to communicate the subtle ways in which beliefs and behaviors related to gender may affect the life experiences and well-being of girls and women at various points of the lifespan.

A holistic training and conducting workshops on development of the psychologists' psychologists are encouraged to apply psychological research findings to major social issues, such as family leave, work–family interface, poverty, discrimination, homelessness, intimate violence, affirmative action policies, the effects of trauma, services for the elderly, and media

depictions of girls and women. The range of potential involvement in education,prevention, and public policy issues is extensive and may include incorporating diversity issues into lectures and presentations, conducting action research that places individual problems in social context, providing pro bonoservices and consultation to community organizations,questioning possible discriminatory and no inclusive theories and practices within psychology and other professions, and diagnosing and working within organizational contexts and with other constituent groups to ensure effective service provision and increase access to psychologicalpractice in its many forms.Finally, psychologists are also encouraged to supporttheir clients' contributions to positive microlevel and/or macrolevel actions that increase a sense of empowerment and influence. For example, microlevel behaviors may involve confronting a supervisor or acquaintance about sexist, racist, or heterosexist practices within one's workplaceor relationships, whereas macrolevel activities may involvehelping to change policy relating to rape, sexual harassment, child or elder abuse at a state or national level.

## REFERENCES

1. Abrams, L. S. (2003). Contextual variations in young women's gender Identity negotiations. Psychology of Women Quarterly, 27, 64 –74.
2. Ackerman, R. J. (1999). An interactional approach to pharmacopsychologists and psychologists: Gender concerns. Journal of Clinical Psychology in Medical Settings, 6, 39 – 47.
3. Adams, D. L. (Ed.). (1995). Health issues for women of color: A culturaldiversity perspective. Thousand Oaks, CA: Sage.Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contextsof help seeking. American Psychologist, 58, 5–14.
4. Alexander, L. L., LaRosa, J. H., & Bader, H. (2001). New dimensions inwomen's health (2nd ed.). Boston: Jones & Bartlett.Altmaier, E. M., Fraley, S. S., Homaifar, B. Y., Maloney, R., Rasheed, S.,& Rippentrop, A. E. (2003). Health counseling: Assessment and inter-vention. In M. Kopala & M. E. Eitel (Eds.), Handbook of counselingwomen (pp. 323–344). Thousand Oaks, CA: Sage.
5. Altman, L. K. (1997, June 22). Is the longer life the healthier life? NewYork Times, p. WH 158.
6. Alvidrez, J., & Azocar, F. (1999). Distressed women's clinic patients:Preferences for mental health treatments and perceived obstacles. Gen-eral Hospital Psychiatry, 21, 340 – 347.
7. American Association of University Women Educational Foundation.(2001). Hostile hallways: Bullying, teasing, and sexual harassment inschool. Washington, DC: Author.American Psychiatric Association. (2000). Diagnostic and statisticalmanual of mental disorders (4th ed., text rev.). Washington, DC:Author.
8. American Psychological Association. (1975). Report of the Task Force onSex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice.American Psychologist, 30, 1169 – 1175.

9. American Psychological Association. (1978). Guidelines for therapy withwomen: Task Force on Sex Bias and Sex Role Stereotyping in Psycho-therapeutic Practice. American Psychologist, 33, 1122–1123.
10. American Psychological Association. (1979). Principles concerning the coun-seling and psychotherapy of women. Counseling Psychologist, 8, 21.
11. American Psychological Association. (1991). Resolution on substanceabuse by pregnant women. Washington, DC: Author.
12. American Psychological Association. (1996). Violence and the family:Report of the American Psychological Association Presidential TaskForce on Violence and the Family. Washington, DC: Author.
13. American Psychological Association. (2000a). The behavioral health careneeds of rural women. Washington, DC: Author.
14. American Psychological Association. (2000b). Guidelines for psychother-apy with lesbian, gay, and bisexual clients. American Psychologist, 55,1440 –1451.
15. American Psychological Association. (2000c). Resolution on poverty andsocioeconomic status. Washington, DC: Author.American Psychological Association. (2000d). Resolution on women andpoverty. Washington, DC: Author.
16. American Psychological Association. (2001). Publication manual of theAmerican Psychological Association (4th ed.). Washington, DC: Author.
17. American Psychological Association. (2002a). Criteria for practice guide-line development and evaluation. American Psychologist, 57, 1048 –1051.
18. American Psychological Association. (2002b). Ethical principles of psy-chologists and code of conduct. American Psychologist, 57, 1060 –1073.
19. American Psychological Association. (2002c). Intimate partner abuse andrelationship violence. Retrieved December 13, 2003, from http://www.apa.org/pi/iparv.pdf
20. American Psychological Association. (2002d). Summit on women anddepression. Washington, DC: Author.
21. American Psychological Association. (2003). Guidelines on multiculturaleducation, training, research, practice, and organizational change forpsychologists. American Psychologists, 58, 377– 402.
22. American Psychological Association. (2004a). Guidelines for psycholog-ical practice with older adults. American Psychologist, 59, 236 –260.
23. American Psychological Association. (2004b). Resolution on culture andgender awareness in international psychology. Washington, DC: Author.
24. American Psychological Association. (2005). Resolution on male violenceagainst women. Washington, DC: Author.
25. American Psychological Association Task Force on Women, Poverty, andPublic Assistance. (1998). Making welfare to work really work. Wash-ington, DC: Author.Ancis, J. R., & Ladany, N. (2001).
26. A multicultural framework for coun-selor supervision. In L. J. Bradley & N. Ladany (Eds.), Counselorsupervision: Principles, process, and practice (3rd ed., pp. 63–90).

27. Philadelphia: Brunner-Routledge.Anderson, K. M., Sharpe, M., Rattray, A., & Irvine, D. S. (2003). Distressand concerns in couples referred to a specialist infertility clinic. Journalof Psychosomatic Research, 54, 353–355.
28. Angold, A., Erkanli, A., Silberg, J., Eaves, L., & Costello, E. J. (2002).Depression scale scores in 8 –17-year-olds: Effects of age and gender.
29. Journal of Child Psychology and Psychiatry and Allied Disciplines, 43,1052–1063.
30. Apter, T. (1996). Path of development in midlife women. Feminism andPsychology, 6, 557–562.
31. Armstrong, M. J. (2001). Ethnic minority women as they age. In J. D.Garner & S. O. Mercer (Eds.), Women as they age (2nd ed., pp.97–111). New York: Haworth.
32. Arroyo, J. A., Simpson, T. L., & Aragon, A. S. (1997). Childhood sexualabuse among Hispanic and non-Hispanic White college women. Journal of Behavioral Sciences, 19, 57– 68.
33. Avis, N. E. (2003). Depression during the menopausal transition. Psy-chology of Women Quarterly, 27, 91–100.
34. Bachanas, P. J., Morris, M. K., Lewis-Gess, J., Sarett-Cuasay, E. J., Sirl,K., Ries, J. K., & Sawyer, M. K. (2002). Predictors of risky sexualbehavior in African American adolescent girls: Implications for pre-vention intervention. Journal of Pediatric Psychology, 27, 519 –530.
35. Ballou, M., & Brown, L. S. (Eds.). (2002). Rethinking mental health anddisorder: Feminist perspectives. New York: Guilford.
36. Ballou, M., Matsumoto, A., & Wagner, M. (2002). Toward a feministtectological theory of human nature: Theory building in response toreal-world dynamics. In M. Ballou & L. S. Brown (Eds.), Rethinkingmental health and disorder: Feminist perspectives (pp. 99 – 141). NewYork: Guilford.
37. Ballou, M., & West, C. (2000). Feminist therapy approaches. In M.Biaggio & M. Hersen (Eds.), Issues in the psychology of women (pp.273–297). New York: Kluwer Academic/Plenum.Banks, M. E., & Kaschak, E. (2003). Women with visible and invisible