Feminine Ideology, Relational Self-Concept, and Internalizing Symptoms in Women

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FEMININE IDEOLOGY, RELATIONAL SELF-CONCEPT, AND INTERNALIZING
SYMPTOMS IN WOMEN

BY ANJALI GEORGE

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York
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by

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

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by

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Background: Investigators have theorized that women may experience internalizing disorders such as depression and anxiety more frequently than men in part because of unique socialization processes that women undergo. One aspect of early socialization thought to contribute to women’s propensity for depression and anxiety is the way women are brought up to relate to themselves in relation to others, often placing greater importance on the needs, desires, and value of others, at times at a psychological cost to themselves. This study attempts to elucidate the relationship between gender socialization, relational self-concept, and internalizing symptoms in women.

Methods: Two hundred and fifty-one participants completed self-report questionnaires assessing the above relationship. The study tested a model in which a number of constructs indexing the way women relate to themselves in the context of interpersonal relationships, i.e. their relational self-concept: (1) self-worth: evaluations of one’s worth relative to that of others, (2) boundaries: the ability to see one’s self as separate in the context of interpersonal relationships, (3) rank: beliefs about the relative ranking of one’s needs and desires over those of others and (4) emotional reliance: the tendency to rely on others for the maintenance of one’s self-esteem — would partially mediate the relationships between feminine ideology (conformity to norms of femininity) and internalizing symptoms (depression and anxiety).
Results: The results partially supported the study’s hypotheses: Higher conformity to feminine norms was associated with lower self-worth, lower boundaries, lower ranking, and higher emotional reliance on others. Higher conformity to feminine norms was also found to be significantly associated with higher levels of anxiety symptoms. Contrary to the study’s hypotheses, there was no statistically significant relationship between feminine ideology and depressive symptoms. Also contrary to the study’s hypotheses, the relationship between feminine ideology and internalizing symptoms was not mediated by any of the proposed relational self-concept variables. A follow-up analysis investigating the study’s hypotheses among different racial/ethnic groups, supported the proposed mediation model: Emotional reliance mediated 15.3% of the relationship between feminine ideology and anxiety symptoms and emotional reliance mediated 52% of the relationship between feminine ideology and depressive symptoms among Latinas.

Conclusions: Current findings demonstrate the continued importance of investigating the relationship between feminine ideology and psychological functioning in women. Findings indicate that the cultural promotion of traditional codes of femininity may be associated with problematic ways of relating to the self in relation to others, placing women in certain cultural groups at greater risk for depression and anxiety.
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**Introduction**

Epidemiological research on gender and mental illness has consistently demonstrated that women are more prone than men to internalizing disorders, such as depression and anxiety which is commonly defined in the literature as disorders characterized by problematic thoughts, feelings, or behaviors directed toward the self (Avison & McAlpine, 1992; Gore, Aseltine, & Colten, 1993; Kessler, 2003; Angst & Dobler-Mikola, 1985; Bruce et al., 2005; Regier, Narrow, & Rae, 1990). Investigators have theorized that women may experience depression and anxiety more frequently than men in part because of the unique socialization processes that women undergo (Hirschfeld, Klerman, Clayton, Keller, & Anderson, 1984; Rosenfield, Lennon, & White, 2005; Turner & Turner, 1999). One aspect of early socialization, posited to differ among genders, is the way individuals relate to themselves in the context of interpersonal relationships (Chodorow, 1978; Gilligan, 1982; Miller, 1976). Indeed, investigators have found that women more so than men tend to hold beliefs about themselves, otherwise termed here in this study as "relational self-concepts," which place others above themselves in value and importance, and that women more than men tend to rely on others for the maintenance of their self-esteem (Rosenfield et. al., 2005; Turner & Turner, 1999).

Drawing from the work of various feminist theorists and researchers who emphasize the developmental and familial constellations that inform and reproduce other-oriented relational self concepts in women that stands in contrast to the more instrumental orientation observed in men (Chodorow, 1978; Gilligan, 1982; Miller, 1976), a cohort of researchers have devoted themselves to studying the role these other-oriented relational self-concepts play in gender differences in mental health (Gore & Colten, 1991; Leadbeater, Blatt, & Quinlan, 1995; Taylor & Turner, 2001; Turner & Turner, 1999;). While Gilligan and Miller are known primarily for
highlighting overlooked salutary aspects of this other-orientation, these latter researchers looked at the negative corollary of this orientation by examining the potential adverse impact that an extreme other-oriented relational concept can have on women’s mental wellbeing.

“Relational self-concept” is a concept crafted for the purpose of this investigation to denote various ways of relating to the self in the context of interpersonal relationships: the evaluation of one’s self worth relative to the worth of others, boundaries between self and other, the ranking of one’s needs and interest in relation to others, and the degree of emotional reliance on others for maintenance of self-esteem. These specific ways of relating to the self and others have all been empirically linked to internalizing disorders and have demonstrated higher prevalence rates in women than in men (Rosenfield et. al., 2005; Turner & Turner, 1999), suggesting that gender normative processes may explain some of the observed gender differences in psychopathology. Yet this body of research has not explicitly studied the presumed gender normative process thought to be instrumental in this pathway to internalizing symptoms.

While it may be true that women as group, appear more uniform in their endorsement of symptoms of internalizing disorders in comparison to men, the diversity of attitudes and beliefs held by women in regards to gender norms (feminine ideology) and their relational self-concept makes it reasonable to expect that some women will be more vulnerable to internalizing disorders than other women. Yet, research on gender norms, relational self-concepts, and mental health has historically focused on differences between men and women, ignoring fertile avenues offered by investigations of within group differences among women.

In this respect, the presumed relationship between relational self-concepts, internalizing symptoms, and gender normative processes has never been explicitly examined. The present study will endeavor to explore the relationship between these factors. It is proposed in this
study that women who adhere strictly to norms of femininity (feminine ideology) will be more likely to endorse relational self concepts that are associated with anxiety and depression than women whose relationship to norms of femininity is more flexible. The following questions will be explored: Do relational self-concepts and feminine ideology mutually inform each other such that their effect on women's mental health work more or less in tandem with each other? Or is feminine ideology indirectly related to internalizing symptoms through its relationship to relational self-concepts? Do these factors have independent relationships to levels of anxiety and depression in women? How do social location factors such as age, ethnicity, and sexuality moderate the relationship between these factors?

*Clarifying terminology used in the present study:*

“Relational self concept”: In the present study, “relational self concept” is used to refer to a way of relating to one’s self and others that ranges from an extreme emphasis on the self to an extreme emphasis on the other. This term refers to the organizing principle that appears to underlie the constructs of “emotional reliance” and the three subcomponents of “self-salience”: worth, boundaries, and rank.

“Gender” and “Sex”: Following the convention in a number of fields, in the present study “sex” refers to the being assigned male or female at birth. “Gender” refers to an identity constructed from codes, roles, and behaviors associated with masculinity, femininity, or positions between that do not inhere to sex.

“Internalizing Problems”: In today’s clinical nomenclature internalizing problems refer to symptoms of depression and anxiety, which have in common the tendency to “turn problematic feelings against the self”(Rosenfield & Mouzon, 2013, p. 277). This classification does not fall far from Freud’s original formulation of depression as a defensive redirecting of anger against
the self (1917). By extension it also reflects Freud’s revised theory of anxiety, which he characterized as a “signal” of the danger of encroaching intolerable feelings (1926), which is experienced internally as agitation in one’s own mind or body. This particular way of both experiencing and defending against difficult feelings leaves behind a trail of “internalizing” symptoms that include but are not limited to low mood, poor appetite, sleep difficulties, excessive tension, restlessness, obsessive ideation, compulsions, and somatization.
Literature Review

Gender Socialization: Cognitive Theories of Gender Development

Cognitive theories of gender development have been primarily concerned with the cognitive mechanisms by which children acquire knowledge about gender groups and develop a sense of membership to a gender group. Implied in the term “acquisition” is the suggestion that gender does not spontaneously flow from sex difference, but rather involves active cognitive processes that take in and organize cues from the social environment. Social-cognitive theory, gender schema theory, and cognitive-development theory represent three major cognitive theories of gender that taken together provide an orchestrated perspective on how individuals first attain a gendered sense of self.

Gender schema theory tells us that children classify and organize salient information such as gender into schemas in an attempt to attain a sense of self-definition and cognitive consistency (Liben & Signorella, 1980; Martin & Halverson, 1981). These schemas are thought to prime the binding of same-sex scripts into memory, which serve to instruct children on how to behave in accordance with gender norms (Ruble & Stangor, 1986). For the most part, gender schema theory focuses on how children attain a traditional sex-typed sense of gender identity.

However researchers have observed that this process can be idiosyncratic, which they interpret as providing evidence for the constructive nature of gender schema formation. For example, researchers, Liben & Bigler (2002) found that children who demonstrate strong personal interests in activities typically associated with the opposite sex, i.e. “tomboys,” may construct more flexible gender schemas than children who engage in gender-typical activities. This seems to suggest that non-stereotyped gender behavior can arise from the active molding of gender schemas to fit the needs and proclivities of the individual.
Cognitive development theory proposes that children come to realize that they are a boy or a girl by the age of two or three, but only attain “gender constancy,” that is the understanding that their sex remains invariant, by age six or seven years old (Martin & Ruble, 2002). Once children acquire gender constancy, gender categories begin to provide a salient platform on which to exercise a sense of mastery and control. For the most part, cognitive developmental theory highlights internally initiated mechanisms by which children become motivated to bring their perceptions and behaviors in line with gender categories. Given its focus on early childhood development, cognitive development theory cannot account for individual differences in gender identity, like sex-typing or gender flexibility, beyond the age of six or seven. Thus it does not provide a theory from which to understand deviations from gender-stereotypical behavior in later stages of development.

Social-cognitive theorists recognize the importance of gender schemas and gender constancy in gender development but do not see these two cognitive structures as necessarily preceding gender-type behavior. According to social cognitive theory (SCT), initially, children’s gender-typed behavior is regulated externally by reinforcement from their social environment. Later, as children acquire knowledge about gender difference, they begin to abstract and internalize outcomes associated with same-sex adults, peers, and media figures to guide their own behavior (Bussey & Bandura, 1999).

According to SCT, children at this point become “personally” inclined to engage in activities that are gender sanctioned and disengage in those activities that are not as heavily reinforced. This has implications for various aspects of one’s life going forward including the talents one cultivates, the conceptions one holds about oneself, and one’s occupational path—all
of which reflect to some degree, gender-typed prescriptions learned in childhood (Bussey & Bandura, 1999).

In more traditional environments that dictate strong adherence to gender roles, it is expected that self-regulatory processes may be more sensitive to environmental sanctioning and less amenable to personal preferences. SCT theorists, however, also insist that this ratio of influence between the social and personal is not fixed (Bussey, 2011). Instead environmental and personal influences are thought to wax and wane in salience over time and across contexts. Unlike cognitive developmental theorists, social-cognitive theorists do not see gender identity following a linear, pre-ordained developmental pattern, but instead view gender identity as an “ongoing process” that can change over the course of a lifetime and that also responds to changing societal views about gender.

Taken together the strength of the cognitive theories lies in their close enumeration of the process by which notions of gender difference are first acquired in childhood. These theories also offer preliminary suggestions on how behaviors and attitudes can deviate from gender norms, though none of these theories are particularly thorough or explanatory in this regard. Also outside the scope of these theories is an explanation for why and how the range of traits and behaviors that constitute gender tend to be distributed dichotomously by sex in terms of femininity and masculinity.

The following section will review the research on the early environment in so far as it can serve to foster gender normativity or gender flexibility. Theories on how norms of femininity and masculinity emerge in society and are reinforced into adulthood will also be discussed. Interspersed throughout this discussion will be counterpoint discussions on the various explanations that have been offered by theorists and researchers to account for individual
variation in terms of gender normativity. Finally empirical research on mental health and gender-related traits and norms will also be reviewed.

**Gender Socialization: The Role of the Environment**

In the following section, I will present the research on two environmental factors that have been associated with gender socialization, namely the family environment and the peer environment. These two areas do not represent an exhaustive examination of the role of the environment on gender cognitions. For instance the influence of school dynamics and media representations on gender socialization have also been studied extensively. The purpose of this brief review is to extend the contextual framework provided by the cognitive theories of gender development to illustrate further how current psychological research has come to understand gender normative processes in the early childhood environment.

**Familial Environment:** Research literature indicates that differential treatment by sex begins at birth. Investigators observing families in a shopping mall were able to identify the sex of nearly all infants by the clothing worn (Shakin, Shakin, and Sternglanz, 1985), suggesting that parents automatically present their children according to the gender role the child is expected to fill. While evidence for differential parent treatment by sex has been shown and replicated (Rubin, Provenzano, and Luria, 1974; Collins and Russell, 1991; Gjerde, 1986; Fagot and Hagan, 1991), studies that look specifically at the impact of differential parent treatment on children’s gender development have generally only shown weak effects, indicating that the effect of differential treatment by parents on children’s gender development may be overestimated in the literature (Maccoby and Jacklin, 1974; Siegel, 1987; Stoneman and Brody, 1981; Lytton and Romney, 1991).
In a meta-analysis on parental effect on gender socialization, results strongly suggest that age may be a crucial variable in differential treatment by parents. Studies indicate that infants between the age of one and two (Fagot and Hagan, 1991), and adolescent children (Gjerde, 1986) may be subject to more intense differential treatment from parents, suggesting that at different points in development, parents may become more concerned about conformity to cultural standards than at other points in development (Fagot, Rodgers, & Leinbach, 2000). These studies help to explain the modest but periodic contribution of differential parent treatment to a young person’s gender development.

The results of research that links individual differences among parents to differences in levels of gender socialization among children has been mixed. For instance a study controlled for income level, Leve and Fagot (1997) found that single mothers and fathers had less traditional gender-role attitudes than parents in two-parent families. The same researchers also found that children in single-parent families did not differ in gender-role preference or knowledge from children in two-parent families. These findings stand in contrast to the findings from a meta-analysis study that used a primarily North American and European sample of parents and children with a mean age of ten years old. In this study, a slight correlation was found between parent gender schemas and children’s gender cognitions (Tennenbaum & Leaper, 2002). In other words, parents with more traditional gender schemas were more likely than parents with more nontraditional schemas to have children with gender-typed cognitions.

Together, these findings suggest that one should exercise caution when evaluating parental influence on the development of children’s gender-related thinking, which may exist but only at modest levels and may wax and wane in intensity depending on the child’s age.
Peer Environment: Despite many modern parents’ efforts to raise their children as more gender flexible, peer groups have been shown to steer children in the direction of gender typed behavior and preferences, particularly in the early school age years. Around the age of three, when the introduction of separate social roles for boys and girls first takes place outside the home, boys and girls begin to participate in different activities, demonstrate different behavioral styles, and generally play more with same-sex peers than they do with opposite-sex peers (Rose & Rudolph, 2006; Whiting & Edwards, 1988; Maccoby, 1988; Martin, Fabes, Evans, & Wyman, 1999). One of the first observational studies that coded children’s activities in nursery school classes found that girls appeared to avoid activities preferred by boys, and when they did engage in play that was gender flexible, such as digging in the sand or riding tricycles, they tended to do so with other girls. In the same study, mixed-sex play was demonstrated to almost always occur when teachers led a group activity (Fagot and Patterson, 1969). These findings were replicated twenty-four years later in Thorne’s study (1993), suggesting that gender segregation takes place from within peer groups rather than enforced from the outside and that children’s—at least young children’s—peer relations may be relatively immune to changing social mores about gender difference (Fagot et. al 2000).

One common explanation for this phenomenon draws on gender schema theory. Studies that investigate the role of gender schemas in the development of same-sex peer groups suggest that in their attempt to understand the nature of gender and environmental messages concerning gender, children engage in same-sex and gender-stereotyped activities (Fagot, Leinbach, & Hagan, 1986). In line with a social-cognitive theory of gender socialization, environmental information from media, adults, and peers is also thought to be learned through modeling and reinforcement to produce same-sex peer preferences (Fagot, et. al, 2000). As was mentioned
previously, gender schema researchers have begun to pay more attention to children who engage in activities typically associated with the opposite sex and have suggested that these children may have more flexible gender schemas due to the influence of strong personal proclivities that can actually override the sway of peer processes (Liben & Bigler, 2002). Taken together, the research on early environment and children’s gender cognitions indicates that environmental influences comingle with personality factors to create both the gender-stereotyped behavior and the more gender flexible behavior observed in children.

**Gender Socialization: Social Role Theory**

The theory that perhaps most convincingly explains how gender differences persist into adulthood is social role theory. Eagly posited in her social role theory that it is different social roles, rather than biological sex, that provide the primary explanation for gender differences in behavior (1987). According to social role theory, gender roles are derived from activities carried out by individuals of each sex in their sex-typical occupational and family roles. Following this logic, in so far as women and men continue to occupy divergent roles, the characteristics required by these activities become stereotypical of women or men.

Eagly believes that what ultimately informs social roles is the sexual division of labor and gender hierarchy typified by the homemaker-provider divide also characterized in terms of the distinction between communal and agentic characteristics (Bakan, 1966; Eagly, 1987). Social role theorists cite cross cultural research which has shown that all known societies have an established division of labor according to sex, and that status and power differ among the sexes, typically favoring men (Leacock, 1978; Pratto, 1996). In the United States, where high levels of female labor exist, but the distribution of occupations still tends to differ according to sex (Reskin & Padavic, 1994; Alonso-Villar, Del Rio, Gradin, 2010; Lippa, Preston, Penner, 2014),
occupational success in female-dominated occupations tends to be associated with communal personal qualities while success in male-dominated occupations tends to be associated with agentic qualities (Cejka & Eagly, 1999).

According to social role theory, it is not necessary that individuals fully internalize gender stereotypes or gender norms for a bifurcation in behavior to develop between males and females. Social pressure, in the form of subtle punishment and reward, can induce gender-stereotyped behavior (Eagly, 1987). Weighing these outcomes, people are thought to steer away from engaging in nonconforming behavior unless some kind of benefit is anticipated. Contextual factors can thus play an important role in eliciting gender-related behaviors or not. For instance, women are often assumed to be “naturally” more empathic than men. Yet in Ickes, Gesn, and Grahm’s meta-analysis (2000), women were shown to be more empathic than men only when gender-role stereotypes were made salient through priming. Research thus appears to support the theory that gender differences in behavior are better explained by social roles than by inherent personality differences between men and women. However this is not to say that social-roles do not influence the construction of personality differences, which are often mistaken as a natural outgrowth of one’s sex.

For instance, social role theory does not stop short of explaining gender-related behavior but also asserts that an individual’s self concept, including one’s personal gender identity, is not immune to the influence of social roles (Eagly, Wood, and Diekman 2000): Gender identity does not ordinarily entail accepting all of the personal attributes that are generally thought to be typical of one’s sex, but it has been shown to often entail some portion of them (Spence, 1993). Social role theorists interpret this distribution of trait difference according to sex as an indication of gender role influences on ideas about the self. According to social role theory, self-definitions
are thought to play their own role in regulating gender-related behavior. Social role researchers have used this self-regulation theory to explain findings that showed that gender-role norms tended to be personally relevant to individuals when experiences that were congruent with gender norms yielded positive feelings about the self, bringing individual’s self concepts closer in line with ideal societal standards (Wood, Christensen, Hebl, & Rothgerber, 1997).

If social role theory holds true, then women’s behaviors should change as the social landscape changes and opportunities for women expand and shift the roles typically associated with women. Also following this logic, differences in social environments, i.e. the extent to which one’s parents held gender-typed schemas, whether one comes from a traditional or non-traditional family or cultural background, historical differences in the social milieu between older and younger generations, and even differential exposure to gender-typed messages in popular culture ought to yield individual differences in terms of the salience of gender norms among women.

**Empirical Research: Masculinity, Femininity, Androgyny and Mental Health**

**Background:** Early psychological research on gender difference conceptualized masculinity and femininity as diametrically opposed personality traits that resided in biological sex (Terman & Miles, 1936). Accompanying this conceptualization was the assumption that cross-sex characteristics signaled a failure to realize biological inheritance and was thus an indicator of psychological dysfunction (Smiler, 2004). These views held sway through the 1960s until feminist researchers within the field of psychology began offering critiques and alternative conceptualizations of gender identity (Stake & Eisele, 2010).

In her seminal article, Constantinople (1973) argued that femininity and masculinity are actually separate rather than opposing dimensions that do not inhere to sex. Concurrently, Bem
(1974) began conducting research based on this orthogonal view of masculinity and femininity. She held that individuals of either sex can subscribe to any combination and level of feminine or masculine gender roles, and she designed the Bem Sex Role Inventory (BSRI: Bem, 1974) to assess the extent to which people endorse these roles. Underlying this model was the assumption that people are never one hundred percent feminine or masculine. Rather, particular combinations of masculine and feminine traits will vary depending on the individual, but in general people can be grouped into “masculine,” “feminine,” “androgynous,” and “undifferentiated” gender types depending on the quantities—“low” or “high”—of masculine and feminine traits they endorse.

Building on this premise, gender researchers, Spence and Helmreich (1980), argued that the BSRI and their own comparable measure the Personal Attributes Questionnaire (PAQ; Spence, Helmreich, & Stapp, 1975) was actually capturing non-diametrically opposed traits of expressiveness (interpersonal orientation) and instrumentality (self-assertive orientation) rather than femininity and masculinity, Spence and Helmreich’s perspective lent support to the notion that the split between masculine and feminine is an artifact of social roles and early gender socialization and does not actually reflect sex-type capacities residing in individuals (Stake & Eisele, 2010).

In line with Spence’s claim that masculinity and femininity correspond to traits of instrumentality and expressivity, “masculinity” items on the BSRI are commonly thought to capture desirable traits most associated with instrumental or agentic aspects of the masculine role such as athletic, self-reliant, analytical, competitive, and aggressive. “Femininity” items are thought to capture desirable traits associated with the expressive or communal aspects of the
feminine role such as affectionate, empathic, compassionate, soft spoken, and warm (Stake & Eisele, 2010).

Given the continued relevance and power of gender roles, it was expected that more women than men would endorse feminine roles than men and that men on the whole would subscribe to masculine roles more strongly than women. However, for the first time, Bem’s model made conceptual room for the non-pathological existence of an “androgynous” woman or man. Turning early conceptualizations of gender and psychological health on its head, Bem (1974) took her theory one step further and proposed that relatively exclusive expressions of either masculine or feminine traits would be related to poor psychological adjustment and mental health problems, whereas a blend of masculinity and femininity—categorized as androgynous—would predict greater flexibility and optimal psychological health.

Empirical Research on Gender Roles and Mental Health: Decades of research based on Bem’s assumption that “androgynous” individuals are more psychologically healthy than sex-type individuals proved this assumption to be only partially true. Masculinity, or in other words instrumentality, has been found to be related positively to self-esteem, well-being, and social confidence (Allgood-Merton & Stockard, 1991; Stein, Newcomb, & Bentler, 1992) and negatively related to depression and anxiety (Bruch, 2002; Hermann & Betz, 2006; Lengua & Stormshak, 2000; Whitley, 1984). Similarly, femininity, or in other words expressiveness has been associated with general self-esteem (Stein et. al, 1992; Woodhill & Samuels, 2003) and social self-esteem (Allgood-Merton & Stockard, 1991; Jones, Chernovetz, & Hannson, 1978) and was shown to be negatively associated with depression and distress (Hermann & Betz, 2006; Sargovi, Koestner, Di Dio, & Aube, 1997).
Overall instrumentality (masculinity) has demonstrated stronger associations to self-esteem than expressiveness (femininity) as well as the combination of expressiveness and instrumentality (androgyny) (Cook, 1987). However, some researchers have found an interactional relationship between instrumentality and expressivity such that expressivity in the presence of high instrumentality predicts better adjustment but will not when accompanied by low instrumentality (Saragovi et. al, 1997). These findings suggest that, on a whole, the advantage offered by an “androgynous” position may be attributable to the presence of instrumentality or the interactional contribution of instrumentality to expressivity rather than the hypothesized flexibility of “androgyny.”

**Empirical Research on Gender Roles and Internalizing Symptoms**: Hoping to contribute to an understanding of the gender differences in psychopathology that tend to show that females suffer more from internalizing symptoms such as depression and anxiety and that males exhibit more externalizing symptoms, such as delinquency, aggression, and conduct disorder, studies have examined the degree to which gender role orientation (expressivity vs. instrumentality) accounts for differences in psychopathology along gender lines. As was stated previously, studies generally found that instrumentality negatively predicts internalizing symptoms such as depression and anxiety. Conversely, expressivity was negatively associated with externalizing disorders (Huselid and Cooper, 1994; Payne, 1987; Hoffman, Powlishta, & White, 2004). A direct positive relationship between instrumentality and externalizing disorders was found (Payne, 1987; Silvern & Katz, 1986), however, an analogous link between expressivity and internalizing disorders was not generally established (Craighead & Green, 1989; Huselid & Cooper, 1994).
These findings suggest that a stereotypical masculine role, reflecting instrumental traits that help impart heightened feelings of competence, may protect against internalizing problems, but when exaggerated may lead to aggressive, externalizing behaviors. On the other hand, a stereotypical feminine role, reflecting expressive traits that emphasize interpersonal competence, may enhance relations with others and thus protect against antisocial, externalizing problems. Though these findings indicate that gender differences in psychopathology are mediated by gender-role, a stereotypical feminine role, reflected in expressive traits, did not help explain internalizing problems in women. One possible reason for why high levels of instrumentality were associated with externalizing symptoms while high levels of expressivity were not related to internalizing symptoms may have to do with the fact that the measures used in these studies—the BSRI and the PAQ—generally capture desirable traits associated with femininity and masculinity. These scales may not be calibrated to pick up more negatively valenced aspects of femininity that may be contributing to internalizing problems in women.

The research on gender-related traits and internalizing disorders indicates that the use of more sensitive and up to date instruments that can capture some of the negative aspects of extreme expressions of femininity may be called for in order to more fully examine the relationship between female gender roles and internalizing symptoms. Additionally, trait constructs of gender are slippery in that internalized social norms, transposed into gender-related traits, often overlap with personality traits, which can be easily mistaken as in-born. Thus a trait model always teeters on the edge of reifying and naturalizing personality differences between men and women.

**Feminine Ideology Research:** Perhaps most in line with social role theory, “gender ideology” is another area of gender research and measurement that, unlike trait measures of
gender, explicitly sets out to assess people’s endorsement of a culture’s ideological beliefs about

gender roles (Smiler & Epstein, 2010). An underlying assumption of gender ideology research

is that these gender beliefs have built into them limitations and restrictions to lived experience

that can be potentially maladaptive (Brannon, 1976). In terms of cognitive theories of gender

and social role theory, these ideologies can also be thought of as regulating peoples’ behaviors

and self concepts to varying degrees based on a host of individual and contextual variables,

including but not limited to personality, sexuality, parent-child social milieu, ethnic background,

media exposure to gender messages, and the innumerable interactions of these various factors.

In the literature, gender ideology is actually used as an umbrella concept for what is in

fact two separate research areas: masculine ideology and feminine ideology (Smiler & Epstein,

2010). As such, each area is focused on within group differences in endorsement of ideology

rather than “traits” that are thought to inhere to masculinity or femininity. This subtle distinction,

in its emphasis on socially constructed roles and on variance within groups, supports the

assumption that women do not fundamentally adhere to norms of femininity in a uniform manner,

but will differ amongst themselves in ways that mimic somewhat the variability usually observed

between men and women.

Feminine ideology research was developed to correspond to the already highly developed

research area of “masculine ideology.” Many of the same researchers that designed the original

measures of “masculine ideology” in the 1980s, 1990s and early 2000s turned their attention to

developing measures of “feminine ideology” after masculine ideology research proved to be a

fertile line of research within the field of men’s psychology. One such measure is the

Conformity to Feminine Norms Inventory (CFNI; Mahalik, Morray, Coonerty-Femiano, Ludlow,

Slattery & Smiler, 2005) developed by gender ideology researchers. It assesses the strength of
women’s conformity to feminine ideology across eight factors: “Nice in Relationships, “Thinness,” “Modesty,” “Domestic,” “Care for Children,” “Romantic Relationships,” “Sexual Fidelity,” and “Invest in Appearance.” The authors developed this multi-factor measure in response to what they felt were real limitations of popular gender role inventories used to measure femininity—such as the BSRI and PAQ (2005). They observed that the BSRI is made up of responses to often socially desirable feminine stereotypes and that the BSRI converges on one global indicator of femininity, namely expressivity and as such is “…unable to differentiate among the many distinct cultural injunctions that define the social construction of femininity” (2005, p.418). They argued further that measures of femininity should account for the fact that individuals will construct their own individual sense of femininity around select norms rather than a whole host of norms, thus a multi-factor measurement is needed to accommodate the variability in salience of norms among women (2005).

Feminine Ideology and Internalizing Symptoms: Given the relative newness of the scale, only a few studies have tested its clinical application. Among those few studies, a number of have demonstrated indirect relationships between feminine ideology and depression and anxiety: A 2007 study found that feminist identification was a protective factor against the CFNI norms of Thinness, Investment in Appearance, and Romantic Relationships, which were in turn found to be directly related to self objectification, defined in the literature as the tendency to be preoccupied with others’ perspectives of one’s body (Hurt, Nelson, Turner, Haines, Ramsey, Erchull, & Liss, 2007). Feminine ideology, specifically the norms of Thinness, Investment in Appearance, and Romantic Relationships, was found to be indirectly related to depression through self objectification variables, Surveillance, e.g., “During the day, I think about how I
look many times”) and Body Shame (e.g., “When I can’t control my weight, I feel like something must be wrong with me”).

A 2012 study that used the CFNI found an indirect relationship between the feminine norm, Romantic Relationships, and depression and anxiety (Schrick, Sharpe, Zvonkovic, & Reifman, 2012). In this study, women were clustered into four categories: “Other-Focused,” “Moderately Appearance Focused,” “Middle of the Road,” and “Reject Appearance Norms.” Women who were “Other-Focused,” which is to say women who tended to be preoccupied with the maintenance of romantic relationships, who silenced their own wants or concerns in favor of fulfilling the wants or concerns of others, whose self-worth hinged on their performance in comparison to others, and who expended energy on outwards attempts to appear perfect in the eyes of others exhibited significantly greater psychological distress in the form of anxiety than all three remaining clusters of women who were generally less outwardly focused. The “Other-Focused” group of women also exhibited significantly higher levels of depression than the bottom two clusters, which were least concerned about others’ experience (Reject Appearance Norms, and Middle of the Road). Additionally this study showed weak but significant correlations between the feminine norm, Romantic Relationships, and clinical outcomes, depression and anxiety.

Both of these studies demonstrate the promise of the CFNI, specifically in terms of the opportunity it provides to contribute to a burgeoning body of literature on feminine ideology, and to test the supposition that there may be psychological costs to women for conforming to a variety of gender role norms.

**Self Concept and “Femininity”**
The idea that gender symbolically informs and organizes self experience has been noted by a number of prominent psychological theorists and researchers (Dimen, 1991; Chodorow, 1978; Markus & Oyserman, 1988). Like many of her contemporaries, psychoanalyst and feminist, Muriel Dimen (1991), thinks about gender not as a marker of anatomical difference but rather as a category, or to use her term, a “force field” that is inextricably tied to cultural representations of masculinity and femininity. According to Dimen, these representations have the power to “set the terms” for self experience, coding what are often “problems of the self” in terms of gender (p. 334). Extending psychoanalytic theories of separation-individuation, Dimen suggests that dualities of “the self” that were once merged in infancy such as independence vs. dependence, subject vs. object, and active vs. passive get split off and mapped onto cultural categories of masculinity and femininity through the process of social inscription, revealing their splits in “transitional spaces” or moments of tension and defense as symptoms.

Recognizing the force field that marries the inherently unrelated contrasts masculine/feminine, self/other, and active/passive to one another permits us to understand, for example, that women’s anxiety in activity may be a problem equally of gender as of self (1991, p. 338).

For a number of feminist writers, psychoanalysis is a site and a text from which to understand how aspects of the self become constituted along gender lines vis-à-vis social inscription in the traditional family structure (Dimen, 1991; Goldner, 1991; Harris, 1991; Elise, 1997; Rubin, 1975), and many of these writers cite Freud’s oedipal complex as one of the most influential hegemonic texts of gender normativity. In his formulations on human sexual development, Freud questioned the notion of inborn femininity and masculinity, believing instead that differences between men and women resulted from a diverging set of complex developmental events that were imaginative and psychological at their core. Much to the chagrin
of many of the feminists who draw inspiration from his writing, Freud never fully embraced the radical implication of his theory of original “bisexuality” but instead succumbed to the prevailing view that this essentially psychological process ultimately functioned to consolidate a preordained biological identity.

Largely formulated as a corollary to the male oedipal complex, female sexual development, according to Freud, began with an essentially “bisexual” girl, who like her male counterpart, is preoccupied with an oedipal desire for her mother, the original love object. Over the course of development, the girl soon begins to recognize that like her mother before her she does not possess a penis. Crestfallen and resentful of this castrated status, the girl develops penis envy accompanied by a deep sense of inferiority. At the resolution of the female oedipal crisis, the little girl diffuses her envy and sense of defeat by substituting her desire for the penis with a desire for a child by the father, thereby obtaining her wish for a penis through anatomically passive means. According to Freud, this transformation from a desiring or aggressive subject to a passive or masochistic object is what unlocks a woman’s feminine “nature” (Chasseguet-Smirgel, 1970).

In a Lacanian re-reading of Freud, Rubin (1975), recasts this transformation from active to passive as a kind of “live” patriarchal discourse that sets the stage for the symbolic coupling of femininity with what are otherwise non-gendered though far from neutral aspects of the self, such as passivity, dependence, inferiority.

The ascendance of passivity in the girl is due to her recognition of the futility of realizing active desire… One can read Freud’s essays on femininity as descriptions of how a group is prepared psychologically, at a tender age, to live with its oppression (pp. 49-50)

The preferred female sexuality would be one that does not protest or actively desire (and in doing so disrupt the system) but rather responds to the desire of others (p. 42)
Similarly critical of Freudian notions of women as biologically different and inferior to men, Chodorow (1978), addresses the question of gender difference in her seminal work, "Reproduction of Mothering," by charting divergences in girls’ and boys’ preoedipal relationship with their mother. She asserts that the separation-individuation process of the preoedipal phase is fundamentally different for boys and girls when the primary attachment figure from which the infant is separating is female, which is still true in the majority of cases in U.S. society today.

For a boy, the sense of difference from the mother and the growing rivalry and identification with the father pushes him to repudiate his mother and gain independence from her. This independence continues to resonate and define his sense of masculine identity in terms of autonomy and discontinuity from others. Whereas for a girl, because her mother tends to experience her as more continuous and like her, and because the girl is attempting to separate from the same object with whom she identifies, the primary mother-infant relationship tends to extend into the girl’s oedipal relationship with her mother, attenuating her separation/individuation process. This developmental difference, Chodorow argues, is what constitutes different forms of “relational potential” in women and men and helps to explain why women come to experience themselves as less differentiated and more continuous and related to others than men. In other words, she argues women are developmentally loaded for relatedness, intimacy, and empathy but are also prone to boundary confusion to the effect that women’s self concept can be fused with the needs and desires of others (1978).

A girl identifies with and is expected to identify with her mother in order to attain her adult feminine identification and learn her adult gender role. At the same time she must be sufficiently differentiated to grow up and experience herself as a separate individual—must overcome primary identification while maintaining and building a secondary identification (p, 177).
In her most celebrated work, *In a Different Voice*, Gilligan (1982) also highlights the dangers of an extreme other-orientation while also challenging the preeminence of what she construes as “androcentric” qualities of autonomy and abstraction in her study of “female” moral development. Though she is best known for championing the salutary qualities of a “feminine” interrelated sensibility, Gilligan also underscores the stage of “goodness” that many women fall prey to or remain fixated on in the course of their moral development. In this stage, the needs, opinions, and voice of others take priority, informed by the feminine convention of self-sacrifice. Over the course of development, there is growing awareness of the hypocritical altruism of caring for others in order to secure love, of the sense of resentment over handing over one’s agency to the authority of others, and of the nagging sense of betrayal from having hurt oneself for the sake of others. This growing awareness clears the path for the next and last stage of “female” moral development, the “nonviolence” stage. In this stage, the conflation of self-sacrifice and care inherent in the feminine norm of “goodness” is reexamined giving way to a new understanding of the universality of care that extends responsibility for nonviolence to include the self as well as others (1982).

How some women come to “reexamine” the norm of “goodness” is not systematically explained by Gilligan, nor does she entertain a scenario in which some women may arrive at the stage of “nonviolence” without having to pass through the gauntlet of more problematic lower stages. This may have something to do with what has been commonly observed in Gilligan’s work as a collapsing of “female” and self-concept categories such as interrelatedness, much in the way that Dimen (1991) highlights and cautions us against. Yet, Gilligan’s elision is understandable since as Dimen has also observed, problems of the self may equally be problems of gender. Still, in assuming that all women pass through a set sequence of stages, Gilligan
forecloses the possibility that some women may be less prone than other women from the outset from forming self-concepts that are associated with strict definitions femininity. In this respect, both Chodorow (1978) and Gilligan (1982) outline, for the most part, models that emphasize pre-determined gender difference.

Those working at the intersection of social and developmental psychology have also sought to explain how self-concepts such as self-sacrifice or self-centeredness are often informed by gender (Hannover, 2000). This model is in many ways compatible with Chodorow’s and other feminist theorists’ model; however, implicated in these models is also an explanation for how within group differences in self-concept may emerge among women or among men. For instance, in her “integrative” social-developmental model, Hannover (2000) proposes that the self is an associative memory network that over the course of development encodes information pertaining to the self by context. For women, one such context is “self as female.” Charting the development of “self as female,” Hannover proposes that gender-congruent information corresponding to the core dimensions of feminine stereotypes get linked to the information node of being female due to their “chronic accessibility,” establishing a woman’s gender related self-construct over the course of time (p.188). For females, these core dimensions include expressiveness, communion, pursuit of harmony, closeness, and interrelatedness with others (p. 180).

“Chronic sources of self knowledge” in the social context are thought to reinforce and establish a relatively stable gender related self-construct. “Chronic sources of self knowledge” is defined somewhat nebulously by Hannover as self-knowledge that has been primed frequently in the past (p. 186). Though Hannover does not specify what some of these chronic sources may be, one can presume that one probable source could be the object relational context in which one
grew up that, as Chodorow (1978) points out, are different for boys and girls when a female is the primary caretaker. Another probable “chronic source” may be women’s relative position of power in society in comparison to men, which feminist psychologist and psychoanalyst, Jean Baker Miller, believes explains the centrality of relationships in women’s lives. As subordinates in a culture dominated by men, Miller has argued that women must be constantly attuned to and responsive to others because it is these others who control their future (1976).

As discussed earlier, other “chronic sources” of self-knowledge may be cultural beliefs pertaining to one’s gender. Inextricably linked to these beliefs, another chronic source may be the family or occupational roles that are encouraged by the social environment. Different sexual orientations may also elicit different chronic sources of self-knowledge from the social environment, such that gender-incongruent information is more likely to get incorporated into the self-concept. Finally the gender schemas maintained by one’s parents can provide chronic sources of self knowledge that help to explain either the rigidity or the flexibility of one’s gender-related self-concept regardless of one’s sex. Thus Hannover’s theory of “chronic sources” and “chronic accessibility” offers not only an explanation for how gender differences in self-concept emerge between men and women… “the differential accessibility of gender-congruent and gender-incongruent self-knowledge can also account for variations in self-perception within the sexes” (2000, p. 188).

In many ways a discussion of gender and self-concept invariably circles back to the basic question of social roles. In essence, many of the “chronic sources” of gender-related self knowledge can be thought of as deriving from social roles. To reiterate, gendered social roles are thought to result from the extent to which women and men are exposed to and play out sex-typical occupational and family roles. With this definition in mind, it can be argued that social
roles set up a scenario in which women are more likely to be primary caretakers, which in turn sets the stage for divergent object relational patterns in boys and girls from the outset. In this sense, social roles and “chronic sources” together resemble what gender schema researchers and theorists, Markus & Oyserman (1988) describe as the mechanism by which men and women typically come to negotiate what is being termed in this study as a “relational self concept” which hinges on the “self/nonself divide.”

Men and women are typically encouraged to make the great divide—self/nonself divide—in very different ways. This divergence comes as a consequence of the different patterns of social interaction and interpersonal experience that are likely to characterize men and women from their earliest experience and throughout their lives (1988, p.100).

However, as has also been discussed, social roles can also be less or more salient depending on one’s sexual orientation, cultural and family background, and individual ego resources, which by extension should also explain some of the individual variability in relational self concepts within the same sex group. An added wrinkle in this discussion is the idea that one’s relational self-concept can also inform one’s individual psychological health (Baldwin, 1902; Erikson, 1968; Jacobson, 1964; Kernberg, 1976), independent of gender influences, such that a male may be susceptible to pathological boundary confusion despite social roles that would suggest otherwise. Thus, for research purposes, constructs that capture relational self-concepts can function not only as an index of internalized social roles but also as an index of psychological health.

The following section will discuss more explicitly a number of constructs that have been noted in the empirical literature for their connection to symptoms of depression and anxiety in women. The fact that relational patterns seem to inform these constructs and tend to diverge along gender lines has not been missed by these researchers. However, very few studies have
endeavored to look at patterns of divergence among women in their relational self-concept and their endorsement of depression and anxiety symptoms. Instead the focus has been primarily on differences between men and women in their relational self-concept.

**Women and Internalizing Problems**

While women and men both suffer from mental health problems at similar rates, research consistently shows that women are more prone to internalizing disorders than men (Avison & McAlpine, 1992; Gore, Aseltine, & Colten, 1993; Kessler, 2003; Rosenfield, et al., 2005). Controlling for gender differences in help-seeking and treatment, the 2003 National Comorbidity Survey Replication found that 46 million women (29%) suffer from depression over their lifetimes, compared to 28 million men (18%) and that 54 million women (34%) in contrast to 36 million men (23%) experience some form of anxiety during their lives (Kessler, 2003).

Various lines of research have sought to explain women’s vulnerability to internalizing disorders. The fact that women contend with intractable inequities and are held to different gender ideals has inspired research based on a differential exposure hypothesis, which attributes women’s vulnerability to particular mental health problems to differences in stressors that women are more likely to face, such as pressures related to running a household, role overload due to combined caretaking and financial responsibilities, lower earnings, and greater vulnerability to particular forms of violence (Bird, 1999; Elliot, 2001; Hatch & Dohrenwend, 2007; Lennon & Limonic; 2009; Mirowsky & Ross, 2003; Roxburg, 2004; Turner & Avison, 2003)

Alternatively, a differential vulnerability hypothesis has informed research that attributes women’s vulnerability to internalizing problems to differences in women’s and men’s reactions to common stressors (Day & Livingstone, 2003; Kessler, McLeod, & Wethington, 1985; Milkie
Peltola, 1999; Pearlin & Lieberman, 1979). Rumination is arguably one of the greatest stress response discrepancies that has been used to explain different rates of depression in men and women. Rumination refers to the tendency to excessively focus on internal symptoms of distress and their causes and consequences (Nolen-Hoeksema, 2001). Research on the etiology of depression has established a strong relationship between rumination and poor mood and depression (Lyubomirsky & Nolen-Hoeksemsa, 1995; Nolen-Hoeksema, 2000). Women’s greater tendency towards rumination is thus thought to at least in part account for women’s higher rates of depressive symptoms (Nolen-Hoeksema, Larson, & Grayson, 1999).

A theory of stress process proposes that women face different life stressors, which produce deficiencies or imbalances in personal resources that make them more vulnerable to internalizing problems. The personal resource of self-esteem has demonstrated strong links to psychological wellbeing, has been negatively associated with depression and anxiety, and is also commonly observed to be lower in women than men in general (Harter, 1999; McMullin & Cairney, 2004; Robins & Trzesniewski, 2005; Thoits, 1995, 2010; Turner & Marino, 1994). On a fundamental level, this discrepancy may be a reflection of continued societal inequities between men and women and also suggests that feminine gender ideals have the potential to harm. More specifically, self-esteem in women has been shown to be contingent on factors often not fully within their control, for instance on their connection with others and on their attractiveness (Banaji & Prentice, 1994, Josephs, Markus & Tafarodi, 1992) as opposed to their accomplishments.

Finally another line of research on gender differences in mental health problems has looked into gender patterns in self concept, particularly as it pertains to one’s relationship to others, which I have referred to here as one’s “relational self concept.” Many theorists and
researchers have written extensively about the ways in which men and women are typically encouraged to engage with the “self/nonself divide” in different ways as a consequence of the different patterns of social interaction and interpersonal experiences that are more or less likely to characterize their experience (Markus & Oyserman, 1988; Chodorow, 1978; Miller, 1976; Gilligan 1982). A number of related constructs or indexes of this “self/nonself divide,” have been linked to internalizing disorders and have shown greater prevalence in women, raising interesting questions about how gendered experience can lead to differences in one’s relational self concept, which in turn informs whether or not one will be more or less vulnerable to internalizing problems.

**Emotional Reliance**

One such index of relational self-concept is “emotional reliance,” which refers to the tendency to rely almost exclusively on the love and attention of others for the maintenance of one’s self-esteem. Excessive emotional reliance has demonstrated strong links to depressive symptoms (Reich, Noyes, Hirschfeld, Coryell, & O’Gorman, 1987; Overholser, 1990; Pilowsky & Katskitis, 1983) and anxiety symptoms (Reich et. al., 1987; Stewart, Knize, & Pihl, 1992), and women more so than men exhibit greater levels of emotional reliance (Alonso-Arbiol, Shaver, & Yarnoz, 2002; Bornstein, Bowers, Bonner, 1996, Turner & Turner, 1999). Taken together, these findings provide one possible explanation among many others for the observed gender differences in internalizing problems. As yet, there have been no studies that look at within-sex differences among women and levels of emotional reliance, though sex roles (BSRI) have been shown to fully mediate the relationship between gender and the overarching construct of interpersonal dependence, under which emotional reliance falls (Alonso-Arbiol, et. al, 2002).
Emotional reliance is derived from a three-part model of a construct called interpersonal dependence, which was first formulated by Hirschfeld and colleagues in 1976 (Hirschfeld, Klerman, Chodoff, Korchin, & Barrett, 1976). Of the three subscales (emotional reliance, lack of social self-confidence, and assertion of autonomy) on the Interpersonal Dependency Inventory (IDI; Hirschfeld, Klerman, Gough, Barrett, Korchin, & Chodoff, 1977), emotional reliance demonstrated the strongest positive correlations to depression and anxiety (Hirschfield et al., 1977; Bornstein, 1994). Interpersonal dependence consists of “complex thoughts, feelings and behaviors which revolve around the need to associate closely with, interact with, and rely upon valued people” (Hirschfeld et al., 1976, p. 374). In Hirschfeld’s model, thoughts pertain to view of self and one’s relationships with others. Feelings associated with these views can be positively valenced, e.g. warmth, closeness, or negatively valenced, e.g. emptiness, loneliness. Behaviors tend to revolve around maintaining interpersonal closeness.

Hirschfield’s model draws from psychoanalytic theory—with its emphasis on the attainment of instinctual aims through interaction with primary love objects (Freud, 1938), social learning theory—with its emphasis on dependency being an acquired experience susceptible to variability depending on factors in the social environment (Dollard & Miller, 1950; Gewirtz, 1969; Whiting, 1944), and attachment theory which emphasizes the centrality of the infant’s initial reliance on primary caretakers. This reliance results in behaviors that foster proximity with caretakers but can also lead to disruptions in emotional homeostasis when separation occurs (Bowlby, 1969; Ainsworth, 1972).

The above theories have been used in etiological explanations for both psychological health and psychopathology. For instance, in the attachment literature, the separation process is thought to initially result in anxiety, which is read as a promising sign that the child relies on and
expects to be taken care of by a primary caretaker. However, after protracted separation, anxiety is often followed by depression and despair (Ainsworth, 1972). By extension, interpersonal dependency is considered a normal component of adult personality, “… not in and of itself pathological” (Hirschfeld, 1977, p. 610), though in excess amounts, it has been linked both theoretically and empirically to depression, alcoholism, and other emotional disorders, such as anxiety and panic (Alonso-Arbiol et. al., 2002; Bornstein, 2005; Loas, Guilbaud, Perez-Diaz, Verrier, Stephan, Lang, Bizouard, Venisse, Corcos, Flament, Jeammet, 2005; Reich et. al., 1987; Stewart, et. al., 1992). Investigators have shown that extreme dependency on others for support, nurturance, and positive reinforcement is linked to low self-esteem and depression (Hirschfield, et. al., 1976; Heiby, Campos, Remick, & Keller, 1987). This simultaneously suggests and supports the notion that excessive reliance on others for reinforcement is likely to result in depression when a dependent person loses a vital source of reinforcement and is incapable of tapping into personal resources to compensate for this loss (Overholser, 1990).

Turner & Turner’s investigation of emotional reliance and depression found that women report greater emotional reliance than men, independent of social status factors, such as marital and parental status, education, income, and occupational prestige, which are often used to explain depression in women (1999). Higher emotional reliance was also associated with higher levels of depression. In a later study the same investigators found that the onset of chronic stress is more affected by self concept characteristics such as emotional reliance, than it is by social status and acute life events such as accidents, illness, death of loved one, and financial crisis etc. (Turner & Turner, 2005), leading the investigators to conclude that “…ongoing interpersonal stressors, although influenced by structural arrangements, may also be substantially ‘self-generated’ through individual behaviors and attributes (p. 228).
Given this patterning along gender lines, Turner and Turner speculated that early socialization experiences must influence self-concept characteristics in ways that contribute to heightened vulnerability to depression in women. They argued that different risk factors for depression can be thought to arise from early socialization experiences for women and men, and proposed that one such risk factor is a heightened dependence on others for the maintenance of well-being (1999). Citing theorists and researchers who have long acknowledged gender differences in relational self-concept that emphasize greater nurturance and mutual emotional exchange (Barnet, Beiner, and Barch, 1987; Gilligan, 1982; Miller, 1976), Turner and Turner reasoned that women may hold different expectations about relationships than men and that their interpersonal worlds may impact their mental health in ways that are different from men (1999). They also weighed in on the debate over whether a more interrelated relational self concept should be thought of as a positive or negative influence in women’s lives, noting the salutary aspects of interdependency (Gilligan, 1982), while also citing those that have argued that it is precisely this emphasis on others that can make relationships a source of stress for women, particularly when social fissures and internal conflict pertaining to relationship arise (Gore and Colten, 1991).

In a way, Turner and Turner (1999) have argued for considering emotional reliance as a kind of index of early gender socialization processes. However in Hirschfield’s original conceptualization, emotional reliance is considered a normal component of personality structure rather than a marker of gender socialization. Indeed as a component of relational self-concept, it is not an inherent expression of gender. Though as has been previously pointed out, aspects of the self can often be informed by gender and the social roles associated with gender, making it
difficult at times to separate certain relational patterns, like dependence or passivity, from stereotypical notions of femininity.

**Self-Salience**

Another expression of relational self-concept that has also been linked to depression and anxiety in women is Rosenfield’ self-salience construct. Self-salience is defined a “set of relational schemas” that refer to “… the relative importance of the self verses the collective in social relations” (Rosenfield et. al., 2005). These schemas can range from high levels that privilege the self over others to low levels that privilege others above the self. Low levels have been empirically linked to depression and anxiety, while high levels have been linked to externalizing problems, such as antisocial behavior and substance use. Healthy individuals are theorized as falling in the medium range for self-salience. Women more often than men fall in the extreme low range of self-salience, while men more often than women have been found in the extreme high range of self-salience (Rosenfield et. al., 2005; Rosenfield, 2012)

Self-salience brings together three separate dimensions that tend to be lower in women and are thus thought to mediate the relationship between gender and internalizing problems: evaluations of self-worth relative to others, boundaries between self and other, and beliefs about one’s relative importance or ranking of self versus others (Rosenfield et. al., 2005). Self-worth evaluations are conceptualized as comparisons people make about their value and competency in relation to others around them. Boundaries refers to the extent to which an individual sees themselves as independent in relation to others versus the extent to which they see the self as inseparable from others. Finally ranking pertains to the relative status of one’s needs, interests, and desires in relation to those of others. Ranking schemas can range from putting other first at
the expense of the self or at the other extreme, privileging the self and devaluing others (Rosenfield et. al., 2005).

Like the research on emotional reliance, self-salience draws on literature that links women’s tendency towards greater connectedness and dependency to both salutary and problematic aspects of the self (Chodorow, 1978; Gilligan, 1982; Miller 1976; Bakan, 1966; Helgeson, 1994). Self-salience is also based in social-cognitive developmental theories of gender, which stress the notion that children actively socialize themselves by behaving in accordance with gender norms as a means of reinforcement and attaining self-consistency. Rosenfield also argues that dominant conceptions of femininity tend to promote self-schemas that privilege the needs of others above the self, thus making it more likely that women will internalize cultural scripts that put them at greater risk for depression and anxiety.

What precisely is the connection between self-salience and depression and anxiety? Rosenfield and colleagues argue that negative self-assessments are more harmful when individuals think there is something “uniquely wrong” with them but that others are flawless. “In this situation, people feel bad about the self in general and because they are worse off than others, which adds an extra measure of distress” (Rosenfield, et. al., 2005, p. 325). Similar but different in subtle ways to the argument for the link between emotional reliance and depression, Rosenfield and colleagues postulate that poor boundaries implies greater reliance on others and also a sense of responsibility for others’ welfare, which can lead to self-blame for others’ problems. Finally, to the extent that others interests come first, individuals may ignore or deny their own needs, the emotional toll of which is likely to manifest in internalizing symptoms (Rosenfield et. al., 2005).
The relative newness of the self-salience construct means that very few studies have been undertaken to test the hypothesis that women and men tend to diverge in their levels of self-salience, and that this divergence may help explain gender differences in internalizing problems. A recent analysis of gender and mental health literature promotes self-salience as “among the best” social explanations for why men tend towards externalizing symptoms (Hill & Needham, 2013), because it provides a unique theoretical explanation for the mental health profiles of women and men that does not assume common underlying etiologies for men and women. Though an inverse relationship was found between self-salience and internalizing symptoms (Rosenfield et. al., 2005), the investigators cite borderline to non-existent gender variations in internalizing symptoms as a reason for why self-salience may not be as well-suited an explanation for the mental health profile of women as it is for men, while also acknowledging that more research is needed to confirm this (Hill & Needham, 2013).

One possible explanation for the lack of significant differences between men and women in internalizing symptoms may have to do with the fact that women can vary widely in their conceptualizations of gender, making it difficult to attain significance in between-sex studies. Indeed, Rosenfield (2012) recently found that black women had significantly higher levels of self-salience than white women, especially white women in higher class groups, which she argues helps explain lower rates of depressive symptoms among black women in comparison to white women. Citing literature that found black women generally hold less traditional attitudes towards women’s roles than white women (Carter, Corra, & Carter, 2009), Rosenfield (2012) Rosenfield, in fact, hypothesized and expected to see differences among women in self-salience based on race and class. That being said, in addition to this within group difference, significant between sex differences were found in this most recent study both in depression and in self-
salience, suggesting that any position which holds that self-salience is a better explanation for men’s mental health than women’s mental health may be premature.

Like Turner and Turner (1999) before her, Rosenfield (2012) also appears to consider self-salience as a kind of index of the gender socialization processes. Indeed, the construct self-salience was in many ways forged to help explain gender differences in mental health. However, like any expression of relational self-concept, self-salience has a tendency to detach and float away from any fixed etiology because self-concepts by their very nature are multi-determined. Thus not long after Rosenfield and colleagues’ 2005 study, a review and analysis of self-salience, entitled, “Not just gender: expanding the boundaries of self-salience theory,” called on researchers to consider self-salience as a marker of internalized racial and class experience in addition to gender (Gibson, 2011).

While Gibson’s paper represents an important step in the direction of delinking self-concepts such as boundaries and self-worth from notions of femininity and masculinity, it also behooves researchers who continue to be interested in the relationship between gender and self-concept to find ways to ground their findings in more explicit markers of gender ideology and social roles than the BSRI and the PAQ, which only look at socially desirable traits of expressivity and instrumentality. Thus the addition of a gender ideology measure like the Conformity to Feminine Norms Inventory (CFNI) in any study that looks at relational self-concept constructs such as self-salience or emotional reliance will be equipped to analyze the unique—though certainly not uncomplicated—contribution of gender-normative processes to mental health outcomes. Moreover, a measure such as the CFNI equips researchers who are interested in analyzing the influence of cultural/ normative pressures in terms of within group differences among women with the tool to do so. This additional but crucial step unambiguously
shifts the philosophical question of gender and mental health from a question about sex to a question about ideology and socialization.

**Synthesis:**

Previous research on gender and mental illness has consistently demonstrated that women are more prone than men to internalizing disorders, such as depression and anxiety (Avison & McAlpine, 1992; Gore et. al., 1993; Kessler, 2003; Rosenfield et. al., 2005). Subsequently, researchers seeking to understand gender divergent vulnerabilities to mental illness have found that relational self-concepts such as self-salience and emotional reliance tend to differ between men and women in patterned ways. More specifically, women tend to exhibit lower self-salience and greater emotional reliance, which researchers believe helps explain women’s greater vulnerability to internalizing symptoms (Rosenfield et. al., 2005; Turner & Turner, 1999). These researchers argue that high emotional reliance and low self-salience can be thought of as byproducts of women’s gender socialization experiences, which in the extreme can become psychologically problematic for women.

Additionally, many researchers in the area of gender and mental illness believe that sex differences in mental illness are most likely mediated by cultural scripts for femininity and masculinity, yet most researchers have not taken the opportunity to investigate how adherence to cultural scripts of femininity (feminine ideology) may result in differing vulnerability to internalizing symptoms among women. Past research, using the measurements, BSRI and PAQ, both of which designated traits of instrumentality and expressivity as representations of “masculinity” and “femininity,” either found no relationship between expressivity, and internalizing symptoms (Craighead & Green, 1989; Huselid & Cooper, 1994) or found negative correlations between expressivity and internalizing symptoms suggesting that high expressivity
may protect against internalizing symptoms such as depression and anxiety (Hermann & Betz, 2006; Sargovi, Koestner, Di Dio, & Aube, 1997). However the overwhelming findings from the literature at large suggest that it is the relative absence of instrumentality that appears to put men and women at the greatest risk for depression and anxiety (Bruch, 2002; Hermann & Betz, 2006; Lengua & Stormshak, 2000; Whitley, 1984). The findings that show either no relationship or an inverse relationship between expressivity and internalizing symptoms may be attributed to the fact that the measures used (BSRI, PAQ) capture only desirable traits associated with femininity and thus may not have been calibrated to pick up more socially undesirable aspects of femininity, that may contribute to internalizing problems in women.

The Conformity to Feminine Norms Inventory (CFNI) on the other hand, is a measure designed to assess conformity to both positive and negative aspects of feminine norms. Additionally, because the CFNI is explicitly grounded in the assumption of femininity as ideology, it provides an opportunity to investigate the impact of gender on women’s mental health not as a function of sex, but much more explicitly as a function of ideology and cultural norms that can vary among women. The few extant studies that have applied this relatively new measure to clinical questions have demonstrated that greater conformity to feminine norms is associated, at least indirectly, with increased risk for experiencing internalizing symptoms (Hurt et. al., 2007; Schrick et. al., 2012).

Taken together, the empirical research suggests that the other-oriented poles of self-salience and emotional reliance contribute at least in part to women’s vulnerability to experiencing internalizing symptoms, and that both of these constructs are likely a product of gender socialization. Empirical research also suggests that strict adherence to norms of femininity may contribute to vulnerability to internalizing symptoms.
These findings raise important questions that have yet to be investigated directly: Do significant differences among women in their levels of feminine ideology index differences in their relational self-concepts? Do women differ in their conformity to feminine norms depending on the degree to which they have internalized other-oriented relational self-concepts? Is the relationship between relational self-concepts and feminine ideology reciprocal? In other words, does the degree to which women conform to norms of femininity inform the kinds of relational self-concepts they are likely to internalize, and do relational self concepts such as emotional reliance and self-salience in turn regulate the degree to which women conform to norms of femininity? If so, how do these two constructs converge on women’s vulnerability to internalizing symptoms?

**Objectives and Hypothesis of the Present Study**

Based on previous empirical research, this study will investigate the proposed model in which relational self-concept partially mediates the relationship between feminine ideology and internalizing symptoms.

Figure 1. *Proposed Study Model: Relational self-concept mediates the relationship between feminine ideology and internalizing symptoms.*
The hypotheses follow:

1) More rigid adherence to feminine ideology would predict greater emotional reliance on others, evaluation of one’s own self-worth as lower than that of others (self worth), seeing one’s self as less separate in the context of interpersonal relationship (boundaries), and privileging the needs of others above those of the self (ranking).

2) More rigid adherence to feminine ideology would predict greater likelihood of experiencing internalizing symptoms, anxiety and depression. Greater emotional reliance on others, evaluation of one’s own self-worth as lower than that of others (self worth), seeing one’s self as less separate in the context of interpersonal relationship (boundaries), and privileging the needs of others above those of the self (ranking) will partially explain (mediate) this relationship.
Methods

Participants

Participants consisted of 251 women of diverse racial and ethnic backgrounds. All participants were asked to report their assigned sex at birth, age, ethnicity, level of education, relationship status, sexual orientation, yearly income, as well as previous or present diagnoses of bi-polar disorder, schizophrenia, psychosis, or dementia. Exclusion criteria included women who received any of the diagnoses listed above as well as women who were not assigned female at birth. A majority of the sample (66.9%) was between the ages of 22 and 34. Additionally, most participants were white/non-Hispanic Caucasians (57.8%) and heterosexual (70.1%). A plurality of participants was non-religious (41.8%) and had a graduate degree (48.2%). There was a wide representation of different levels of socio-economic status in the sample.

Procedure

Participants were recruited online using Facebook, Reddit, and Craigslist. In order to create incentive to participate, subjects were given the option of entering into raffle drawings (5) to win $100.00 Amazon.com Certificates.

All self-report measures and consent forms were hosted on Psychdata.com. First, participants were asked to report exclusionary information. Once eligibility was determined, participants were directed to an informed consent form, where they were assured of the confidentiality of their responses and their identity among other pertinent information necessary for informed consent. There was a total of 166 self-report items given, which, took approximately 25-45 minutes to complete when done in one sitting.

Measures

Internalizing Disorders
Internalizing disorders is a term used in clinical nomenclature to refer to behaviors or actions that direct problematic energy toward the self. Depression and anxiety are typically referred to as internalizing problems when grouped together. In order to measure internalizing problems, participants were administered the Beck Depression Inventory-II and the Beck Anxiety Inventory.

The *Beck Depression Inventory-II* (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item questionnaire measuring symptoms of major depressive disorder such as sadness, loss of pleasure, guilty feelings, and self criticism. Respondents are asked to rate how much each of these symptoms bother them on a 4 point likert scale. Examples of items include “I feel sad much of the time,” “I don’t enjoy things as much as I used to,” “I feel guilty all the of the time,” and “I criticize myself for all of my faults.” Rating of 0 indicates an absence of symptoms, while a rating of 3 reflects severe symptomatology. The total score for the BDI-II ranges from 0 to 63 with higher scores corresponding to higher levels of depression. The BDI-II has shown good internal consistency with a Cronbach’s alpha of 0.90 (Grothe, Dutton, Jones, Ancona, & Brantley, 2005).

The *Beck Anxiety Inventory* (BAI; Beck, Steer, & Brown, 1993) is a 21-item self-report questionnaire measuring symptoms of clinical anxiety. Respondents are asked to rate the degree to which each of symptoms bother them on a 4 point likert scale. Examples of items include “unable to relax,” “fear of losing control,” “hands trembling,” and “terrified or afraid.” Rating of 0 indicates an absence of symptoms, while a rating of 3 reflects severe symptomatology. The total score for the BAI ranges from 0 to 63 with higher scores corresponding to higher levels of anxiety. The BAI was normed on an adult psychiatric outpatient population. Cronbach’s alpha was .92 (Beck, Epstein, Brown, & Steer, 1988). In 2008, it was a used on a nonclinical
population of mixed racial background. An alpha level of .93 was reported for this study, indicating that the BAI is appropriate and psychometrically sound for use on a nonclinical sample (Eack, Singer, & Greeno, 2008). The measure is estimated to take 12 to 15 minutes to complete.

**Feminine Ideology**

*The Conformity to Feminine Norms Inventory- 45* (CFNI- 45; Parent & Moradi, 2009) is an abbreviated form of the original CFNI inventory (Mahalik et. al., 2005). The CFNI-45 measures the extent to which women conform to dominant feminine norms in the United States. The CFNI-45 consists of 45 items that measure the degree of conformity to 9 feminine norms that were confirmed through factor analysis. Norms include Thinness (e.g. I would be perfectly happy with myself even if I gained weight), Domestic (e.g. I enjoy spending time making my living space look nice), Investment in Appearance (e.g. I regularly wear makeup), Modesty (e.g. I always downplay my achievements), Relational (e.g. I don’t go out of my way to keep in touch with friends), Involvement with Children (e.g. I like being around children), Sexual Fidelity (e.g. I would only have sex with the person I love), Romantic Relationship (e.g. Being in a romantic relationship is important), and Sweet and Nice (e.g. I rarely go out of my way to act nice). Items are scored on a four point likert scale ranging from strongly disagree to strongly agree. All nine scales have been verified to have strong internal consistency with Cronbach’s alphas ranging from .68 to .98. (Parent & Moradi, 2009)

**Relational Self-Concept**

*Emotional Reliance:* Emotional reliance is one of three dimensions of the Interpersonal Dependency Inventory developed by Hirschfield and colleagues (Hirschfield et. al., 1977) that consists of thoughts, feelings, and behaviors related to the need to associate closely with, interact
with, and *rely upon valued people* for the maintenance of one’s self-esteem (Hirschfield et. al, 1976). Emotional reliance is assessed by a 17-item likert scale ranging from 1 (strongly agree) to 5 (strongly disagree). Example items include: “The idea of losing a close friend is terrifying to me,” “I think most people do not realize how easily they can hurt me,” “I would feel completely lost if I did not have someone special,” and “I would feel hopeless if I were deserted by someone I love.” The reliability coefficient for this scale is .68 (Turner & Turner, 1999).

**Self-Salience:** The self-salience inventory was created to assess three components of self-salience. (Rosenfield, et. al., 2005). Rosenfield and colleagues combined items from the Personality Research Form (PRF; Jackson, 1974) and the Personal Attributes Questionnaire (PAQ: Spence & Helmreich, 1978) to create the self-salience scale.

To measure self-worth, Rosenfeld and colleagues used a single question from the PAQ, asking respondents to report their level of self-confidence (ranging from 1 to 5), higher scores indicating higher levels of self worth (Rosenfield, et. al., 2005). Rosenfeld and colleagues also created a measure to assess the degree to which individuals perceive themselves as separate or fused in the context of interpersonal relationships by subtracting scores on the nurturance subscale from scores on the autonomy subscale of the PRF. The investigators referred to this scale as boundaries with higher scores indicating perception of one’s self as being more separate (2005). Finally, Rosenfeld and colleagues created a scale called ranking to measure the degree to which an individual privileges the needs of others over his or her own. This scale was created by subtracting scores on the abasement subscale from scores on the dominance scale of the PRF. Higher scores on this scale indicate an individual’s tendency to privilege one’s own needs (2005). These measure have been verified as having strong internal constancy (Stricker, 1974).
Correlations and factor analysis support the theorized structure of the components of self-salience. (Rosenfeld et. al., 2005).

**Study Hypothesis**

The study tested the following hypothesis:

1) Higher scores on the CFNI will be predict lower scores on Rosenfeld and colleagues’ self-worth subscale, lower scores on Rosenfeld and colleagues’ boundaries subscale, lower scores on Rosenfeld and colleagues’ ranking subscale, and higher scores on Hirschfeld and colleagues’ emotional reliance scale.

2) Higher scores on the CFNI will be associated with higher scores on the BDI-II (depression) and higher scores on the BAI scales (anxiety). Higher scores on Hirschfeld and colleagues’ emotional reliance scale, lower scores on Rosenfeld’s self-worth scale, lower scores on Rosenfeld and colleagues’ boundaries scale, and lower scores on Rosenfeld and colleagues’ rankings scale will partially explain (mediate) this relationship.

**Analysis**

Power analysis showed that a sample of at least 250 people would be necessary to obtain statistical power of .8 or higher. SPSS was used to generate descriptive statistics for the demographics. Confirmatory Factor Analysis (CFA), which hypothesized 3 factors, including (a) Feminine Ideology, (b) Relational Self-Concept, and (c) Internalizing Symptoms was performed. CFA analysis was performed using maximum likelihood estimation. Analysis was performed using the latent variable analysis (LAVAAN) package version .05-20 for R.

The goodness-of-fit statistics for the CFA indicated that the model did not adequately “fit” the data using the model fit chi-square statistic, $\chi^2(12) = 107.46, p < .001$. Additionally, the root mean square error of approximation (RMSEA) and the Comparative Fit Index (CFI) were
used to compute goodness-of-fit statistics. According to the RMSEA and the CFI the model did not adequately fit, RMSEA = .187 and CFI = .77 (Kline, 2011). Since the hypothesized model did not adequately fit the data, path analysis, a special case of SEM without latent variables, and correlation analysis were used to analyze the hypotheses.
Results

All tests were conducted at the 95% confidence level ($\alpha = .05$) and data analysis was performed in SPSS 22. Statistical analysis was conducted in several steps. Sample characteristics were computed. Then, descriptive statistics of study measures were calculated and internal consistency of study measures was verified. Additionally, correlation analysis of study measures was performed and confirmatory factor analysis was used to assess goodness-of-fit of study measures for three hypothesized latent constructs and loadings for each latent construct (factor) were reported. Finally, structural equation modeling (SEM) was used to analyze the research question.

Descriptive Statistics

There were 251 women in the sample; this sample size met the requirements of the power analysis. Demographic characteristics, relationship and family life characteristics, and employment characteristics were computed for the sample. Table 1 displays the demographic characteristics of the sample. A majority of the sample (67%) was between the ages of 22 and 34. Additionally, most participants were white/non-Hispanic Caucasians (58%) and heterosexual (70%). A plurality of participants was non-religious (42%) and had a graduate degree (48%). There was a wide representation of different levels of socio-economic status in the sample.

Table 1.
Demographic Characteristics of the Sample ($N = 251$)

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</table>

Table 2 displays the relationship and family life characteristics of the sample. There was a wide representation of different levels of different relationship statuses in the sample. A majority of participants (79%) did not have children. Table 3 displays the employment
characteristics of participants in the sample. A plurality was employed full-time (49%) and a plurality was employed in the education and health care (40%).

Table 2. 
Relationship and Family Life Characteristics of the Sample

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<tr>
<td>Children</td>
<td>Yes</td>
<td>52</td>
<td>20.7</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>199</td>
<td>79.3</td>
</tr>
<tr>
<td>Living Arrangement</td>
<td>Currently living with child under 18</td>
<td>43</td>
<td>17.1</td>
</tr>
<tr>
<td></td>
<td>Parent with dependent child under 18 who lived in household in the past.</td>
<td>7</td>
<td>2.8</td>
</tr>
<tr>
<td></td>
<td>Never lived with child</td>
<td>13</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Table 3. 
Employment Characteristics of the Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Type</td>
<td>Part-time for wages</td>
<td>28</td>
<td>11.2</td>
</tr>
<tr>
<td></td>
<td>Full-time for wages</td>
<td>122</td>
<td>48.6</td>
</tr>
<tr>
<td></td>
<td>Self-employed</td>
<td>28</td>
<td>11.2</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td>9</td>
<td>3.6</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>59</td>
<td>23.5</td>
</tr>
<tr>
<td></td>
<td>Homemaker</td>
<td>5</td>
<td>2.0</td>
</tr>
<tr>
<td>Industry</td>
<td>Construction</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td></td>
<td>Manufacturing</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td>Wholesale and retail trade</td>
<td>6</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>Information</td>
<td>15</td>
<td>6.6</td>
</tr>
<tr>
<td></td>
<td>Arts, entertainment, recreation</td>
<td>26</td>
<td>11.4</td>
</tr>
<tr>
<td></td>
<td>Financial Activities</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Professional and business services</td>
<td>39</td>
<td>17.0</td>
</tr>
<tr>
<td></td>
<td>Education and health services</td>
<td>91</td>
<td>39.7</td>
</tr>
<tr>
<td></td>
<td>Leisure and hospitality</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Public administration</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Management</td>
<td>7</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>Administrative/ Support Staff</td>
<td>19</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td>Basic and Applied Sciences</td>
<td>10</td>
<td>4.4</td>
</tr>
<tr>
<td></td>
<td>Armed Forces</td>
<td>1</td>
<td>0.4</td>
</tr>
</tbody>
</table>
Descriptive statistics were also computed for study measures. Descriptive statistics, including mean, median, standard deviation, minimum, maximum, and range were calculated for each study variable and are displayed in Table 4. Each variable demonstrated adequate variation (non-zero range).

Table 4. Characteristics of the Study Measures

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self- Salience - Self-Worth</td>
<td>7.60</td>
<td>9.00</td>
<td>2.93</td>
<td>.00</td>
<td>12.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Self- Salience - Boundaries</td>
<td>-2.09</td>
<td>-2.00</td>
<td>4.15</td>
<td>-12.00</td>
<td>11.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Self- Salience - Ranking</td>
<td>1.21</td>
<td>1.00</td>
<td>4.05</td>
<td>-9.00</td>
<td>11.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Emotional Reliance</td>
<td>46.41</td>
<td>46.00</td>
<td>7.05</td>
<td>21.00</td>
<td>66.00</td>
<td>45.00</td>
</tr>
<tr>
<td>CFNI- 45</td>
<td>120.75</td>
<td>121.00</td>
<td>12.56</td>
<td>72.00</td>
<td>149.00</td>
<td>77.00</td>
</tr>
<tr>
<td>BAI-II</td>
<td>11.80</td>
<td>9.00</td>
<td>9.50</td>
<td>.00</td>
<td>51.00</td>
<td>51.00</td>
</tr>
<tr>
<td>BDI-II</td>
<td>13.74</td>
<td>10.00</td>
<td>10.92</td>
<td>.00</td>
<td>52.00</td>
<td>52.00</td>
</tr>
</tbody>
</table>

Pearson Correlations have been computed for study variables and are displayed with Table 5. Significant associations were found between depression and anxiety symptoms, \( r(249) = .66, p < .001 \), and between self-worth and ranking \( r(249) = .43, p < .001 \). In other words higher levels of depression were associated with higher levels of anxiety and lower evaluation of one’s self-worth was associated with lower ranking of one’s needs relative to those of others. Emotional reliance had a statistically significant inverse relationship to all three self-salience dimensions, including worth, boundaries, and ranking, respectively \( r(249) = -.24, p < .001 \), \( r(249) = -.33, p < .001 \), and \( r(249) = -.12, p = .049 \) such that the greater the emotional reliance on others for one’s sense of well-being and self-esteem the lower one’s evaluation of one’s self-worth, the less one experiences oneself as separate from others, and the lower one ranks one’s needs relative to those of others. Finally, there was no statistically significant association between self-worth and boundaries and boundaries and ranking, respectively \( r(249) = .02, p < .78 \) and \( r(249) = \).
Analysis of Study Hypotheses

Since the hypothesized model did not adequately fit the data, path analysis, a special case of SEM without latent variables, and correlation analysis were used to analyze the hypotheses. First, Hypothesis 1 was analyzed. Hypothesis 1 stated that more rigid conformity to feminine ideology would be associated with emotional reliance on others, evaluation of one’s own self-worth as lower than that of others (self-worth), seeing one’s self as less separate in the context of interpersonal relationship (boundaries), and privileging the needs of others above those of the self (ranking). Higher conformity to feminine norms was associated with higher emotional reliance on others, $r(249) = .45, p < .001$. Higher conformity to feminine norms was also associated with lower evaluation of one’s own self-worth, $r(249) = -.20, p < .001$, seeing one’s self as less separate in the context of interpersonal relationships $r(249) = -.54, p < .001$, and privileging the needs of others above those of the self $r(249) = -.15, p = .014$ (Table 5).

Hypothesis 2 was also analyzed using correlation analysis and path analysis. Hypothesis 2 stated that more rigid conformity to feminine ideology would be associated with greater levels of depressive symptoms and greater levels of anxiety symptoms. Hypothesis 2 also stated that
emotional reliance on others, evaluation of one’s own self-worth (self-worth), one’s perception of one’s self in the context of interpersonal relationship (boundaries), and the level of privileging the needs of others above those of the self (ranking) would partially explain (mediate) this relationship. Rigid conformity to feminine ideology was significantly associated with higher levels of anxiety symptoms $r(249) = .13, p = .031$. However, there was no statistically significant relationship between conformity to feminine ideology and depressive symptoms $r(249) = .12, p = .067$.

According to Baron and Kenny (1986), there are four requirements to establishing mediation between two variables, a predictor and outcome, and mediating variables. These requirements include: (1) establishing a statistically significant relationship between the predictor and the outcome; (2) establishing a statistically significant relationship between the predictor variable and the mediator; (3) establishing a statistically significant relationship between the mediator and the outcome variable; and (4) analyzing the mediation effect of the mediator on the relationship between the predictor and the outcome. There was no statistically significant relationship between conformity to feminine ideology and depressive symptoms and therefore no path analysis was conducted to analyze this relationship, $r(249) = .12, p = .067$. However, there was a statistically significant relationship between conformity to feminine ideology and higher levels of anxiety symptoms. Additionally, there was a statistically significant relationship between conformity to feminine ideology and mediation variables including emotional reliance on others, self-worth, boundaries, and ranking, $r(249) = .45, p < .001$, $r(249) = -.20, p < .001$, $r(249) = -.54, p < .001$, and $r(249) = -.15, p = .014$. There was also a statistically significant relationship between the mediation variables emotional reliance and self-worth and the outcome variable anxiety symptoms, $r(249) = .36, p < .001$, $r(249) = -.24, p < .001$; greater emotional
reliance was associated with significantly greater levels of anxiety and greater levels of self-worth were associated with lower levels of anxiety symptoms. However, there was no statistically significant relationship between the mediator variables boundaries and ranking and anxiety symptoms, \( r(249) = -0.089, p < .16 \) and \( r(249) = -0.11, p < 0.71 \). The variables conformity to feminine ideology (predictor), anxiety symptoms (outcome), emotional reliance and self worth (mediators) met requirements (1-3) for establishing mediation from Baron and Kenny (1986).

In order to test mediation relationships of self worth and emotional reliance on the relationship between conformity to feminine ideology and anxiety symptoms, path analysis was used. Figure 2 displays the path analysis diagram.

![Path Analysis Diagram](image)

Figure 2. Path Analysis Diagram for Dependent, Independent Variables and Mediator Variables.

In the path analysis model, the sign of the mediation effects is opposite the sign of the direct relationship between femininity and anxiety; the relationship between anxiety and femininity is negative while the mediation effects are positive (see Table 6). According to MacKinnon, Fairchild, and Fritz (2007) if the sign of the mediation effects is the opposite of the
sign of the direct relationship, the mediation is referred to as inconsistent mediation, suggesting that the mediator and the predictor act on the outcome independently and no mediation exists.

Table 6. 

*Relationships in the Path Analysis Model*

<table>
<thead>
<tr>
<th>Relationship</th>
<th>$\beta$</th>
<th>Std. Error</th>
<th>Z-value</th>
<th>$p$ -value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femininity Predicts Worth</td>
<td>-.20</td>
<td>.062</td>
<td>-3.29</td>
<td>.001</td>
</tr>
<tr>
<td>Femininity Predicts Emotional Reliance</td>
<td>.46</td>
<td>.056</td>
<td>8.09</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Worth Predicts Anxiety</td>
<td>-.17</td>
<td>.059</td>
<td>-2.91</td>
<td>.004</td>
</tr>
<tr>
<td>Emotional Reliance Predicts Anxiety</td>
<td>.34</td>
<td>.065</td>
<td>5.22</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Femininity Presents Anxiety</td>
<td>-.053</td>
<td>.066</td>
<td>-.81</td>
<td>.42</td>
</tr>
<tr>
<td>Mediation Through Worth</td>
<td>.035</td>
<td>.016</td>
<td>2.18</td>
<td>.029</td>
</tr>
<tr>
<td>Mediation Through Emotional Reliance</td>
<td>.15</td>
<td>.035</td>
<td>4.38</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

**Follow-up Analysis**

Follow-up analyses were conducted to investigate the relationship between feminine ideology and internalizing symptoms and the mediating effect of emotional reliance, boundaries, rank, and self-worth among different racial/ethnic groups. The groups investigated include Caucasian, Latina, and African American.

**Analysis of Caucasian Subjects**

Higher conformity to feminine norms was associated with greater emotional reliance, $r(143) = .47$, $p < .001$, lower self-worth $r(143) = -.22$, $p = .008$, lower boundaries $r(143) = -.49$, $p < .001$, and lower ranking in expected directions $r(143) = -.18$, $p = .027$ (Table 7). Higher conformity to feminine ideology was not significantly associated with higher levels of anxiety symptoms $r(143) = .13$, $p = .13$. 
Table 7.  
Correlations of Study Measures for Caucasian Subgroup

<table>
<thead>
<tr>
<th></th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self- Worth</td>
<td>-</td>
<td>-.03</td>
<td>.44**</td>
<td>-.31**</td>
<td>-.22**</td>
<td>-.25**</td>
<td>-.44**</td>
</tr>
<tr>
<td>2. Boundaries</td>
<td>-</td>
<td>.03</td>
<td>-.29**</td>
<td>-.49**</td>
<td>-.16</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>3. Ranking</td>
<td>-</td>
<td>-.19*</td>
<td>-.18*</td>
<td>-.18'</td>
<td>-.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. ER</td>
<td>-</td>
<td>.47**</td>
<td>.40**</td>
<td>.36**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. CFNI- 45</td>
<td>-</td>
<td>.13</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. BAI-II</td>
<td>-</td>
<td>.58**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. BDI-II</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *p < .05, **p < .01

There was also no statistically significant relationship between conformity to feminine ideology and depression symptoms $r(143) = .07, p = .40$. Therefore, no path analysis was conducted.

**Analysis of African-American Subjects**

Higher conformity to feminine norms was associated with greater emotional reliance on others, $r(21) = .49, p < .02$. Higher conformity to feminine norms was also associated with lower boundaries $r(21) = -.47, p < .02$. There was no relationship between conformity to feminine norms and self-worth, $r(21) = .06, p = .76$. Additionally, there was no relationship between feminine norms and ranking $r(21) = .18, p = .41$.

Higher conformity to feminine norms was not significantly associated with higher levels of anxiety symptoms $r(21) = -.11, p = .64$. There was also no statistically significant relationship between conformity to feminine ideology and depressive symptoms $r(21) = -.12, p = .60$. 
Table 8. 
Correlations of Study Measures for African-American Subgroup

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-.20</td>
<td>.28</td>
<td>-.15</td>
<td>.07</td>
<td>-.23</td>
<td>-.49*</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>.28</td>
<td>-.34</td>
<td>.47*</td>
<td>.17</td>
<td>.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>-.15</td>
<td>.18</td>
<td>.08</td>
<td>.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>.49*</td>
<td>.32</td>
<td>.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>-.11</td>
<td>-.12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>.76**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *p < .05, **p < .01

Because there was no statistically significant relationship between conformity to feminine norms and depressive symptoms or anxiety symptoms, path analysis was not conducted.

Analysis of Latina Subjects

Higher conformity to feminine norms was associated with greater emotional reliance on others, \( r(25) = .68, p < .001 \). Higher conformity to feminine norms was also associated with lower boundaries, \( r(25) = -.75 p < 0.01 \). There was no relationship between conformity to feminine norms and self-worth, \( r(25) = -.15, p = .45 \). Additionally, there was no relationship between conformity to feminine norms and ranking \( r(25) = -.23, p = .25 \) (see Table 8).

Table 9. 
Correlations of Study Measures for Hispanic/Latina Subgroup

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.15</td>
<td>.41*</td>
<td>-.28</td>
<td>-.15</td>
<td>-.28</td>
<td>-.27</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>.33</td>
<td>-.50**</td>
<td>-.75**</td>
<td>-.41*</td>
<td>-.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>-.03</td>
<td>-.23</td>
<td>-.07</td>
<td>-.19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>.68**</td>
<td>.57**</td>
<td>.54**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>.70**</td>
<td>.49**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>.72**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *p < .05, **p < .01

Higher conformity to feminine ideology was significantly associated with higher levels of anxiety \( r(25) = .70, p < .001 \). As was stated earlier, there was a statistically significant
relationship between predictor variable conformity to feminine norms and mediation variables emotional reliance and boundaries. There was also a statistically significant relationship between the mediation variables emotional reliance and boundaries and the outcome variable anxiety symptoms, \( r(25) = .57, p < .002, r(25) = -.41, p < .03 \) in expected directions. However, there was no statistically significant relationship between the mediator variables self-worth and ranking and anxiety symptoms, \( r(25) = -.28, p < .16 \) and \( r(25) = -.07, p < .73 \). Therefore, the only variables that met requirements for establishing mediation for the outcome variable anxiety were conformity to feminine ideology (predictor), anxiety symptoms (outcome), emotional reliance and boundaries (mediators).

In order to test mediation relationships of emotional reliance and boundaries on the relationship between adherence to feminine ideology and anxiety symptoms, path analysis was used. Figure 3 displays the path analysis diagram.

![Path Analysis Diagram](image)

Figure 3. Path Analysis Diagram for Dependent, Independent Variables and Mediator Variables for Latina subgroup: Anxiety
The sign of the mediation effect of boundaries is opposite the sign of the direct relationship between feminine ideology and anxiety suggesting that the mediator and the predictor act on the outcome independently. Therefore, the mediator, boundaries was excluded from the model. The model below contains emotional reliance as the single mediator between conformity to feminine norms and anxiety.

![Path Analysis Diagram](image)

Figure 4. Path Analysis Diagram for Dependent, Independent Variables and Mediator Variables without Boundaries for Latina subgroup: Anxiety

According to path analysis, the relationship between feminine ideology and anxiety was partially mediated by emotional reliance. Emotional reliance mediated 15.3% of the relationship between feminine ideology and anxiety.

Table 10.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>β</th>
<th>Std. Error</th>
<th>Z-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femininity Predicts Emotional Reliance</td>
<td>.20</td>
<td>.24</td>
<td>.85</td>
<td>.39</td>
</tr>
<tr>
<td>Emotional Reliance Predicts Anxiety</td>
<td>.45</td>
<td>.14</td>
<td>3.23</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Femininity Presents Anxiety</td>
<td>.40</td>
<td>.081</td>
<td>4.87</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Direct</td>
<td>.081</td>
<td>.096</td>
<td>.84</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
Next the mediation model was tested for the outcome variable, depression. Higher conformity to feminine ideology was significantly associated with higher levels of depression $r(25) = .49, p = .009$. As stated earlier, there was a statistically significant relationship between conformity to feminine norms (predictor) and emotional reliance and boundaries (mediators). There was also a statistically significant relationship between the mediation variable emotional reliance and the outcome variable depressive symptoms, $r(25) = .54 p < .004$. However, there was no statistically significant relationship between the mediator variables boundaries, worth, and ranking, and outcome variable depressive symptoms, $r(25) = -.29, p < .15$, $r(25) = -.27, p < .18$, and $r(25) = -.19, p < .34$. Therefore, the only variables that met requirements for establishing mediation for the outcome variable depression were feminine ideology (predictor), depression symptoms (outcome) and emotional reliance (mediator). In order to test mediation relationships of emotional reliance on the relationship between conformity to feminine norms and depressive symptoms, path analysis was used. Figure 5 displays the path analysis diagram.

Figure 5. Path Analysis Diagram for Dependent, Independent Variables and Mediator Variables for Latina subgroup: Depression.
According to path analysis, the relationship between feminine ideology and depression was partially mediated by emotional reliance. Emotional reliance mediated 52% of the relationship between feminine ideology and depressive symptoms.

Table 11. Relationships in the Path Analysis Model for Latina Group - Depression

<table>
<thead>
<tr>
<th>Relationship</th>
<th>β</th>
<th>Std. Error</th>
<th>Z-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femininity Predicts Emotional Reliance</td>
<td>.40</td>
<td>.081</td>
<td>4.80</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Emotional Reliance Predicts Depression</td>
<td>.59</td>
<td>.34</td>
<td>1.74</td>
<td>.081</td>
</tr>
<tr>
<td>Femininity Presents Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct</td>
<td>.21</td>
<td>.20</td>
<td>1.07</td>
<td>.29</td>
</tr>
<tr>
<td>Mediation Through Emotional Reliance</td>
<td>.23</td>
<td>.15</td>
<td>2.9</td>
<td>.003</td>
</tr>
</tbody>
</table>

Summary of Findings

Hypotheses were analyzed using appropriate statistical tests. Hypothesis 1 stated that greater conformity to feminine norms would be associated with emotional reliance on others (emotional reliance), evaluation of one’s own self-worth as lower than that of others (self worth), seeing one’s self as less separate in the context of interpersonal relationship (boundaries), and privileging the needs of others above those of the self (ranking). Hypothesis 1 was supported by the data.

Hypothesis 2 stated that more rigid adherence to feminine ideology would be associated with greater levels of depressive symptoms and greater levels of anxiety symptoms. Hypothesis 2 also stated that emotional reliance on others, evaluation of one’s own self-worth (self worth), one’s perception of one’s self in the context of interpersonal relationship (boundaries), and the level of privileging the needs of others above those of the self (ranking) would partially explain (mediate) this relationship. There was no evidence of a relationship between feminine ideology and depressive symptoms. Greater levels of feminine ideology were associated with greater levels anxiety symptoms. There was no evidence or mediation of this relationship by emotional reliance, self worth, boundaries, or ranking.
Follow-up analysis also revealed several important findings. Among Caucasian women adherence to feminine norms was associated with emotional reliance on others, evaluation of one’s own worth as lower than that of others (self-worth), seeing self as less separate in the context of interpersonal relationships (boundaries), and privileging the needs of others above those of the self (ranking). Additionally, there was no statistically significant relationship between adherence to feminine ideology and depressive symptoms or anxiety symptoms and therefore no path analysis was conducted.

Among African-American women, adherence to feminine norms was associated with emotional reliance on others (emotional reliance) and was also associated with seeing one’s self as less separate in the context of interpersonal relationships (boundaries). There was no relationship between adherence to feminine norms and evaluation of one’s own worth as lower than that of others (self-worth), and there was no relationship between feminine ideology and privileging the needs of others above that of the self (ranking). Additionally, there was no statistically significant relationship between adherence to feminine ideology and depressive symptoms or anxiety symptoms, and therefore no path analysis was conducted.

Among Latina subjects, adherence to feminine norms was associated with emotional reliance on others (emotional reliance) and was also associated with seeing one’s self as less separate in the context of interpersonal relationships (boundaries). There was no relationship between adherence to feminine norms and evaluation of one’s own worth (self-worth) and there was no relationship between adherence to feminine norms and privileging the needs of others above those of the self (ranking). Additionally, emotional reliance mediated 15.3% of the relationship between femininity and anxiety symptoms and emotional reliance mediated 52% of the relationship between femininity and depressive symptoms.


**Discussion**

The present study investigated the relations among feminine ideology, relational self-concepts—(1) self-worth, (2) boundaries, (3) rank, and (4) emotional reliance, and internalizing disorders—depression and anxiety. Participants were women between the ages of 18 and 65 years. It was hypothesized that women who endorsed higher levels of feminine ideology would possess relational self-concepts that privileged others over the self. Thus it was expected that higher levels of feminine ideology would be associated with a greater tendency to rely emotionally on others, evaluate one’s self-worth as lower than that of others, possess weaker boundaries between self and other, and rank one’s needs and desires as less than those of others.

Based on scant but potentially burgeoning research that showed that higher levels of feminine ideology were associated with increased risk for experiencing internalizing symptoms (Hurt et al., 2007; Schrick et al., 2012), it was also hypothesized that higher levels of feminine ideology would be associated with greater levels of depression and anxiety symptoms. Furthermore, it was hypothesized that this relationship would be partially explained by a relational self concept marked by greater emotional reliance on others, weaker boundaries between self and other, lower ranking of one’s needs in comparison to those of others, and lower self-worth in relation to others.

The findings partially supported the hypotheses. Confirmatory Factor Analysis (CFA) indicated that the latent factor “relational self-concept” did not exist as a latent variable within this study’s dataset. As a result, path analysis, a special case of SEM without latent variables, and correlation analysis were used to analyze the hypotheses. As expected, the first main finding of the study showed that women who conformed more highly to feminine norms were more likely to possess weaker boundaries between self and other, rely more heavily on others emotionally,
evaluate one’s self-worth as lower than that of others, and rank one’s needs and desires as lower than that of others.

The second main finding of the study is that higher conformity to feminine norms was associated with greater levels of anxiety but not depression. Thus the first part of the study’s second hypothesis was partially confirmed. Out of the potential mediating factors—boundaries, emotional reliance, self worth, and rank—only emotional reliance and self worth were associated with the predictor variable, feminine ideology, and the outcome variable, anxiety. Thus, in order to test the hypothesis that the relationship between feminine ideology and internalizing symptoms would be partially mediated, only the variables that fit the mediation model—feminine ideology, emotional reliance, self-worth and anxiety were analyzed. This led to the third main finding of the study that showed that, contrary to the study’s hypothesis, higher emotional reliance and lower self-worth did not explain the relationship between feminine ideology and anxiety. Instead, this finding suggests that the proposed mediators, emotional reliance and self worth, and the predictor, feminine ideology, act on the outcome, anxiety, independently.

**Feminine Ideology, Emotional Reliance, Boundaries, Rank, and Self Worth**

Despite this study’s failure to verify the existence of a latent relational self-concept construct, the finding that emotional reliance correlates with all three self-salience components and that all four variables—emotional reliance, boundaries, rank, and worth—correlated with feminine ideology in expected directions, gives credence to the argument that emotional reliance, worth, boundaries, and rank represent aspects of one’s self-concept that index gender socialization processes even if they do not adhere strictly to gender (Rosenfield, et. al., 2005; Turner & Turner, 1999). The findings also resonate with psychoanalytic theory, social-
developmental theory, and social role theory, which to varying degrees echo the notion that gender normative processes inform and organize self-experience in ways that code the self in terms of gender. This is especially true for self-experience having to do with self-in-relation to others.

Psychoanalyst and feminist Nancy Chodorow (1978) notes that the traditional family structure, in which women tend to be the primary caretaker, leaves girls to face the unique developmental challenge of both having to identify with and differentiate from the same object. Chodorow argues that this sets the stage for an object relational situation in which girls from the outset are experienced and experience themselves as more continuous with others, and thus results in them relating to the world in more gender stereotyped ways, i.e. concerning themselves with relationships and others.

Social-developmental theory dovetails with Chodorow’s thesis by offering an explanation for how self-concepts such as expressiveness, communion, pursuit of harmony, closeness, and interrelatedness with others over the course of development get encoded and laid down in terms of gender due to repeat encounters with “chronic sources” of information, such as the traditional family configuration, which reinforce the relationship between femaleness and other-oriented self concepts. However, unlike psychoanalytic theory, social-developmental theory and social role theory also provide a more complete explanation for why women may vary as a group in terms of their internalization of self-concepts that privilege relationships or others over the self.

Both social role and social-developmental theories posit that differential exposure to gender-congruent and gender-incongruent experience determines whether or not a given group or individual will be more or less likely to endorse particular traits or roles. In fact, social role theory strongly suggests that social roles can be more or less salient depending on one’s cultural
and family background, one’s sexual orientation, media exposure, and individual ego resources, which by extension should account for variability in relational self-concepts within a same sex group.

To reiterate, the study’s findings showed significant differences among women such that women who endorsed greater adherence to cultural roles and scripts of femininity were more likely to see themselves as less differentiated from others, more likely to rank their needs below those of others, more likely to see their worth as lower than others, and more likely to rely emotionally on others than women who conformed less to norms of femininity. This finding extended previous empirical findings, which showed that women more so than men endorsed other-oriented configurations of emotional reliance, boundaries, ranking, and worth (Rosenfield et al., 2005, Turner & Turner, 1999). By factoring in a measure for gender normative processes, namely the Conformity to Feminine Norms Inventory (CFNI), this study strengthened the argument made by both Rosenfield and Turner (2005, 1999) that the differences observed between men and women in their approach to the relational self/nonself divide is most likely an artifact of gender socialization rather than a result of inherent gender differences.

**Feminine Ideology and Internalizing Symptoms**

The present study’s finding, which showed that higher conformity to feminine norms was associated with greater levels of anxiety, resonated with previous research findings (Hurt et. al., 2007; Schrick et. al., 2012). Like the present study, these previous studies were interested in looking at relationships among depression and anxiety and various gender-informed variables some of which include norms of femininity as enumerated in the CFNI—namely thinness, investment in appearance, and romantic relationships. Hurt’s study demonstrated that higher conforming to feminine norms was associated with increased body surveillance and increased
body shame which were both in turn related to higher levels of depression. Schrick’s study showed significant but weak correlations between the feminine norm, romantic relationships, and depression and anxiety. Furthermore, Schrick’s study demonstrated that when the norm, romantic relationships, was included in a cluster analysis with other variables, it was found that women who were “Other-Focused had significantly higher levels of anxiety. Additionally the “Other-Focused” cluster of women also exhibited significantly higher levels of depression.

Schrick’s model were grounded in Self-Objectification Theory (Fredrickson & Roberts, 1997) and Impression Management Theory (Goffman, 1959). Self-Objectification Theory (Fredrickson & Roberts, 1997) posits that in patriarchal societies, women are socialized to conceptualize their bodies through an internalized “male gaze” which promotes unrealistic images of perfection that have been linked with a multitude of negative outcomes. Impression Management Theory (Goffman, 1959) states that people manage their behaviors to mesh with expectations associated with social roles and norms. Integrating Self Objectification Theory and Impression Management Theory, Schrick argues that women’s worry about embodying cultural norms and images of femininity lends to a self-concept in which one sees oneself as an object to be evaluated rather than the subject of one’s own experience. Schrick further argues that this objectified self-concept forecasts negative psychological consequences.

Under this broad rubric, devotion to successful achievement of particular feminine norms can be seen as validating one’s worth and success at a great psychological cost. Unlike previous research on feminine ideology, the present study’s hypotheses did not pre-select feminine norms to be investigated based on their presumed potential for psychological harm. However, the fact that higher levels of feminine ideology as a total score predicted higher levels of anxiety,
suggests that many of these norms, when pursued rigidly, do indeed have negative psychological consequences to women.

Similar to Schrick’s study that found stronger relationships among feminine norms and anxiety as compared to depression, the present study found no significant relationship between feminine ideology and depression. One might speculate that for women who concern themselves with the needs and perceptions of others, the threat of losing the approval and love of others could potentially permeate their everyday experience, making them first and foremost vulnerable to anxiety rather than depression. According to Freud, anxiety often represents a content-less signal to the psyche that loss is forthcoming. This threat is experienced physiologically as well as cognitively in the form of worry, dread, and bodily arousal.

On the other hand, depression or to use Freud’s term, “melancholia,” is associated with the experience of unnamed or unconscious loss. According to Freud, depressive symptoms such as guilt, depletion, and self-hatred result from a series of complex steps beginning with the narcissistic introjection of a lost object, the turning of the ego against the self in displaced anger, alongside the simultaneous preservation/denial of loss of the loved object in unconscious fantasy. In cognitive psychology, depression is associated with views of oneself or one’s life as deficient or failed and feelings of hopelessness about recovering from these deficits (Beck, Rush, Shaw, & Emery, 1979). Thus it could be argued that depression will more likely result from perceived failures to meet the approval of others alongside the concomitant experience of loss—conscious or unconscious—and rage over this loss directed at the self. This possibility may loom large for women who tend to focus on the needs and perceptions of others, but may not materialize very often especially when the possibility of loss is constantly preempted by successful attempts to maintain connection and approval.
Depression, in this sense, could be thought of as a byproduct of perceived failure and unconscious loss rather than a more immediate and diffuse experience of threat of loss as seen in anxiety. Still, the two constructs are highly correlated, and it is often the case that people who experience anxiety also experience depression as a result of distressing anxiety symptoms. The fact that depression and anxiety were highly correlated in this study’s sample, that the relationship between anxiety and feminine ideology was significant, and finally that the relationship between depression and feminine ideology approached significance suggests that feminine ideology may be at least indirectly related to depression through self-worth and emotional reliance.

**Emotional Reliance, Self-Worth, and Internalizing Symptoms**

Self-worth and emotional reliance proved to be the mediating factors of the proposed four to have relatively strong significant correlations with depression and anxiety symptoms. As predicted, the findings indicated that the more one relies emotionally on others for the maintenance of one’s self-esteem and the lower one evaluates one’s self-worth in comparison to that of others, the more one will endorse symptoms of depression and anxiety. These findings resonated with previous research that demonstrated significant relationships between self-salience—under which self-worth is subsumed—and internalizing symptoms of depression and anxiety (Rosenfield et. al, 2005; Rosenfield, 2012) The findings also were consistent with previous research that demonstrated significant relationships between emotional reliance and internalizing symptoms of depression (Reich et. al, 1987; Overholser, 1990; Pilowsky & Katskitis, 1983; Turner & Turner, 1999) and anxiety (Reich et. al., 1987; Stewart, et. al., 1992).

Rosenfield (2005 framed her understanding of how self-worth contributes to vulnerability to internalizing disorders by theorizing that the view of one’s worth as relatively low in
comparison to others can leave individuals feeling that they are inherently deficient, and that they are generally worse off than others around them. These psychological consequences mirror some of the defining features of depression, namely the view of oneself as failed or deficient. Yet, the relationship between self worth and internalizing symptoms has not been independently explored outside the superordinate construct of self-salience up until the present study. A related construct to self-worth, namely, self-esteem, has been shown repeatedly to have a strong relationship with depression (Kernis et al., 1998; Orth, Robins, & Meier, 2009; Orth, et al., 2009; Roberts & Monroe, 1992; Burwell & Shirk, 2006; Shahar & Henrich, 2010), as well as a significant negative relationship to anxiety (Roberts, 2006; Lee & Hankin, 2009; Riketta, 2004; Watson, Suls, Haig, 2002). It may be helpful, therefore, to contextualize the present study’s findings within the more robust theoretical and empirical literature on self-esteem and internalizing disorders as a way of thinking about how self worth contributes to vulnerability for depression and anxiety.

Self worth, as conceptualized by Rosenfield (2005), can be thought of as a kind of quotient of one’s worth derived from comparisons made between one’s perceived worth relative to the perceived worth of others. Like Rosenfield’s self worth construct, self-esteem has been conceptualized in the literature as a socially contingent construct: Early self-esteem theorists proposed that self-esteem is made up of self-views based upon information gathered from explicit or implicit feedback from others (Cooley, 1902; Goffman, 1959; Mead, 1934) which is then integrated into one’s self-concept. While these theorists do not explicitly point to self-other comparisons as being an essential aspect of self-esteem, it is conceivable that one important strand of “implicit feedback” coming from others derives from an aggregate of the perceived
sense of one’ value in comparison to others’ value within various salient social contexts, such as school, work, family, and friend groups.

More contemporary, “sociometric,” self-esteem theorists conceptualize self-esteem as having less to do with self-views and instead define self-esteem as an evaluative function within the self which calibrates one’s value in terms of one’s relational value, or the degree to which one might be considered fit for inclusion in important social groups (Leary & Baumeister, 2000). The empirical findings indicate that the greater one’s self-esteem, or in sociometric terms, the greater one’s measure of being valued and fit for inclusion in society, the greater one’s success in various life areas including relationship satisfaction, job satisfaction, and psychological health as indexed by lower levels of depression. Lower self esteem, on the other hand, predicts negative outcomes in various life areas and functioning (Shackelford, 2001; Trzesniewski et al., 2006).

Complicating the picture further, contemporary self-esteem researchers have not only found strong relationships between low self-esteem and psychological distress; they have made the additional observation that extreme high self-esteem is likely to predict antisocial behavior and interpersonal violence. Many researchers have concluded that extreme high self-esteem in fact translates into low self-esteem when the model controls for the confounding effect of narcissism (Donnellan, Trzesniewski, Robins, Moffitt, & Caspi, 2005; Paulhus, Robins, Trzesniewski, & Tracy, 2004). This way of conceptualizing low self-esteem’s bimodal relationship to psychopathology is very much in line with Rosenfield’s findings which showed that extreme high self-salience, which may actually capture a narcissistic set, was associated with externalizing disorders and tended to appear at greater frequencies in men than women (Rosenfield, et. al., 2005). Low self-salience, on the other hand, predicted internalizing disorders and was represented predominantly in women.
In this context, Rosenfield’s concept of comparative self-worth can be thought of as a bimodal marker of low self-esteem, in which one might expect self-valuations that are either narcissistically inflated in comparison to valuations of others (high self-worth) or deflated in comparison to valuations of others (low self-worth) will predict negative psychological outcomes. The corollary of this would be to say “true” high self-esteem renders self-worth comparisons—whether this means inflating or deflating your self-worth in relation to others—unnecessary and thus will be relatively absent or neutralized in the presence of “true” high self-esteem. While the present study did not explicitly test this bimodal model of low-self esteem and negative outcomes, it did confirm at least one half of the model, which predicted that lower levels of self-worth—which can otherwise be thought of as a marker of low self-esteem—would be associated with greater levels of psychological distress, namely greater levels of depression and anxiety.

The other proposed mediating factor, which demonstrated a significant relationship to internalizing symptoms was emotional reliance. Excessive emotional reliance, or the tendency to rely almost exclusively on the love and attention of others for the maintenance of one’s self-esteem, has previously demonstrated strong links to depressive symptoms (Reich, et. al., 1987; Overholser, 1990; Pilowsky & Katskitis, 1983) and anxiety symptoms (Reich et. al., 1987; Stewart, Knize, & Pihl, 1992) and has also been shown to have higher prevalence rates in women than in men (Alonso-Arbiol, et. al., 2002; Bornstein et. al., 1996, Turner & Turner, 1999). Theoretically speaking, the construct of emotional reliance is grounded in Hirschfield’s interpersonal dependency model that posits that dependency on others is a normative function of our original reliance on primary caretakers (Hirschfield et. al., 1977). However when disruptions in attachment interfere with the establishment of a stable sense of self, dependency can become
excessive in character, resulting in a highly contingent sense of wellbeing and sense of self-esteem that must be vigilantly maintained by gaining approval and reassurance from others.

Emotional reliance is thought to result in depression when a dependent person loses a vital source of reinforcement and is incapable of tapping into personal resources to compensate for this loss (Overholser, 1990). The present study’s findings that self worth and emotional reliance are correlated and that both predict greater levels of anxiety and depression is consistent with this line of thinking and dovetails with existing theoretical models of depression and anxiety: Women who tend to rely on others emotionally for the maintenance of self-esteem may be primed to be on the look out for threats to loss of approval and love, and thus may be more vulnerable to anxiety. These same women will also experience perceived failures to meet the approval of others as devastating losses rather than commonplace occurrences attributable to the normal vicissitudes of close relationships, and thus may be more vulnerable to depression.

**No Mediation between Feminine Ideology and Internalizing Symptoms**

To reiterate, worth and emotional reliance proved to be the only mediating factors to have relatively strong significant correlations with depression and anxiety symptoms. One reason for why the remaining proposed factors, boundaries and ranking, did not possess strong or significant enough relationships with depression and anxiety may have to do with the inadequacy of the measures assessing boundaries and ranking within the self-salience inventory. Unlike the Self Salience-Worth subscale, which was a uniform scale that inquired about perceived self-confidence levels, the boundaries and ranking scales were made up of composite scales adapted from the Personality Research Form (Jackson, 1974)

Rather than assessing boundaries and ranking directly through construct specific scales, boundary scores were calibrated by subtracting PRF Nurturance scores from PRF Autonomy
scores and ranking score were calibrated by subtracting PRF Abasement scores from PRF Dominance scores. While nurturance, autonomy, abasement, and autonomy all bear on boundaries and ranking conceptually, composites of these scores are unlikely to result in measures that possess adequate content validity for boundaries and ranking. In other words, composite scales make it difficult to evaluate the extent to which the measures actually assess all facets of the constructs they purport to measure. Thus, if the measures used to assess boundaries and rank fail to adequately measure the intended constructs, one might expect that the predicted relationships between boundaries, ranking, and psychological distress might not materialize, as was the case in the present study.

Because feminine ideology was found to have a significant relationship with anxiety but not depression, the only eligible mediation path left to explore was one that examined the relationship among feminine ideology (predictor), anxiety (outcome), and the remaining mediators that fit the model, i.e. worth/emotional reliance. In the end, path analysis showed no evidence of mediation, indicating that emotional reliance and self-worth and feminine ideology act on the outcome, anxiety, independently.

**No Latent Construct: Relational Self-Concept**

As was stated earlier, Confirmatory Factor Analysis did not verify the existence of a latent relational self-concept construct. A closer analysis of the individual measures of emotional reliance and self-salience suggests that the problem with finding a latent relational self-concept construct may be at the level of measure rather than theory. Interestingly, correlations of the study’s measures indicate that emotional reliance was significantly correlated with all three components of self-salience, i.e. worth, boundaries, and ranking; whereas not all of the self-salience components were correlated with each other. Specifically, the boundaries
subscale was not correlated with the rank or worth subscales, which suggests poor internal validity of the measure as well as poor construct validity of self-salience. As such, validity issues with the self-salience instrument may be at the root of the failure to detect the latent construct of relational self-concept.

**Follow-up Analysis: Caucasian Subjects**

In the Caucasian subgroup, feminine ideology was tied to all the mediating factors in the model—emotional reliance, self-worth, boundaries, and ranking, and this pattern replicated the findings of the general sample. Additionally, among Caucasian women the relationship between feminine ideology and emotional reliance was particularly strong. Parallel findings in the general sample and the Caucasian subgroup were not wholly unexpected given that Caucasian women represented 57.8% of this study’s general sample. Moreover, the CFNI was constructed based on Eurocentric cultural norms of femininity and the CFNI was normed on a mostly Caucasian college-age sample. Thus one would expect the CFNI to most effectively index gender norms in Caucasian women and that these would be likely to map onto relational self-concepts, i.e. emotional reliance, self-worth, boundaries, and ranking, that are thought to be informed by gender normative processes as well.

Again, similar to the general sample, self worth and emotional reliance had strong relationships to depression and anxiety among Caucasian women. However in the Caucasian subsample, there was no distinguishing relationship found at all between feminine ideology and depression and anxiety symptoms. This suggests that the means by which Caucasian women emotionally rely on others or value their worth in comparison to others may be less informed by norms of femininity than expected. In other words, in this particular sample of Caucasian women—relatively young and unmarried—failing to meet norms of femininity may not rise to
the level of threat of loss of social status, which might result in marked anxiety and depressive symptoms. The corollary of this is that among young Caucasian women, meeting norms of femininity may not confer the same level of validation that one might expect in an older or a more culturally traditional cohort of women. Therefore, even though the way these women emotionally rely on others and value their worth in comparison to others relates to their tendency towards depression and anxiety, these women may concern themselves with the needs and perceptions of others in ways that are less informed by the extent to which they meet norms of femininity, at least in an observable way.

Another possibility is that the relationship between feminine norms and depression and anxiety may be indirect among Caucasian women. Feminine ideology was correlated with emotional reliance, boundaries, self-worth, and ranking and feminine ideology had particularly strong relationships to emotional reliance and boundaries. Additionally, emotional reliance and self-worth had relatively strong correlations with depression and anxiety. These results suggest that, among Caucasian women, rather than a mediated relationship, the relationship between feminine norms and depression/anxiety may be indirect, i.e. via emotional reliance and self-worth. In other words, feminine ideology either informs the relational self-concepts, emotional reliance/self-worth or feminine ideology and emotional reliance/self-worth are, perhaps more likely, undergirded by the same latent gender informed construct, such as self-objectification, i.e. seeing oneself as an object rather than an active subject of experience.

As Schrick and colleagues (2012) eloquently pointed out, that self-objectification is not just about managing a body image that fits the image offered by society as the ideal to meet, it also involves emotional management, i.e. corralling one’s emotional/relational life to be consistent with femininity. Therefore, it may be that Caucasian women who tend to be
externally preoccupied in terms of their emotional well-being (emotional reliance) and who also monitor and compare their worth in comparison to others’ worth (self worth) are at least in part engaged in some kind of ‘objectification’ of their emotional/ relational life. When these same women relate to themselves as female, they may also be more likely to rely on ‘objectifying mechanisms,’ leading them to comport themselves as closely as possible to cultural scripts of femininity. The objectifying, “feminine” impulse therefore could be thought to weave through and tie together the tendency to rely on others for one’s emotional well-being, to monitor and compare one’s worth in comparison to others’ worth, and to conform to rigid scripts of femininity among a certain group of Caucasian women.

**Follow-up Analysis: African-American Subjects**

In the African-American subgroup, feminine ideology was associated with mediating factors, emotional reliance and boundaries. It is worth noting that while these correlations were relatively strong, the significance levels were not as robust as that of the Caucasian subgroup’s corresponding relationships. This may have to do with the fact that African-American women conform to a slightly different set of norms than that of the ones captured by the CFNI. It also appears as though this offset difference may in fact act as a protective factor against depression and anxiety in African-American women: For instance, it has been shown that sensitivity to others’ needs plays just as central a role in Black women’s conceptions of femininity as it does in White women’s conceptions of femininity. However an emphasis on self-sufficiency and inner strength in Black women’s conception of femininity is a notable divergence from the more submissive and subordinate stance in White women’s conception of femininity (Cole & Zucker, 2007; Settles, Pratt-Hyatt, & Buchanan, 2008).
It has also been demonstrated that Black communities have historically called for the incorporation of certain traits and behaviors among their female members that are not in keeping with hegemonic femininity—including strength, assertiveness, wage labor, and community leadership (Gilkes, 2001)—particularly when doing so in the service of family, community, or racial advancement. Additionally, Black cultural conceptions of motherhood encompass economic provision along with caretaking, with responsibilities for children’s material as well as emotional well-being (Giddings, 1984), which may in part be related to Black males’ restricted resources due to poverty, incarceration, unemployment, and self-sufficiency (Hill, 2002). The mitigating influence of Black feminine norms of strength, assertiveness, leadership, and material aspiration may help explain why, among African-American women, feminine norms were correlated with self-depreciating patterns of emotional reliance and boundaries at an attenuated level, at least in terms of significance levels, as compared to White women. These tempering forces may also help to explain why there was no relationships found between feminine ideology and depression and anxiety among African-American women.

Self worth was the only mediating factor that had a strong correlation to depression. Otherwise, none of the mediating factors of the model were related to depression or anxiety among African-American women. To clarify, self-worth was not related to feminine norms as was predicted among African-American women. Thus, among African-American women, self-worth most likely poses as a risk for depression independently of feminine norms.

**Follow-up Analysis: Latina/ Hispanic Subjects**

Among Latinas, emotional reliance and boundaries were very strongly tied to feminine ideology. Higher conformity to feminine norms was also significantly associated with higher levels of anxiety and depression among Latinas. Additionally, emotional reliance mediated
15.3% of the relationship between femininity and anxiety symptoms and emotional reliance mediated 52% of the relationship between femininity and depressive symptoms. These results suggest that among Latinas, conceptions of femininity strongly inform the way they relate to themselves in relation to others, and that emotional reliance is highly implicated in Latinas’s risk for depression and to a lesser extent, anxiety.

One can speculate that for Latina in particular maintaining connections to others consciously or unconsciously feels somewhat contingent on meeting stringent cultural expectations of femininity. Latinas who are especially reliant on obtaining a sense of well-being through others may find feminine norms to be a particularly salient means of securing these relationships. In other words, though there may be multiple paths by which one can stay connected to others and meet others’ approval, for Latinas, femininity may be an overdetermined means of connecting to others due to intense cultural pressures around femininity.

Political scientist, Evelyn Stevens, crafted the term ‘marianismo’ to shed light on the feminine counterpart to machismo and call attention to cultural inequalities between men and women in Latin cultures (1973). According to Stevens, marianismo is a cultural code that holds Latinas to a highly unattainable and idealized image of purity, passivity, sacrifice, and subordination to the needs of others. Thus, marianismo provides a strict dictum for attending to others needs and deriving approval through successful conformity to the marianismo code. Therefore, it could be said that Latinas who are prone to emotional reliance may do so in culturally coded terms, equating success in relationships to successful performance of marianismo commandments. It can also be said that emotional reliance itself dovetails nicely with marianismo, and that marianismo may even prime Latinas for a more “objectified” relationship to their own emotional experience in the manner posited by Self-Objectification
Theory (Fredrickson & Roberts, 1997). In other words, marianosimo may promote a chronic tendency to see oneself and one’s experience as measured against a cultural yardstick, supporting the view of oneself as an object to be evaluated rather than the subject or agent of one’s experience.

Perhaps it is this confluence of traditional feminine norms and emotional reliance that poses the greatest risk for depression and anxiety among Latinas: One could argue that up to a certain point, conforming to an idealized feminine image may be protective against lowered social status among Latinas. However past a certain threshold, this self-objectifying tendency may trigger pathological levels of emotional reliance, taking a heavy toll on psychological well-being. As was stated earlier in this discussion, precariously high levels of emotional reliance may leave women feeling under constant siege of losing the approval and love of others, resulting in anxiety. These same women may also perceive failures to meet the approval of others as devastating losses, leaving them especially vulnerable to depression.

Pathological levels of emotional reliance most likely require that Latinas put the needs of others first at the expense of self-expression. One can speculate that a compromise of this magnitude might leave women churning with self-directed anger on the inside for betraying themselves while appearing pleasingly effeminate on the outside. This presents yet another explanation for the strong link between depression, emotional reliance, and feminine norms among Latinas. Additionally, as people grow closer to and more dependent on others, they experience increased desire to be authentic with others. For Latinas, who feel the pressure to adhere to the tenets of the marianismo code, intimacy and authenticity may threaten their sense of cultural belonging and approval. Women in this predicament may be left feeling entrapped, isolated, and hopeless, paving a slippery road to despair and clinically observable depression.
Implications

The higher prevalence of depression among women as compared to that of men is one of the most widely documented findings in psychiatric epidemiology, with female to male risk ratios roughly 2:1 (Kessler, 2003). Women are also significantly more likely than men to develop an anxiety disorder throughout the lifespan, with female to male risk ratios roughly 1.7:1 (McLean, Asnaani, Litz, & Hofman, 2011). Many researchers have tried to understand these higher prevalence rates among women by looking at biological or environmental factors that affect women more than men (Kessler, 2003 etc.). This line of inquiry may have its benefit but is incomplete. Framing the problem as a gender difference issue tends to biologize differences between men and women and misses the opportunity to examine the role that gender normative processes play in women’s greater risk for depression and anxiety. Moreover, sex difference studies do not help to differentiate among women and therefore identify which women may be at greater risk for depression and anxiety.

Within group studies, such as the present study, that look at differences among women in terms of their vulnerability to depression and anxiety as well as differences in their internalization of gender norms represent an understudied area that could contribute to our understanding of the potential harmful effect of gender normative processes on women. The present study’s within group structure also helps to problematize the issue of gender differences while acknowledging the ways in which prevailing cultural ideologies of femininity are lived out in women’s minds and bodies, impacting various areas of psychological functioning, including their mental health.

The present study represents one among a handful of studies that have looked at the relationship between feminine ideology and psychological functioning in women. Despite the
recent operationalization of the feminine ideology construct and development of feminine ideology measures—Conformity to Feminine Norms Inventory (Mahalik et al., 2005) and the Femininity Ideology Scale (Levant, Richmond, Cook, House, & Aupont, 2007)—this area of study is much less established than the literature that looks at masculine ideology and psychological functioning. Therefore, this study contributes to a growing area of research that is in desperate need of testing, validating, and application.

Harnessing an empirical measure of feminine ideology (CFNI-45) made it possible to empirically demonstrate rather than simply theorize that gender normative processes play a role in women’s risk for anxiety and depression. Older gender trait measures, namely the BSRI and the PAQ, which tend to capture socially desirable aspects of feminine gender roles, would not have served adequately for this purpose. The utilization of the CFNI-45 also enabled this study to draw a connecting line between the degree to which women adhere to cultural norms of femininity and their relational self-concept—their sense of themselves in relation to others—again an idea that has been theorized to be related but very rarely studied empirically. Specifically, this study demonstrated that it is important to recognize that the extent to which women depend on others for validation and emotional stability (emotional reliance) may be especially informed by internalized gender roles. This implies that women’s approach to the relational self/nonself divide is at least in part dependent on or informed by the extent to which they have internalized gender norms and roles.

When working with women in a clinical setting, it may be helpful to bear in mind that women who tend to play stereotypical gender roles may be at greater risk for anxiety and depression. This may be more or less true depending on sociocultural background. For instance, among Latinas, strict traditional codes of femininity appear to exacerbate the effect of gender
role on depression and anxiety. In other, less traditional cultural groups, the effect of gender role may inform risk for depression and anxiety much less or may have a much more subtle connection to internalizing symptoms. In yet other groups, whose norms of femininity may be radically different from dominant Eurocentric concepts of femininity, as is the case among African-American women, cultural norms of femininity may actually be protective against depression and anxiety.

On an individual case-by-case basis, however, it remains important to find ways to explore women’s attachment to gender roles: It will prove useful to examine the promises that these roles hold for women as well as the potential costs that these roles can incur. Moreover when treating women with significant internalizing problems, it may be helpful to work backwards and consider rigid gender roles as a potential factor among many interrelated factors contributing to depression and anxiety, always keeping in mind cultural background as a rough guide for possibly ruling out or pursuing this line of thinking further.

Additionally, it will also help to listen for the ways in which the constant threat of failing to meet the needs and approval of others takes a toll on the psyche. Finally any preoccupations with comparisons between self and other, i.e. themes of envy, jealousy, and exclusion, may be indicators of poor-self esteem, and may even be coded in subtle and not so subtle ways in terms of gender roles. Drawing connections between the preoccupation with others, poor self-esteem, gender coded themes, and depression and anxiety, can help to inform how we listen for and target each link in the pathway to psychological distress in our female clients.

Limitations and Further Research

A significant limitation of this study was that a majority of this study’s sample was Caucasian (58%) and between the ages of 22 and 34 (67%). Although this sample was quite
diverse in terms of income level, which distinguishes it from many studies in the field, the relatively narrow age range and cultural range of participants, limits the generalizability of the findings. Though analyses were conducted on two minority groups, African-American and Hispanic/Latina, these sample sizes were relatively small ($N = 23, N = 27$ respectively) and would need to be tested on much larger samples to make scientific claims with any level of confidence. Thus, it may be helpful to test the hypotheses of these studies in various cohorts of large sample sizes, not just by ethnicity, but also by age or even by sexual orientation, to isolate the influence of these important factors on the model being studied.

Another limitation of the study was the questionable internal validity and construct validity of the self-salience measure. Some of the self-salience constructs were not correlated with each other in this study’s sample. Specifically, boundaries were not correlated with rank or worth. Additionally, the composite construction of the scales for self-salience variables made it somewhat difficult to ascertain the extent to which these composite scales actually assessed the constructs they purported to measure. The failure to find the latent variable, relational self-concept, may be attributed to both the internal and construct validity problems in the self-salience inventory. Thus, the failure to find significant relationships between some of the self-salience variables and internalizing symptoms may have resulted from a problem at the level of measurement rather than theory.

In this study’s general sample, feminine ideology did not have a significant relationship to depression. However, depression and anxiety are extremely related both empirically and theoretically. The fact that depression and anxiety were highly correlated in this study’s sample, that the relationship between anxiety and feminine ideology was significant, and finally that the relationship between depression and feminine ideology approached significance indicates that
further examination and testing of the relationship between depression and feminine ideology is warranted.

The relationship (in the general sample) between feminine ideology and internalizing symptoms was not found to be mediated by relational self-concept variables, emotional reliance, self-worth, boundaries and ranking. This suggests that there may be other mediating constructs not considered in this study that inform the relationship between relational self concepts, feminine ideology, and internalizing symptoms. For instance Hirschfield’s interpersonal dependency model theorizes that disruptions to attachment will lend themselves to excessive emotional reliance. It may be fruitful to study the relationship between emotional reliance and attachment style, particularly anxious attachment style and feminine ideology. Other promising avenues of study may be found in looking at the relationship between feminine ideology, internalizing symptoms, and object relations, i.e. the individual's internalized representations of self and significant figures.

Finally it is important to consider the salutary effects of cultural ideology that promotes empathy, intimacy, and emotional expression. Feminine ideology captures both the socially desirable and undesirable aspects of cultural norms of femininity. It is worth expanding the frame of psychological health beyond symptoms by looking at other aspects of psychological well-being, such as interpersonal aptitude and psychological flexibility. It may very well be that some of the norms that place women at greater risk for certain psychological distress may also put them at an advantage in other areas of psychological functioning.
APPENDIX I: Pre-Study Screening Questionnaire

PLEASE COMPLETE THE FOLLOWING ANONYMOUS QUESTIONNAIRE TO DETERMINE IF YOU ARE ELIGIBLE TO PARTICIPATE IN THIS STUDY.

1. Are you between the ages of 18 and 65?
   a) Yes
   b) No

2. What is your assigned sex at birth?
   a) Male
   b) Female
   c) Other

3. Your gender is?
   a) Female
   b) Male
   c) Transgender

4. Do you live in the United States?
   a) Yes
   b) No

5. Have you ever been diagnosed with any of the following psychological or psychiatric conditions? (check all that apply)
   a) Bipolar disorder
   b) Schizophrenia
   c) Psychosis
   d) Dementia
   e) None of the Above

6. Can you speak, understand, and read in English?
   a) Yes
   b) No
APPENDIX II: Demographics Questionnaire

THE FOLLOWING QUESTIONS WILL ASK YOU TO PROVIDE SOME BACKGROUND INFORMATION ABOUT YOU.

1. Your age range:
   a) 18-21
   b) 22-34
   c) 35-44
   d) 45-54
   e) 55-65

2. What category best describes your ethnic and racial background?
   a) African-American, Black
   B. East Asian-American, East Asian
   C. South Asian-American, South Asian
   H. White Caucasian – Non Hispanic
   I. Hispanic or Latino
   J. Native American
   I. Middle Eastern
   M. More than one race
   N. Unknown or not reported
   O. Decline to answer

3. Your sexual orientation?
   a) Straight
   b) Bisexual
   c) Lesbian/Gay
   e) Queer
   f) Questioning/ Unsure
   g) Unlabeled
   h) Other _______________________

4. How important is religion in your life?
   a) not at all
   b) a little bit
   c) somewhat
   d) quite a bit
   e) very

5. What is the highest level of education you have completed?
   a) Some high school
   b) High school diploma
   c) Some college
   d) 2-yr college degree
   e) 4-yr college degree
f) Grad. School degree

6. What category best describes your annual income?
   a) under 10K
   b) 20-29.999K
   c) 30-39.999K
   d) 40-49.999K
   e) 50-74.999K
   f) 75-99.999K
   g) 100K- 150K
   h) over 150K

7. Check all that apply to you as it pertains to your relationship status:
   a) single
   b) cohabiting
   c) married
   d) separated
   e) divorced (past and current)
   f) Other ____________________________

8. Were you ever a parent?
   a) Yes
   b) No

9. If you answered yes to being a parent, what best describes your parental status?
   a) Parent with dependent child/children under 18 living in household currently
   b) Parent with dependent child/children under 18 who lived in household in the past.
   c) Children never lived with me

10. Which category best describes your employment status?
    a) Part-time for wages
    b) Full-time for wages
    c) Self Employed
    d) Unemployed
    e) Student
    f) Homemaker

11. Which of following category best describes your work? *
    a) Agriculture, forestry, fishing, and hunting
    b) Mining, quarrying, and oil and gas extraction
    c) Construction
    d) Manufacturing
    e) Wholesale and retail trade
    f) Transportation and utilities
    g) Information
    h) Arts, entertainment, recreation
i) Financial Activities
j) Professional and business services
k) Education and health services
l) Leisure and hospitality
m) Public administration
n) Administrative/ Support Staff
o) Other ________________________________
APPENDIX III: Study Questionnaire

DEPRESSION SCREENER (BDI-II)

THIS QUESTIONNAIRE CONSISTS OF 21 GROUPS OF STATEMENTS. PLEASE READ EACH GROUP OF STATEMENTS CAREFULLY, AND THEN PICK OUT THE ONE STATEMENT IN EACH GROUP THAT BEST DESCRIBES THE WAY YOU HAVE BEEN FEELING DURING THE PAST TWO WEEKS, INCLUDING TODAY. IF SEVERAL STATEMENTS IN THE GROUP SEEM TO APPLY EQUALLY WELL, CHOOSE THE HIGHEST NUMBER FOR THAT GROUP. BE SURE THAT YOU DO NOT CHOOSE MORE THAN ONE STATEMENT FOR ANY GROUP, INCLUDING ITEM 16 (CHANGES IN SLEEPING PATTERN) OR ITEM 18 (CHANGES IN APPETITE).

1. Sadness:
   0) I do not feel sad.
   1) I feel sad much of the time.
   2) I am sad all the time.
   3) I am so sad or unhappy that I can’t stand it.

2. Pessimism
   0) I am not discouraged about my future.
   1) I feel more discouraged about my future than I used to be.
   2) I do not expect things to work out for me.
   3) I feel my future is hopeless and will only get worse.

3. Past Failure
   0) I do not feel like a failure.
   1) I have failed more than I should have.
   2) As I look back, I see a lot of failures.
   3) I feel I am a total failure as a person.

4. Loss of Pleasure
   0) I get as much pleasure as I ever did from the things I enjoy.
   1) I don’t enjoy things as much as I used to.
   2) I get very little pleasure from the things I used to enjoy.
   3) I can’t get any pleasure from the things I used to enjoy.

5. Guilty Feelings
   0) I don’t feel particularly guilty.
   1) I feel guilty over many things I have done or should have done.
   2) I feel quite guilty most of the time.
   3) I feel guilty all of the time.

6. Punishment Feelings
   0) I don’t feel I am being punished.
1) I feel I may be punished.
2) I expect to be punished.
3) I feel I am being punished.

7. Self-Dislike
   0) I feel the same about myself as ever.
   1) I have lost confidence in myself.
   2) I criticize myself for all of my faults.
   3) I blame myself for everything.

8. Self-Criticalness
   0) I don’t criticize or blame myself more than usual.
   1) I am more critical of myself than I used to be.
   2) I criticize myself for all of my faults.
   3) I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
   0) I don’t have thoughts of killing myself.
   1) I have thoughts of killing myself, but I would not carry them out.
   2) I would like to kill myself.
   3) I would kill myself if I had the chance.

10. Crying
    0) I don’t cry anymore than I used to.
    1) I cry more than I used to.
    2) I cry over every little thing.
    3) I feel like crying, but I can’t.

11. Agitation
    0) I am no more restless or wound up than usual.
    1) I feel more restless or wound up than usual.
    2) I am so restless or agitated that it’s hard to stay still.
    3) I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
    0) I have not lost interest in other people or activities.
    1) I am less interested in other people or things than before.
    2) I have lost most of my interest in other people or things.
    3) It’s hard to get interested in anything.

13. Indecisiveness
    0) I make decisions about as well as ever.
    1) I find it more difficult to make decisions than usual.
    2) I have much greater difficulty in making decisions than I used to.
    3) I have trouble making any decisions.
14. **Worthlessness**
   0) I do not feel I am worthless.
   1) I don’t consider myself as worthwhile and useful as I used to.
   2) I feel more worthless as compared to other people.
   3) I feel utterly worthless.

15. **Loss of Energy**
   0) I have as much energy as ever.
   1) I have less energy that I used to have.
   2) I don’t have enough energy to do very much.
   3) I don’t have enough energy to do anything.

16. **Changes in Sleep Pattern**
   0) I have not experienced any change in my sleeping pattern.
   1a) I sleep somewhat more than usual.
   1b) I sleep somewhat less than usual.
   2a) I sleep a lot more than usual.
   2b) I sleep a lot less than usual.
   3a) I sleep most of the day.
   3b) I wake up 1-2 hours early and can’t get back to sleep.

17. **Irritability**
   0) I am no more irritable than usual.
   1) I am more irritable than usual.
   2) I am much more irritable than usual.
   3) I am irritable all the time.

18. **Changes in Appetite**
   1) I have not experienced any change in my appetite.
   1a) My appetite is somewhat less than usual.
   1b) My appetite is somewhat greater than usual.
   2a) My appetite is much less than before.
   2b) My appetite is much greater than usual.
   3a) I have no appetite at all.
   3b) I crave food all the time.

19. **Concentration Difficulty**
   0) I can concentrate as well as ever.
   1) I can’t concentrate as well as usual.
   2) It’s hard to keep my mind on anything for very long.
   3) I find I can’t concentrate on anything.

20. **Tiredness or Fatigue**
   0) I am no more tired or fatigued than usual.
   1) I get more tired or fatigued more easily than usual.
   2) I am too tired or fatigued to do a lot of things I used to do.
3) I am too tired or fatigued to do most of things I used to do.

21. **Loss of Interest in Sex**
   0) I have not noticed any recent change in my interest in sex.
   1) I am less interested in sex than I used to be.
   2) I am much less interested in sex now.
   3) I have lost interest in sex completely.

**ANXIETY SCREENER (BAI)**

BELOW IS A LIST OF 21 COMMON SYMPTOMS OF ANXIETY. PLEASE CAREFULLY READ EACH ITEM IN THE LIST. INDICATE HOW MUCH YOU HAVE BEEN BOTHERED BY THAT SYMPTOM **DURING THE PAST MONTH, INCLUDING TODAY**, BY CHOOSING THE NUMBER THAT BEST FITS YOUR EXPERIENCE OF THAT SYMPTOM.

1. **Numbness or tingling**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.

2. **Feeling hot**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.

3. **Wobbliness in legs**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.

4. **Unable to relax**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.

5. **Fear of worst happening**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.
6. **Dizzy or lightheadedness**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.

7. **Heart pounding/racing**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.

8. **Unsteady**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.

9. **Terrified or afraid**
   0) Not at all.
   1) Mildly but it didn’t bother me.
   2) Moderately- it wasn’t pleasant at times.
   3) Severely- it bothered me a lot.

10. **Nervous**
    0) Not at all.
    1) Mildly but it didn’t bother me.
    2) Moderately- it wasn’t pleasant at times.
    3) Severely- it bothered me a lot.

11. **Feeling of choking**
    0) Not at all.
    1) Mildly but it didn’t bother me.
    2) Moderately- it wasn’t pleasant at times.
    3) Severely- it bothered me a lot.

12. **Hands trembling**
    0) Not at all.
    1) Mildly but it didn’t bother me.
    2) Moderately- it wasn’t pleasant at times.
    3) Severely- it bothered me a lot.

13. **Shaky/unsteady**
    0) Not at all.
    1) Mildly but it didn’t bother me.
2) Moderately- it wasn’t pleasant at times.
3) Severely- it bothered me a lot.

14. Fear of losing control
0) Not at all.
1) Mildly but it didn’t bother me.
2) Moderately- it wasn’t pleasant at times.
3) Severely- it bothered me a lot.

15. Difficulty breathing
0) Not at all.
1) Mildly but it didn’t bother me.
2) Moderately- it wasn’t pleasant at times.
3) Severely- it bothered me a lot.

16. Fear of dying
0) Not at all.
1) Mildly but it didn’t bother me.
2) Moderately- it wasn’t pleasant at times.
3) Severely- it bothered me a lot.

17. Scared
0) Not at all.
1) Mildly but it didn’t bother me.
2) Moderately- it wasn’t pleasant at times.
3) Severely- it bothered me a lot.

18. Indigestion
0) Not at all.
1) Mildly but it didn’t bother me.
2) Moderately- it wasn’t pleasant at times.
3) Severely- it bothered me a lot.

19. Faint/ lightheadedness
0) Not at all.
1) Mildly but it didn’t bother me.
2) Moderately- it wasn’t pleasant at times.
3) Severely- it bothered me a lot.

20. Face/ flushed
0) Not at all.
1) Mildly but it didn’t bother me.
2) Moderately- it wasn’t pleasant at times.
3) Severely- it bothered me a lot.

21. Hot/ cold sweats
FEMININE IDEOLOGY MEASURE (CFNI-45)

THIS QUESTIONNAIRE CONSISTS OF 45 STATEMENTS ABOUT HOW WOMEN MIGHT THINK, FEEL, OR BEHAVE. THE STATEMENTS ARE DESIGNED TO MEASURE ATTITUDES, BELIEFS, AND BEHAVIORS ASSOCIATED WITH BOTH TRADITIONAL AND NON-TRADITIONAL FEMININE GENDER ROLES. THINKING ABOUT YOUR ACTIONS, FEELINGS, AND BELIEFS, PLEASE INDICATE HOW MUCH YOU PERSONALLY AGREE OR DISAGREE WITH EACH STATEMENT BY SELECTING “STRONGLY DISAGREE,” “DISAGREE,” “AGREE,” OR “STRONGLY AGREE,” BELOW EACH STATEMENT. READ EACH STATEMENT CAREFULLY AND RESPOND AS HONESTLY AS POSSIBLE. YOU MAY FEEL YOUR RESPONSE WILL VARY DEPENDING ON CONTEXT, PLEASE ANSWER AS BEST AS YOU CAN BASED ON WHAT IS TRUE FOR YOURSELF MOST OF THE TIME.

1. I would be happier if I was thinner.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

2. It is important to keep your living space clean.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

3. I spend more than 30 minutes a day doing my hair and make-up.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

4. I tell everyone about my accomplishments.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

5. I clean my home on a regular basis.
   a. Strongly Disagree
   b. Disagree
   c. Agree
d. Strongly Agree

6. I feel attractive without makeup.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

7. I believe that my friendships should be maintained at all costs.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

8. I find children annoying.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

9. I would feel guilty if I had a one-night stand.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

10. When I succeed, I tell my friends about it.
    a. Strongly Disagree
    b. Disagree
    c. Agree
    d. Strongly Agree

11. Having a romantic relationship is essential in life.
    a. Strongly Disagree
    b. Disagree
    c. Agree
    d. Strongly Agree

12. I enjoy spending time making my living space look nice.
    a. Strongly Disagree
    b. Disagree
    c. Agree
    d. Strongly Agree

13. Being nice to others is extremely important.
    a. Strongly Disagree
b. Disagree
c. Agree
d. Strongly Agree

   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

15. I don’t go out of my way to keep in touch with friends.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

16. Most people enjoy children more than I do.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

17. I would like to lose a few pounds.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

18. It is not necessary to be in a committed relationship to have sex.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

19. I hate telling people about my accomplishments.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

20. I get ready in the morning without looking in the mirror very much.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree
21. I would feel burdened if I had to maintain a lot of friendships.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

22. I would feel comfortable having casual sex.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

23. I make it a point to get together with my friends regularly.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

24. I always downplay my achievements.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

25. Being in a romantic relationship is important.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

26. I don’t care if my living space looks messy.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

27. I never wear make-up.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

28. I always try to make people feel special.
   a. Strongly Disagree
   b. Disagree
   c. Agree
29. I am not afraid to tell people about my achievements.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

30. My life plans do not rely on my having a romantic relationship.
   a. Strongly Disagree
   e. Disagree
   f. Agree
   g. Strongly Agree

31. I am always trying to lose weight.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

32. I would only have sex with the person I love.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

33. When I have a relationship, I enjoy focusing my energies on it.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

34. There is no point to cleaning because things will get dirty again.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

35. I am not afraid to hurt people’s feelings to get what I want.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

36. Taking care of children is extremely difficult.
   a. Strongly Disagree
b. Disagree  
c. Agree  
d. Strongly Agree

37. I would be perfectly happy with myself even if I gained weight.  
a. Strongly Disagree  
b. Disagree  
c. Agree  
d. Strongly Agree

38. If I were single, my life would be complete without a partner.  
a. Strongly Disagree  
b. Disagree  
c. Agree  
d. Strongly Agree

39. I rarely go out of my way to act nice.  
a. Strongly Disagree  
b. Disagree  
c. Agree  
d. Strongly Agree

40. I actively avoid children.  
a. Strongly Disagree  
b. Disagree  
c. Agree  
d. Strongly Agree

41. I am terrified of gaining weight.  
a. Strongly Disagree  
b. Disagree  
c. Agree  
d. Strongly Agree

42. I would only have sex if I was in a committed relationship like marriage.  
a. Strongly Disagree  
b. Disagree  
c. Agree  
d. Strongly Agree

43. I like being around children.  
a. Strongly Disagree  
b. Disagree  
c. Agree  
d. Strongly Agree
44. I don’t feel guilty if lose contact with a friend.
   a. Strongly Disagree  
   b. Disagree  
   c. Agree  
   d. Strongly Agree  

45. I would be ashamed if someone thought I was mean.
   a. Strongly Disagree  
   b. Disagree  
   c. Agree  
   d. Strongly Agree  

EMOTIONAL RELIANCE (ER subscale of the IDI)

This questionnaire consists of 17 statements that describe you in relation to others. Thinking about how you think and feel in relation to others, please indicate how much you personally agree or disagree with each statement by selecting “STRONGLY DISAGREE,” “DISAGREE,” “AGREE,” or “STRONGLY AGREE,” below each statement. Read each statement carefully and respond as honestly as possible. You may feel your response will vary depending on context, please answer as best as you can based on what is true for yourself most of the time.

1. I do my best work when I know it will be appreciated.
   a. Strongly Disagree  
   b. Disagree  
   c. Agree  
   d. Strongly Agree  

2. I believe people could do a lot more for me if they wanted to.
   a. Strongly Disagree  
   b. Disagree  
   c. Agree  
   d. Strongly Agree  

3. As a child, pleasing my parents was very important to me.
   a. Strongly Disagree  
   b. Disagree  
   c. Agree  
   d. Strongly Agree  

4. Disapproval by someone I care about is very painful to me.
   a. Strongly Disagree  
   e. Disagree  
   f. Agree  
   g. Strongly Agree
5. The idea of losing a close friend is terrifying to me.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

6. I would be completely lost if I didn’t have someone special.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

7. I get upset when someone discovers a mistake I’ve made.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

8. I easily get discouraged when I don’t get what I need from others.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

9. I must have one person who is very special to me.
   a. Strongly Disagree
   b. Disagree
   c. Agree
   d. Strongly Agree

10. I’m never happier than when people say I’ve done a good job.
    a. Strongly Disagree
    b. Disagree
    c. Agree
    d. Strongly Agree

11. I need to have one person who puts me above all others.
    a. Strongly Disagree
    b. Disagree
    c. Agree
    d. Strongly Agree

12. I tend to imagine the worst if a loved one doesn’t arrive when expected.
    a. Strongly Disagree
    b. Disagree
SELF-SALIENCE INVENTORY (SSI)

NEXT YOU WILL ENCOUNTER MULTIPLE SETS OF QUESTIONS ALL OF WHICH PERTAIN TO HOW YOU BEHAVE/SEE YOURSELF IN RELATION TO OTHERS. READ EACH STATEMENT CAREFULLY AND RESPOND AS HONESTLY AS POSSIBLE. YOU MAY FEEL YOUR RESPONSE WILL VARY DEPENDING ON CONTEXT, PLEASE ANSWER AS BEST AS YOU CAN BASED ON WHAT IS TRUE FOR YOURSELF MOST OF THE TIME.

PLEASE ANSWER TRUE OR FALSE TO THE FOLLOWING STATEMENTS:

(PRFR- Autonomy Scale)
1. I find that I can think better when I have the advice of others.
   a. True
   b. False

2. I delight in feeling unattached.
   a. True
   b. False

3. Family obligations make me feel important.
   a. True
   b. False

4. I would feel lost and lonely roaming about the world alone.
   a. True
   b. False

5. I could live alone and enjoy it.
   a. True
   b. False

6. I would not mind living in a lonely place.
   a. True
   b. False

7. I would like to be alone and be my own boss.
   a. True
   b. False

8. I like to do whatever is proper.
   a. True
   b. False

9. I would like to have a job in which I would not have to answer to anyone.
   a. True
   b. False

10. I usually try to solve my problems with someone who can help me.
    a. True
    b. False

11. I am quite independent of the opinions of others.
    a. True
    b. False

12. I don’t want to be away from family too much.
PLEASE ANSWER TRUE OR FALSE TO THE FOLLOWING STATEMENTS:

(PRFR- Nurturance Scale)
1. I feel no great concern for the troubles of other people.
   a. True
   b. False

2. I would rather have a job serving people than a job making something.
   a. True
   b. False

3. It doesn’t affect me one way or another to see a child being spanked.
   a. True
   b. False

4. I have never done volunteer work for charity.
   a. True
   b. False

5. If someone is in trouble, I try not to become involved.
   a. True
   b. False

6. People like to tell me their troubles because they know I will help them.
   a. True
   b. False

7. If I could, I would hire a nurse to care for a sick child rather than do it myself.
   a. True
   b. False

8. It is very important to me to show people I am interested in their troubles.
   a. True
   b. False

9. Seeing an old or helpless person makes me feel that I would like to take care of them.
   a. True
   b. False

10. I am not always willing to help someone when I have other things to do.
   a. True
    b. False
11. I feel most worthwhile when I am helping someone disabled.
   a. True
   b. False

12. Sometimes when a friend is in trouble, I cannot sleep because I want so much to help them.
   a. True
   b. False

PLEASE ANSWER TRUE OR FALSE TO THE FOLLOWING STATEMENTS:

(PRIF- Dominance Scale)
1. I would like to be a judge.
   a. True
   b. False

2. I avoid positions of power over other people.
   a. True
   b. False

3. I try to control others rather than permit them to control me.
   a. True
   b. False

4. I don’t like to have the responsibility for directing the work of others.
   a. True
   b. False

5. I would like to play a part in making laws.
   a. True
   b. False

6. I have little interest in leading others.
   a. True
   b. False

7. In an argument, I can usually win others over to my side.
   a. True
   b. False

8. I feel uneasy when I have to tell people what to do.
   a. True
   b. False
9. The ability to be a leader is very important to me.
   a. True
   b. False

10. Most community leaders do a better job than I could possibly do.
    a. True
    b. False

11. I would like to be an executive with power over others.
    a. True
    b. False

12. I would not want to have a job enforcing the law.
    a. True
    b. False

PLEASE ANSWER TRUE OR FALSE TO THE FOLLOWING STATEMENTS:

(PRFAbasion Scale)
1. I like to be the first to apologize after an argument.
   a. True
   b. False

2. I would never call attention to any of my weaknesses.
   a. True
   b. False

3. I don’t like running errands for others, even my friends.
   a. True
   b. False

4. I have often let others take credit for something I have done rather than be impolite.
   a. True
   b. False

5. Several people have taken advantage of me, but I always take it like a good sport.
   a. True
   b. False

6. I resent being punished.
   a. True
   b. False

7. If someone accidentally burned me with a cigarette I would certainly mention it.
   a. True
b. False

8. When someone bumps into me in a crowd, I usually say I am sorry.
   a. True
   b. False

9. When people try to make me feel important, I feel uncomfortable.
   a. True
   b. False

10. I do not particularly enjoy being the object of someone’s jokes.
    a. True
    b. False

11. I remember my failures more easily than my successes.
    a. True
    b. False

12. When standing in line, I don't let other people get ahead of me.
    a. True
    b. False

THE ITEM BELOW IS MADE UP OF A PAIR OF CHARACTERISTICS WITH LETTERS A THROUGH E BETWEEN THEM. THE LETTERS FORM A SCALE BETWEEN TWO OPPOSITES (FROM NOT AT ALL TO VERY MUCH). PLEASE CHOOSE A LETTER THAT DESCRIBES WHERE YOU THINK YOU FALL ON THE SCALE.

(PAQ)

Not at all self-confident A B C D E Very self-confident
Call for Women Participants!!

Femininity and Mental Well-Being Study

Are you a Woman, age 18-65???

If so, you are invited to participate in an online survey about societal standards of femininity, characteristic ways of relating to yourself and others, and mental well-being.

If you are a woman living in the U.S., age 18-65, you may be eligible to participate in this 20-40 minute online study. Completion of the survey qualifies you to enter for a chance to win one of five Amazon Gift Cards valued at $100. To participate, head over to https://www.psychdata.com/s.asp?SID=168419


San Antonio, TX: Psychological Corporation.


