

UC Berkeley

UC Berkeley Previously Published Works

Title

Coping styles and factors in male/female social intergration

Permalink

<https://escholarship.org/uc/item/66k22367>

Journal

Acta Psychiatrica Scandinavica, 61(1)

ISSN

0001-690X

Authors

Segal, SP
Everett-Dille, L

Publication Date

1980

DOI

10.1111/j.1600-0447.1980.tb00561.x

Copyright Information

This work is made available under the terms of a Creative Commons Attribution-NonCommercial-NoDerivatives License, availalbe at <https://creativecommons.org/licenses/by-nc-nd/4.0/>

Peer reviewed

Coping styles and factors in male/female social integration

S. P. SEGAL AND L. EVERETT-DILLE

As part of a larger research undertaking which explores the overall life-experience of former mental hospital patients living in community-based sheltered-care facilities in California, predictors of resident social involvement – both within the facility and outside in the community at large – were delineated. In our sample of 499 residents, we found that the types of variables indicating higher levels of social integration differed between male and female residents. The predictors that were most significant for men tended to indicate a coping style based upon access to community resources and feasibility of becoming socially involved. Thus, the opportunities made available to men in sheltered-care facilities tended to be taken advantage of provided the residents' psychological handicap was not too debilitating. Predictors of higher levels of social involvement for women residents on the other hand, involved the acceptability of such behavior as appropriate by the community and the facility operator. Women residents thus appeared to be more sensitive to social, rather than environmental contingencies.

Key words: Mentally ill – sex roles – community care – coping – mental health – socialization.

Little is known about the coping styles of mentally ill men and women. Generally, social expectations about the coping styles of men and women facing life-stresses differ markedly. Stereotypically, men are seen as active, and analytic or impulsive, and women as passive, and emotional or sensitive. However, social research has not yet indicated whether sex role differences really condition distinct coping styles between the sexes, and, if so, what the nature of the distinction is. This study considers the distinct coping styles of formerly mentally ill men and women living in community-based sheltered-care facilities in California.

While there is a body of literature analyzing the causal impact of the sex role on the development of mental disorder, most analyses of sex role differences are based on observations from the general population. While many of these analyses (*Komarovsky* (1946, 1953), *Angrist* (1969), *Bardwick & Douvan* (1971), *Cautley & Borgatta* (1973)) examine biological differences between the sexes, focusing especially on the contingent nature of the reproductive life cycle of the woman, few extend this to systematically examine differences in coping styles between men and women. In her hallmark research on internal conflict

within the feminine sex role, *Komarovsky* (1946, 1953), for example, found that young college women "played dumb" in order to maximize their dating and marriage potential. Analyzing the determinants of family size, *Cautley & Borgatta* (1973) reviewed several studies (*Angrist* (1969), *Steinman & Fox* (1966)) that documented the importance of children and marriage to shaping the woman's life plans. Neither of these studies extended their findings to characterize these differences as a feminine coping style. One of the few researchers to see a pattern of coping in the response of women to their biological origins was *Angrist*. Her 1966 study found that among working mothers, marriage, but not work, had been explicitly anticipated. Her longitudinal research on the role aspirations of college women also showed that women's occupational preferences and the strength of those preferences vacillated radically throughout the college years (*Angrist* (1969)). Hypothesizing that women are trained to maintain flexibility, *Angrist* concluded that preparing for and adjusting to contingencies is built into female sex role socialization. The primary contingencies women face are marriage and motherhood, though divorce and widowhood can and frequently do change their role requirements.

The literature on sex role differences with regard to the coping of men is even less specific. In a more psychophysiological approach, *Bardwick & Douvan* (1971) support the stereotypic conception of the active and independent coping of men. They hypothesize that boys' impulsivity and sexuality, which are considered to be sources of enormous pleasure independent of anyone else's response, lead to the development of a sense of autonomy – the primary characteristic of the male sex role. For girls, *Bardwick & Douvan* see the formation of gender identity as more continuous and easier than for boys up to the age of puberty. At puberty, however, girls are suddenly brought under a great deal of pressure to conform to female sex role imperatives vis-a-vis the reproductive cycle. This generates ambivalence, rather than autonomy, as the primary characteristic of the female sex role.

Recognition of the importance that such key contingencies as marriage and childbirth play in elaborating male and female sex roles is therefore widespread though few studies examine the implications of the contingencies in terms of coping styles. The research on coping *per se* indirectly supports the importance of contingencies to women and *Angrist's* hypothesis that flexibility in handling these life contingencies and a tolerance for ambivalence constitutes a coping style more characteristic of women.

Investigating repression versus isolation as coping mechanisms, *Becker* (1969) found some evidence that femininity (as measured by the California Psychological Inventory, Femininity Scale) was associated with removing the affective charge from the stress (isolation) as an ego defense while masculinity tended to be associated with repression as an ego defense. These differences held up regardless of the biological sex of the respondent. *Becker*, however, did not connect these psychological defense mechanisms to actual problem-solving behavior. Examining such behavior, though, *Bezdek & Strodtbeck* (1970) found no differences in choices of strategy for problem-solving between males and females.

Hall (1972) in one of the few studies of sex role coping styles, hypothesized three strategies of coping with conflicting role norms for women. He found that the more externally oriented the coping behavior, i.e. the more the woman attempted to change the role demands of others rather than herself, the more satisfactorily she coped. However, *Hall* did not compare the females in his study with a male population to identify potential differences in coping styles.

Pearlin & Schooler (1978) did compare the coping of men versus women. In a study of the effectiveness of various coping responses for reducing stress coming from strains in parental, marital and occupational roles by sex, they found that the *single* coping devices men used were more often externally directed and were the most effective for reducing stress. While this finding confirms *Becker's* findings, it does not compare response *patterns* or whole styles of coping characteristic of each sex. Interestingly, for all subjects, a multiplicity of responses to stress was found to be quite common and effective, but the authors did not consider whether a single or multi-faceted approach to problem-solving was more characteristic of males or females.

The literature on sex role differences in problem solving can also be supplemented by looking at the literature on competitiveness and dependency in male versus female group behavior; the experimental situation in each case can be viewed as a "problem" with which the subject must cope. Previous research has inferred that women seek accommodative (no loser) strategies. However, *Lirtzman & Wahba* (1972) in a study of male versus female coalition formation under conditions of certainty and uncertainty found that women formed more utility-oriented coalitions than expected. Situational differences, such as the use of real money for reward, a clearly competitive structure, and the inclusion of a "luck" factor for winning, seemed responsible for changing the behavior of the female subjects between experiments, leading the authors to conclude that "situational demands seem to be the determinant of female coalitional behavior."

Another area of research that demonstrates a more contingency-oriented coping style for women is the expanding literature on "fear of success" (*Horner* (1970)) which, despite the controversial nature of the "fear of success" syndrome, has consistently shown that achievement and competitiveness of women vary both with their life situation and the context of testing. *Tangri* (1969) for example, found young women to be more non-traditional in life plans if they had male support while *Tomlinson-Keasey* (1974) found fear of success to be greater among non-married coeds than among married coeds. Likewise, *Jellison et al.* (1975) found that both male and female subjects significantly raised or lowered their scores on an IQ test, depending which direction was rewarded, but that female scores were much more affected by the sex of the psychologist supposedly delivering the rewards than were male scores. In each of these cases, female responses were more strongly influenced by the environmental context than were male scores.

The present research examines differences in predictors of social involvement between mentally ill men and women, considering these to reflect differences in sex-based coping styles. Looking at the impact of individual, facility, and community characteristics on the social integration of mentally ill residents living

in sheltered-care facilities in California, we found evidence that social integration for men depends primarily on access to means of social involvement whereas social integration for women depends more on social acceptance and support for these involvements. While the men in our sample appeared to integrate into the community quite autonomously the women appeared to integrate more flexibly in response to a broad range of contingencies present in the environment.

METHODOLOGY

This study is part of a larger research project exploring the overall life-experience of community-based sheltered-care residents in California (*Segal & Aviram* (1978)). In 1973, interviews were conducted with a sample of 499 sheltered-care residents drawn from California's population of 12,400 nonretarded mentally ill between the ages of 18 and 65 living in community-based sheltered care. Our research operationalized the concept social integration in two scales which measure levels of both internal and external integration for residents living in community-based sheltered care.

We defined internal integration as the degree to which an individual becomes socially involved in activities sponsored by the facility. We defined external integration as the degree to which an individual independently becomes involved in the community outside. Our index of external integration is composed of seven subscales which measure the amount of time an individual spends outside of the facility, his access to goods and services available in the community, his social contacts and participation in community activities, his contribution to the community through work or study, and his activities as a consumer of goods and services. Internal integration is composed of five subscales which assess similar involvements that occur within or are mediated by the facility.

The present study uses analysis of covariance techniques to examine the predictors of internal and external integration within sex groups. We selected our major predictor variables by eliminating those variables which were not significantly related to either internal or external integration scores for either males or females. Using six exploratory step-wise regressions, we then tested the significant and independent contribution each remaining variable made when predicting internal and external integration for males and females separately.

Two predictive models were developed for males and females separately in the study. Predictors used in our final models, other than straightforward questionnaire items include: 1) *Moos'* (1974) Community Oriented Programs Environment Scales (COPEs), 2) the Consumer Response Scale (*Segal & Aviram* (1978)), 3) the *Overall & Gorham* (1962) Brief Psychiatric Rating Scale (BPRS), and 4) the Langner Scale (1962) for assessing psychological disturbance.

The COPEs scales are a 102-item forced choice assessment of facility characteristics made by facility residents. There are 10 subscales, nine of which were used in our study. These nine scales are: program involvement, support, spontaneity, autonomy (measuring the Treatment Program dimension) practical orientation, personal problem orientation, anger and aggression (measuring the Relationship dimension), order and organization, and program clarity (measuring

the System Maintenance dimension). Taken together, higher scores on the COPES' subscale reflect a generalized conception of an ideal psychiatric environment.

The Consumer Response Scale is a 20-item scale which assesses the residents' evaluations of the quality of the program and services they receive in their sheltered-care environment.

Level of psychopathology, employed both as a predictor and as a control variable, was measured by two assessment devices: the Overall & Gorham Brief Psychiatric Rating Scale (BPRS), and the Langner Scale of Psychopathology. The Langner Scale is a 22-item self-assessment form completed by residents. The BPRS is an interviewer assessment form. Trained social workers, with at least a year's experience in working with psychotic patients, were used as interviewers. They were trained, with the aid of films of released mental hospital patients, to assess the level of psychopathology using the BPRS. A small sample of joint and independent ratings of residents by psychiatrists and our interviewers showed 90 % agreement between our raters and three psychiatrists on the assessment of level of psychopathology.

RESULTS

Male residents in our sample represented 54 % of the total sheltered-care population ($n = 6710$) and female residents represented 46 % ($n = 5720$). The males tended to be slightly younger than the females with a mean age of 43 as compared with 47, respectively. They were also much more likely than the females never to have been married (73 % vs. 44 %, respectively). Females (50 %) were more likely than males (22 %) to have been divorced or separated from their spouse.

Using *Reiss'* (1961) Index of Socioeconomic Status, the social class of the parents of males and females did not differ significantly, though females had a slightly higher social status than males.

External integration

External integration is the extent to which the resident becomes independently involved in the community outside of the facility in which he or she resides. Male residents were likely to score higher, or to be more externally integrated than were female residents. The mean standardized external integration score for men is 0.105; for women it is -0.097 ($P < 0.05$). This difference lies largely in the subscale reflecting access to and participation in community groups, and facilities. On the average, women residents have less access to and participate less in community groups and consequently are less likely to develop external community involvements (Table 1).

Factors that facilitate and hinder external integration

The characteristics found to be significant predictors of external integration in either the male or female population are considered in three groups – community characteristics, facility characteristics, and resident characteristics. Results reported in Table 2 indicate that factors facilitating or hindering external inte-

Table 1. Mean external integration subscale scores*

Subscale and types of involvement	Men	Women	$P < **$
1) Attending to oneself – presence and consumption	0.001	-0.012	NS
2) Community groups and facilities – access	0.174	-0.173	0.01
3) Basic resources – access	0.027	-0.011	NS
4) Family – access and participation	-0.013	0.011	NS
5) Friends – access and participation	0.026	-0.006	NS
6) Community groups – participation	0.151	-0.157	0.01
7) Community facilities – participation	0.228	-0.149	0.01

* Means are reported as standard z scores.

** Determined by a t-test for difference in means.

Table 2. Factors that facilitate and hinder external integration

<i>Resident characteristics</i>			
Males	β^*	Females	β^*
Psychopathology assessment, Overall & Gorham (BPRS)	-0.29	Psychopathology assessment, Langner	-0.14
Have enough money	0.28	Resident controls his/her own money	0.13
Resident age	-0.13	Resident age	-0.14
<i>Community characteristics</i>			
Males	β^*	Females	β^*
Neighbors invite resident contact	0.20	Neighbors invite resident contact	0.34
		Many facilities in neighborhood	0.18
<i>Facility characteristics</i>			
Males	β^*	Females	β^*
Closeness of facility to community resources	0.18	Operator discourages contact with neighbors	-0.20
Facility emphasizes program of treatment	0.11	Age of oldest resident in facility	-0.18
Facility has recreation program at house	0.09	Closeness of facility to community resources	0.15
Cost of care	-0.08	Facility emphasizes program of treatment	0.14
		Facility emphasizes spontaneity	0.09
$R^2 = 0.33$		$R^2 = 0.42$	

* Partial standardized regression coefficients.

gration for males are primarily characteristics of the individual, but for females primarily are characteristics of the community or the environment of the facility.

Males. The two strongest predictors of external integration in the male sample are individual characteristics – psychological disturbance and economic sufficiency. Psychopathology was negatively related to external integration; having enough money to spend was positively related.

Only one community characteristic proved significant in enhancing a male's level of social integration – the willingness of neighbors to invite contact with sheltered-care residents. This variable, however, was the third strongest predictor in the overall model.

Among all the significant predictors in the male model, facility characteristics were the weakest. The closeness of the facility to community resources, the emphasis of the facility on a treatment program, and the presence of a recreation program in the facility were all positively related to the external integration of male residents. The closeness of the facility to community resources is important because it speaks most directly to the feasibility of doing things. The fact that it was the strongest facility characteristic predicting external integration for the male group supports our argument that males depend primarily upon factors that make it feasible for them to reach out into the community.

Females. The strongest predictors of external integration among females, on the other hand, were community characteristics, followed by facility characteristics, and lastly, by the individual characteristics of the residents themselves.

Two community characteristics facilitate female external integration. Neighbors inviting contact with residents was positively related to resident external integration and was almost twice as powerful as the other predictors in the model. The presence of other sheltered-care facilities in the same neighborhood indicates an environment that provides easily accessible social contacts for residents and therefore encourages them to involve themselves in the external community.

Facility characteristics as a group are second in importance for the women. In order of importance these are: 1) operator discourages contact with neighbors, 2) age of oldest resident in the facility, 3) closeness of the facility to community resources, 4) facility emphasis on a treatment program, and 5) facility emphasis on spontaneity.

A facility policy of discouraging residents' contact with other members of the external community reduced the level of external integration of female residents, but interestingly, had no effect on the external integration of male residents.

The age of the oldest resident in the facility is one indicator of a facility's program orientation. By orienting its procedures and activities to the limitations of older residents, a facility with very old residents may discourage external integration among other residents. The three other facility characteristics noted above positively enhance a female resident's external integration, but only weakly so.

Characteristics of the resident herself constitute the weakest group of characteristics predicting female external integration. Residents with a high degree of psychological disturbance (as indicated by the Langner Assessment of Psychopathology) tend to be less externally integrated, as do older female residents and those without control over their financial affairs.

Males and females. The data in Table 2 just summarized indicate that context of the community and facility is more important in furthering external integration for women compared with individual effort for men. This does not mean that context does not play a role in the external integration of males, but that on the whole it is of lesser importance.

The treatment program in the facility is, however, a contextual characteristic that is significant in enhancing the external integration for both men and women, but aspects of the program that are important differ by sex. Encouraging autonomy within the treatment program for example, generates more externally-oriented behavior among women than among men. The external integration of men, on the other hand, is enhanced by a treatment program encouraging them to express anger and aggression. Both men and women, however, benefit equally from expressing personal problems.

The importance of the facility context, particularly for women, is also illustrated by the importance of spontaneity, another significant predictor in our model and a factor in the relationship among facility residents. It is related to higher external integration scores for females but is not significant for males.

Internal integration

Internal integration defines the extent to which residents orient themselves socially within the facility and/or the extent to which the facility mediates their contacts with the community outside the facility. Female residents are more integrated into the facility than are male residents (the mean standardized internal integration score for women is 0.131; for men -0.040). Two subscales – the extent to which the facility provides access to basics (e.g. laundry service, clothing, toiletries and telephone), and the extent to which the resident socializes in the house – account for most of this difference. While socializing in the house is normative behavior for female residents, the higher score of women on the basic necessities subscale is harder to understand. Perhaps the latter indicates a greater willingness on the part of operators to care for a female population (Table 3).

Factors that facilitate and hinder internal integration

Table 4 lists the individual, facility and community characteristics that best predict internal integration for men and women living in sheltered-care facilities. Although living in an “ideal psychiatric environment” is one of the strongest factors promoting internal integration for both men and women, we find significant differences between the sexes when examining other predictor variables.

Males. In order of their relative importance, the four resident characteristics that significantly predict internal integration for males are: 1) psychological dis-

Table 3. Mean internal integration subscale scores*

Subscale and types of involvement	Men	Women	$P < **$
1) Operator provides transportation to community resources	0.018	0.093	NS
2) Operator facilitates access to activities	0.012	0.049	NS
3) Operator provides access to basics	-0.112	0.164	0.05
4) Socializing in the house	-0.123	0.208	0.01
5) Basics are purchased from house	0.140	-0.017	NS

* Means are reported as standard z scores.

** Determined by t-test for a difference of means.

Table 4. Factors that facilitate or hinder internal integration

<i>Resident characteristics</i>			
Males	β^*	Females	β^*
Psychopathology assessment, Overall & Gorham (BPRS)	-0.22	Obligation to facility operator	0.31
Consumer response	0.18	Time in a state hospital	-0.15
Socioeconomic status (SES)	-0.16	Psychopathology assessment, Overall & Gorham (BPRS)	-0.10
Living closer to hometown	0.12		
<i>Community characteristics</i>			
Males	β^*	Females	β^*
Neighbors invite resident contact	0.11	Neighbors invite resident contact	0.16
Living in a farm facility	0.11	Living in an open community	0.16
Living in a downtown area facility	-0.10	Living in a downtown area facility	-0.12
<i>Facility characteristics</i>			
Males	β^*	Females	β^*
Ideal psychiatric environment (COPEs)	0.29	Ideal psychiatric environment (COPEs)	0.22
Men only in residence	0.10	All or some residents keep medication	-0.13
Most facility residents from state mental hospital	0.09	Operator provides transportation to therapy	-0.11
House recreation	0.07		
$R^2 = 0.40$		$R^2 = 0.42$	

* Partial standardized regression coefficients.

turbance; 2) positive consumer response to the facility; 3) socio-economic status of the resident; and 4) proximity of the facility to the resident's home town. Male residents manifesting higher levels of psychopathology and those of higher socio-economic status were least likely to integrate themselves into the facility, while residents who perceived the facility as being a good place to live (consumer orientation) or who were living close to their hometown tended more to integrate into the facility.

Two community characteristics were positively related to internal integration of the male resident: 1) living in an environment that is socially supportive (i.e. where neighbors invite resident contact); and 2) living in a rural or farm area. Living in a downtown area, on the other hand, decreases the internal integration for the male resident. These findings indicate that male residents will involve themselves in a facility if other alternatives for activity are limited; hence internal integration tends to increase when facilities are located in rural areas and decrease when located in urban, downtown areas.

Four facility characteristics predict internal integration for men, all positively: 1) living in an "ideal psychiatric environment"; 2) living in an all-male facility; 3) living in a facility where most of the residents come from a state mental hospital; and 4) the presence of a recreation program in the house. Assessment of the facility environment as ideal on the COPES is the single most important characteristic predicting internal integration for men. Among the nine subscales composing the COPES index, only one – the resident's evaluation of the emphasis the facility placed on the expression of anger and aggression – was not significantly related to internal integration. Our finding that internal integration is enhanced for men (but not for women) by living in same-sex resident groups, or groups in which most residents come from state mental hospitals, appears to support *Tiger's* (1971) hypothesis that men in groups, especially groups that share a commonality of experience and status, form bonds not duplicated by groups of women.

Living in a facility that had a recreational program enhanced a resident's internal integration. This finding supplements the findings with respect to consumer response and the ideal psychiatric environment. Apparently, if one is to involve a male in a community care facility, the facility must provide an appealing atmosphere.

Females. Among all the characteristics predicting internal integration for women a sense of obligation to the facility operator is the strongest, and women who have this are most likely to become extensively involved in the facility. Such a sense of obligation, implying as it does a relationship of dependency had, however, little effect on the internal integration scores of male residents. It appears too that, unlike men, women who have spent large amounts of time in state mental hospitals want out of the mental health care system totally and are reluctant to involve themselves in any community care facility. The presence of manifest psychopathology, for women and men alike, reduces resident involvement in the facility, perhaps because it impairs the ability to form relationships.

Three community characteristics predict female internal integration. Living in a supportive environment generating good feelings toward the residents of community-based sheltered-care facilities (i.e. one where neighbors invite resident contact) and living in an open neighborhood enhance internal integration for women, but living in a downtown area, for females as well as for males, reduces it.

Of the nine COPEs subscales that measure the ideal psychiatric environment, only six are significantly related to internal integration for women. Encouraging the expression of anger and aggression, a need for order and organization, and a practical orientation are not significant. It seems that women seek a therapeutic environment that emphasizes protective and supportive relationships and are less concerned about the order and organization of the facility. It seems too that the internal integration of women, like men, is not affected by an environment that encourages them to express anger and aggression.

Two other facility characteristics are related to internal integration for women, both negatively. Internal integration was significantly reduced among female residents when some, or even all of them, were able to control their medication, and was also reduced when some residents were provided with transportation to therapy outside the facility. These latter findings seem to indicate that when structure is reduced within the facility, women tend to become less involved with its ongoing operation.

Comparison of males and females. Apparently, men integrate into sheltered-care facilities differently than do women. The male resident seems to depend more on a peer group for his involvement and the female more on the support of the facility operator. While feelings of obligation to the operator are not significant in predicting internal involvement for men, they are crucially important for women. However, levels of psychological disturbance do sharply influence integration attempts for men, much more so than for women, perhaps because the disturbed female presents less of a threat to the ongoing operations of the facility than does a comparatively disturbed male.

Summary of results

1. Men integrate into the community external to the facility to a slightly greater extent than women, but women tend to integrate internally into the facility slightly more than men. Differences between men and women are greater, however, between external than between internal integration scores.

2. The presence of overt symptomatology sharply hinders both external and internal integration for males, but has much less impact upon the integration levels of females.

3. The most important factor strengthening the external integration of men is the availability of personal and social resources; for women it is the existence of social support and freedom for integration.

4. An emphasis on good group or personal relationships encourages both internal and external integration for men, though its effect on internal integration is greater. Encouraging autonomy, on the other hand, especially furthers external

integration among women, while women's internal integration depends more heavily upon her relationship to the facility operator.

5. A supportive open community environment enhances internal integration strongly for women and moderately for men.

CONCLUSION

Our analysis of the predictors of both external and internal integration reflects different coping styles for men and women living in sheltered-care residences. Male residents reach out and participate in the general community, depending on their personal competence (age and psychopathology) and the availability of direct tangible resources, such as money and distance to community activities. They seem to "cope" with the problem of integrating into the external community in a direct and resource-limited manner.

The external integration of women residents, on the other hand, is less direct and is more contingent on the presence of social freedom and a supportive social environment. While less limited by tangible resources than are men, women rely more heavily on intangible resources, such as personal relationships.

Men become involved in facilities when they perceive a "high quality" environment, with available peer relationships and when their options for external involvement are reduced or nonexistent. Internal involvement is both a desired and an alternative adjustment to external involvement. In the latter situation, direct tangible resources are again important to coping but may be used to "get out of" rather than into the facility.

Women, on the other hand, become involved in the facility under a broader range of conditions, accepting dependency at times and involving themselves internally in the facility even when the general community is open and accepting. Again, the range and indirectness of conditions which can affect the internal involvement of women suggest a coping style that emphasizes responding to environmental contingencies and maximizing flexibility.

The move to a system of community care as a means of servicing the needs of the former mental patient was largely precipitated by the failure of the hospital to provide an adequate social situation for an individual to establish a socially healthy life style. This experience emphasized the need to become cognizant of the way people interact in their environments in building a foundation for successful clinical intervention. Given the coping styles we have discovered in this paper, an emphasis on resource availability in the placement situations offered to men and on the presence of a supportive social environment in providing adequate placements for women might better enable the resident to establish a socially healthy life style in which he or she can work on their mental health problems.

Further research is also needed to compare coping styles employed by a more normal population with those employed by former patients. This comparison would indicate changes in coping styles which may have resulted from involvements in the mental health system or from psychological disorder. Such changes may be good indicators of where clinical intervention may help to facilitate the psychological as well as the social reintegration of former patients.

ACKNOWLEDGMENTS

This research is supported by the National Institute of Mental Health, Center for Epidemiologic Studies, Grant # SR01 MH25417-05 ESR.

REFERENCES

- Angrist, S.* (1966): Role constellation as a variable in women's leisure activities. *J. soc. Forces* 45, 423-431.
- Angrist, S.* (1969): The study of sex roles. *J. soc. Issues* 25, 215-232.
- Bardwick, J. M., & E. J. Douvan* (1971): Ambivalence: The socialization of women. In *Cornick, V., & B. Moran* (eds.): *Women in a sexist society*. Basic Books, New York.
- Bezdek, W., & F. L. Strodbeck* (1970): Sex role identity and pragmatic action. *Amer. soc. Rev.* 35, 491-502.
- Becker, G.* (1969): Ego defense pattern, extraversion-introversion, and sex-role adjustment. *Brit. J. soc. clin. Psychol.* 8, 275-285.
- Cautley, P. W., & E. F. Borgatta* (1973): Population growth - a challenge to psychologists. *Represent. Res. soc. Psychol.* 4, 5-22.
- Hall, D. T.* (1972): A model of coping with role conflict: the role behavior of college educated women. *Admin. Sci. Quart.* 17, 471-476.
- Horner, M.* (1970): The motive to avoid success and changing aspirations of college women. *Women on campus: Symposium*. University of Michigan, pp. 12-23.
- Jellison, J. M., R. Jackson-White & R. A. Bruder* (1975): Achievement behavior: a situational interpretation. *Sex Roles* 1, 369-383.
- Komarovsky, M.* (1946): Cultural contradictions and sex roles. *Amer. J. Soc.* 52, 184-189.
- Komarovsky, M.* (1953): *Women in the modern world, their education and their dilemmas*. Little Brown, Boston.
- Langner, T. S.* (1962): A twenty-two item screening score of psychiatric symptoms indicating impairment. *J. Hlth Hum. Behav.* 3, 269-276.
- Lirtzman, S. J., & M. A. Wahba* (1972): Determinants of coalitional behavior of men and women: sex roles or situational requirements? *J. appl. Psychol.* 56, 406-411.
- Moos, R. H.* (1974): *Evaluating treatment environments*. Wiley-Interscience, New York.
- Overall, J. E., & D. R. Gorham* (1962): The brief psychiatric rating scale. *Psychol. Rep.* 10, 799-812.
- Pearlin, L. I., & C. Schooler* (1978): The structure of coping. *J. Hlth soc. Behav.* 19, 2-21.
- Reiss, A. J.* (1961): *Occupations and social status*. The Free Press, MacMillan, New York.
- Segal, S. P., & U. Aviram* (1978): *The mentally ill in community-based sheltered care*. Wiley-Interscience, New York.
- Steinman, A., & D. J. Fox* (1966): Male-female perceptions of the female role in the United States. *J. Psychol.* 64, 265-276.
- Tangri, S.* (1969): *Innovation in occupational choice* (Ph.D. Dissertation). University of Michigan, Ann Arbor.
- Tiger, L.* (1971): *Men in groups*. Panther Publishers, London.
- Tomlinson-Keasey, C.* (1974): Role variables: their influence on female motivational constructs. *J. cons. Psychol.* 21, 232-237.

Received May 14, 1979

Steven P. Segal, Ph.D.
School of Social Welfare
University of California
Berkeley, CA
U.S.A.