



1979

Personality Characteristics and Reported Symptoms of Women Seeking Psychotherapy: Feminists, and Other Females

Kay Bienemann
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_theses



Part of the [Psychology Commons](#)

Recommended Citation

Bienemann, Kay, "Personality Characteristics and Reported Symptoms of Women Seeking Psychotherapy: Feminists, and Other Females" (1979). *Master's Theses*. 3246.

https://ecommons.luc.edu/luc_theses/3246

This Thesis is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Master's Theses by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License](#).
Copyright © 1979 Kay Bienemann

PERSONALITY CHARACTERISTICS AND REPORTED SYMPTOMS OF
WOMEN SEEKING PSYCHOTHERAPY, FEMINISTS, AND OTHER FEMALES

by

Kay Bienemann

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of

Master of Arts

November

1979

ACKNOWLEDGMENTS

I wish to thank Dr. Al DeWolfe and Dr. Cliff Kaspar for their continued encouragement and support. I'd also like to thank the agencies that offered their facilities and the subjects that gave generously of their time and effort.

VITA

The author, Kay Bienemann, is the daughter of Alfred Rorem and Marie (Broadus) Rorem. She was born February 29, 1944, in Ottawa, Illinois.

Her elementary education was obtained in the public schools of Ottawa, Illinois, and she graduated from Ottawa Township High School in June, 1962.

In September, 1973, she received the degree of Bachelor of Arts from Governors State University, Park Forest South, Illinois, with a major in behavioral sciences.

In September, 1974, she was granted an internship at the Loyola Guidance Center at Loyola University of Chicago. In July, 1979, she became Director of Psychological Services, Department of Physical Medicine and Rehabilitation at Mercy Hospital in Chicago, Illinois.

TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS.....	ii
VITA.....	iii
LIST OF TABLES.....	v
CONTENTS OF APPENDIX.....	vi
INTRODUCTION.....	1
REVIEW OF RELATED LITERATURE.....	3
Women, Therapy, and Attitudes Toward Feminine Characteristics.....	3
Studies of Feminist Women.....	7
The Bem Sex Role Inventory and Other Studies of Masculinity/Femininity.....	8
Self/Ideal-Self and Self/Other Congruence.....	16
The Hopkins Symptom Checklist.....	23
Hypotheses.....	28
METHOD.....	29
Subjects.....	29
Materials.....	33
Procedure.....	35
RESULTS.....	37
DISCUSSION.....	44
REFERENCE NOTE.....	55
REFERENCES.....	56
APPENDIX A.....	64

LIST OF TABLES

Table	Page
1. Subjects.....	31
2. Analysis of Variance for Total Symptom Scores, Hopkins Symptom Checklist.....	38
3. Chi-square Contingency Table, Self/Ideal-Self Congruence.....	39
4. Chi-square Contingency Table, Bem Sex Role Inventory Categories.....	41
5. Chi-square Contingency Table, Self/Ideal Man Congruence.....	42

CONTENTS OF APPENDIX

	Page
APPENDIX A Measures.....	64
I. The Bem Sex Role Inventory.....	65
II. The Hopkins Symptom Checklist.....	66
III. The Semantic Differential.....	68

INTRODUCTION

At the 1973 annual meeting of the American Psychological Association Division 35, the Psychology of Women division, was created. The need to encourage research about women has been stated by many psychologists. Rae Carlson (1972) of the extramural research program of the National Institute of Mental Health, called for a serious consideration of the psychology of women to correct the impoverishment and imbalance in current personality conceptions. Weisstein (1972) stated that "Psychology has nothing to say about what women are really like, what they need and what they want, essentially because psychology does not know."

Garai (1970) stated the need for differential criteria for the evaluation of mental health for men and women with separate norms for each sex.

Rice and Rice (1973) recommended training therapists as experts on the research of sex differences and the psychology of women as core parts of therapy training programs. Sherman (1976) stated that the welfare of women would be better served if the psychological identity of women was based on research rather than ideology, and added that many basic questions regarding women remain unanswered in the scientific literature.

Hill (1976) declared that in research about women, women as a homogeneous group have been focused on too much and recommended that

client variables be specified more clearly in order to examine differences between women. It is the purpose of the present study to attempt to expand the basic research on the psychology of women by comparing on several variables three groups of women: women seeking psychotherapy for themselves or their families at community mental health centers; women who define themselves as feminists and have been actively involved in the woman's movement; and women who are neither feminists nor seeking therapy.

REVIEW OF RELATED LITERATURE

Women, Therapy, and Attitudes Toward Feminine Characteristics

Gove and Tudor (1973) surveyed the literature on mental illness and sex of patient, defining "mental illness" as a functional disorder involving severe distress and/or mental disorganization not caused by organic or toxic conditions -- chiefly neuroses or functional psychoses. They used 1967 National Institute of Mental Health figures for the United States, looking at first admissions to mental hospitals, psychiatric wards of general hospitals, and outpatient psychiatric clinics. They also used community surveys and studies of private outpatient facilities.

Examining statistics for persons age 18 and over for 1967, they estimated 834 women per 100,000 were admitted for the first time to mental hospitals compared to 671 men per 100,000 (NIMH, 1967a; NIMH, 1967b; NIMH, 1967c). They estimated that 1793 women per 100,000 were treated in outpatient clinics in 1967, while only 1242 men per 100,000 were treated in such clinics (NIMH, 1967e). From NIMH (1967d) figures they estimated 3413 women per 100,000 received psychiatric care in general hospitals, compared to 2029 men. Seventeen community surveys were examined and in each case, more women than men were found to be mentally ill according to the above definition. Five studies were found relating the proportion of women to men seeking private outpatient psychiatric care. Women outnumbered men seeking care in all

studies. Gove and Tudor concluded that under all conditions of selection, more women than men seek treatment for mental illness. They emphasized the need for research exploring the role of women related to mental illness to discover the important factors underlying these statistics.

The Joint Commission on Mental Health, as reported by Gurin, Veroff, and Feld (1960), found greater distress and symptoms reported by women than by men in all adjustment areas, with the sex differences most frequent at younger age intervals. They reported that unmarried persons appear to have greater potential for psychological distress than married persons.

Other studies have resulted in similar statistics, with women patients sometimes outnumbering men patients at a rate of 3 to 2 (Bahr, Conwell, and Hurley, 1965). The fact that more women seem to admit to problems and seek treatment is not necessarily an indication that women are more pathological than men, but may mean instead that women are more likely to admit to stress and seek treatment than men. This may indicate that women are likely to be less defensive and/or have more insight than men.

Carlson and Carlson (1960) examined 298 studies in 14 consecutive issues of the Journal of Abnormal and Social Psychology [Volume 56(1) through Volume 60(2)] and found that sex differences had been widely ignored in studies of personality, with males generally preferred as subjects (38%). Five per cent of studies used females exclusively. Twenty-two per cent did not report sex of subject. Carlson and Carlson

suggested that tests of significance for sex differences be a standard procedure in research in the social sciences.

Garai and Scheinfeld (1968) studied 12 consecutive issues of the Journal of Personality and Social Psychology in 1966, six years after the Carlson and Carlson (1960) study. They examined 242 studies and found that 35% used only males, 12% used only females. Fifteen per cent failed completely to report sexual composition of subjects. Eight studies investigated sex differences. It was suggested that current theories of individual and group differences in psychological traits be subject to a thorough re-evaluation, and recommended that future investigators test for sex differences.

Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) found that both women and men clinicians stated that the traits of a psychologically healthy man and a psychologically healthy adult did not differ significantly from each other, but that traits of a psychologically healthy woman did differ significantly from the other two, with the woman being described as more submissive, less independent, less adventurous, more easily influenced, less objective, less aggressive, and more emotional. Broverman et al. suggested that "adjustment" may mean good adjustment to the environment, therefore making understandable in a societal framework the contrasting judgment of a psychologically healthy woman as compared to that of a psychologically healthy man or adult.

They concluded that this may be a dilemma for women clients and advised clinicians to critically examine their ideas of adjustment for

women, and ways they believe women should achieve this adjustment.

Fabrikant (1974) used an adjective checklist describing role characteristics that had been judged either "masculine" or "feminine" and found that male psychotherapists rated 70% of the "feminine" words negatively and 71% of the "masculine" words positively. Female psychotherapists rated 68% of the "feminine" words negatively and 67% of the "masculine" words positively.

Kahn (1977) sampled female clinicians referred by feminist organizations, other female clinicians, and male clinicians. Included was a section as in Broverman et al. (1970) and the sample was found more likely, on a written questionnaire, to expect the same characteristics in a psychologically healthy woman as previously expected in a psychologically healthy man and adult. However, in using vignettes, women who lacked traditionally feminine traits were judged to be more pathological than women who appeared to be more traditionally feminine. Male clinicians showed the most evidence of this double standard, and feminist-referred therapists appeared least stereotyped and most consistently egalitarian in their judgment of women and men clients.

The high incidence of women seeking psychotherapy, and low incidence of research studies investigating sex differences, and the apparent double standard of some clinicians toward female clients indicate a need for further exploration in the area of personality characteristics of women. Women seeking psychotherapy should be included so that they might be compared to other groups of women.

Studies of Feminist Women

Feminist women appear to differ from other women in some characteristics. Steinmann (1974) used an instrument designed to study values related to women's activities and satisfaction (MAFERR Inventory of Feminine Values), scored on a continuum from "strongest possible family oriented" (-68) to "strongest possible self-achieving position" (+68). A sample of 54 members of feminist organizations scored themselves as extremely self-achieving and as rejecting stereotyped feminine behaviors, especially those related to marriage and family. A national composite group of 762 women had a mean score of +3.05 and a mean ideal score of -26. The feminist group, however, had a mean score of +28.9 with a mean ideal score of +32.2.

Hjelle and Butterfield (1974) used 2 groups of college-age females differing on the Helmreich Attitude Toward Women Scale, designed to measure feminism. They chose 20 feminist-oriented and 20 nonfeminist women from a group of 98 tested. The chosen women took the Shostrom Personality Orientation Inventory, designed to assess values and self-percepts associated with self-actualization. The feminist women had significantly higher scores than the nonfeminist women on 10 of 12 POI subscales, 6 significant at p less than .01, 4 significant at p less than .05. The conclusion was that women with profeminist attitudes have a higher level of personal growth as measured on the POI, including more positive self-acceptance.

Goldberg (1974) tested 19 female members of the National Organization of Women, a feminist organization, and 12 female controls

on a masculinity/femininity scale and on conformity. It was found that the control group conformed significantly more than the NOW group (p less than .05) with no significant difference in masculinity/femininity.

Kravetz (1978) stated that the woman's movement focuses on problems due to sex role stereotyping, sex bias and discrimination, and attempts to change attitudes and behaviors of women. Brodsky (1973) stated her belief that consciousness-raising groups, assertiveness training, and independence from others is necessary for women clients to counteract many years of discouragement in their competence. Holroyd (1976) suggested women's groups as a way to counteract deficiencies in socialization skills and sexism in therapy. Since participation in a feminist organization is participation in a woman's group, active feminists will be one group examined in this study to determine whether they differ significantly from the other groups.

The Bem Sex Role Inventory and Other Studies of Masculinity/Femininity

Women, too, seem to reflect therapists and/or society's negative attitudes toward women and "feminine" characteristics. Rosenkrantz, Vogel, Bee, Broverman, and Broverman (1968) explored sex-role stereotypes and self-concepts and found that women held their worth negative in value to that of men even in the highly selected group of young college women they investigated. Murray (1976) developed a measure of stereotyped behavior (The Measurement of Attitudes Toward Stereotypic Behavior) on which 281 diverse women rated "masculine" behaviors as more healthy than "feminine" behaviors.

In this review, the terms "androgyny," "androgynous," "masculine,"

"high-masculine," "feminine," "high-feminine," and "undifferentiated" reflect these words as used in the literature and are not necessarily a judgment as to whether there actually are sex-role differences between men and women or whether the instruments discussed accurately measure such differences, if they do exist.

According to Block (1973) an androgynous sex role definition with an integration of masculine and feminine traits and values is the highest possible development of sex role identity. Block found those with an androgynous self-image to also have greater maturity and moral judgment using Kohlberg's Moral Judgment Test. Heilbrun (1973) defined androgyny as a condition under which sex roles are not rigidly defined, and suggested that androgyny allows a full range of behavior to both women and men.

Hefner, Rebecca, and Oleshansky (1975) described their opinion that the highest level of sex-role development as one of "Sex Role Transcendence," at which one can move freely from one situation to another and behave adaptively in each. They equated this stage to androgyny. According to Kagan (1964) and Kohlberg (1966), the individual typed strongly according to one sex is motivated to keep his/her behavior consistent with the internalized sex-role as he/she understands it. This is presumably done by suppressing behaviors felt to be inappropriate to the sex-role. This might inhibit an individual's range of behavior, whereas a mixed or androgynous self-concept might allow one to engage in an enlarged repertoire of behaviors.

Spence, Helmreich, and Stapp (1975) found that subjects classified

as androgynous were highest in self-esteem, followed by subjects high in masculinity and low in femininity. Those lowest in both masculinity and femininity were lowest in self-esteem.

Gump (1972) stated that her data suggested that more traditionally "feminine" women have less ego-strength than others, and that more resourceful women have a less traditional sex-role orientation. As stated before, Goldberg (1974) found no significant difference in masculinity/femininity between controls and feminists.

Sandra Bem (1974) suggested that masculinity has been primarily associated with instrumentality, or getting things done, while femininity has been associated with expressivity, or effective concern for others. She hypothesized that psychological androgyny implies the possibility of a person being assertive and compassionate, instrumental and expressive, depending on the needs of a particular situation (Bem, 1977). Bem has developed a sex-role inventory that treats masculinity and femininity as two dimensions independent of each other. A person may score high on one or the other, or on both dimensions (androgynous).

The Bem Sex Role Inventory (BSRI) contains a masculinity scale and a femininity scale, each containing 20 personality characteristics based on a conception of typically socially desirable sex-typed standards. The BSRI originally characterized an individual as masculine, feminine, or androgynous according to the difference between his/her masculine and feminine personality characteristics with a high difference implying androgyny. More recently added was the concept of a low-low, or undifferentiated type (Bem, Martyna, & Watson, 1976).

Bem stated that use of the BSRI would help question the idea that sex-typed individuals are socially desirable models of mental health, and aid in looking at more flexible sex-role self concepts (Bem, 1974).

Preliminary characteristics for the BSRI were judged by two separate samples of female and male judges to be more masculine or feminine (p less than .05 on a 2-tailed t test). Judges choosing final items were 100 Stanford undergraduates, half male and half female. Twenty items were selected for the masculinity scale and 20 for the femininity scale. Twenty neutral characteristics were judged independently by males and females to be no more desirable for one sex than the other. Ten were judged neutral positive characteristics, and ten neutral negative. These are included on the BSRI as a neutral desirability scale used during development of the instrument to insure that it was not tapping a tendency to endorse generally desirable traits (Bem, 1974).

Normative data for the BSRI was obtained from administration to 444 males and 279 females at Stanford University and 117 males and 77 females at Foothill Junior College. Internal consistency was estimated by computing coefficient alpha separately for masculinity, femininity, and social desirability scores. All three scores were highly reliable. Alpha in the Stanford sample was .86 for masculinity, .80 for femininity, and .75 for social desirability. In the Foothill Junior College sample it was .86 for masculinity, .82 for femininity, and .70 for social desirability. Coefficient alpha was computed for the femininity minus masculinity (androgyny difference score), with a reliability of .85 for

the Stanford sample and .85 for the Foothill sample (Bem, 1974).

Masculinity and femininity scores were found to vary independently, with scores for Stanford males having a correlation of .11, Stanford females of $-.14$, Foothill males of $-.02$, and Foothill females of $-.07$ (Bem, 1974).

Test-retest data was obtained by retesting 28 males and 28 females from the Stanford sample approximately 4 weeks after the first administration. Subjects were explicitly instructed not to try to remember how they had previously responded. The product-moment correlation between the first and second administration for masculinity was .90, for femininity .90, for androgyny .93, and for social desirability .89 (Bem, 1974).

Olds (1977) used the BSRI to find groups of androgynous males, androgynous females, masculine-identified males and feminine-identified females. Two-hour tape-recorded interviews conducted by the investigation and content-analyzed ratings by two friends supported the construct validity of the BSRI.

Gaudreau (1977) stated that the BSRI was developed so recently that there is very little reliability or validity data on it. A factor-analytic approach was used to analyze individual items on the BSRI and to establish construct validity for BSRI scores. The analysis found the test to successfully differentiate between "feminine" women and "masculine" men. The conclusion was that the conceptualization of masculine and feminine as two separate dimensions rather than as ends of a polar dimension is correct.

Many researchers have used the BSRI since it was developed to measure masculinity/femininity/androgyny. In some unique experiments measuring nurturing behaviors toward a kitten, a baby, or a student. Bem (1975) found "high masculine" males low in nurturance directed toward a kitten, and "high feminine" males low in independence. She found "high feminine" and "high masculine" females constricted, but not significantly less nurturing to a kitten than androgynous females. "High feminine" women were most constricted -- low in independence and low in nurturing a kitten.

Bem and Lenney (1976) found that highly sex-typed individuals as measured on the BSRI avoided stereotyped cross-sex tasks such as preparing a baby bottle or oiling a hinge and reported experiencing some discomfort and temporary loss of self-esteem if required to perform such tasks. They found that more androgynous individuals performed cross-sex behavior with little reluctance or discomfort.

Bem et al. (1976) analyzed data on subjects nurturing a baby. They also reanalyzed previous data. Findings were that masculine subjects nurtured a baby significantly less than feminine or androgynous subjects, and that feminine and androgynous subjects did not differ in nurturing behavior. In nurturing a lonely fellow student, masculine subjects were also less nurturing than feminine or androgynous subjects, and feminine and androgynous subjects did not differ significantly.

Bem et al. (1976) summarized the data on the BSRI and noted that for men, only androgynous males were high in instrumental and

expressive behaviors -- they could be firm in an opinion and cuddle a kitten. High feminine males were low in independence while high masculine males were lower in nurturance but more independent. The data for women showed the same pattern emerging: androgynous women were high in independence and nurturance; high feminine women were low in independence; and high masculine women were low in nurturance. They concluded that androgynous individuals are less constricted and that sex typing restricts functioning.

Bem et al. (1976) reanalyzed BSRI data using a new category, low-low or undifferentiated. Undifferentiated individuals were found to have significantly lower self-esteem than high-high scorers and to be significantly less nurturing to a kitten. By excluding low-low scorers from previous data, original findings were strengthened for both sexes.

Pettus (1977) used 120 psychology students as subjects to examine the relationship between sex role category on the BSRI and psychological health, sex stereotyping, and I.Q. Self-reports of self-actualization, trait anxiety, and adjustment were used. It was found that women high on the androgyny scale had significantly greater self-actualization and lower trait anxiety than more highly sex-typed individuals. No I.Q. or sex stereotyping differences were found. The conclusion was that, for women, androgyny has positive consequences for functioning.

Schiff (1978) used the BSRI, a self-esteem scale (Self II), and other measures on 100 undergraduate women. The results showed higher self-esteem in androgynous women than in "high feminine" or undifferentiated women. There were no significant differences between androgynous and "high masculine" women.

Murray (1976) examined 281 women's self perception and ideal-self perceptions in relation to sex role using the BSRI. Most women showed a wish for increased masculine and feminine traits from real to ideal self -- a wish to be more androgynous. Greater interest was expressed in masculine traits, with fewer women wanting, ideally, to be more highly feminine. Women high in androgyny on the BSRI had the highest "psychological health" ratings. Women exposed to the feminist movement were found to ascribe more highly to masculine qualities on the self/ideal BSRI as compared to uninvolved women. Age and marital status were not relevant. More highly educated women, professional women, and women students ascribed to more masculine qualities than unemployed women or housewives, two groups combined by Murray, who ascribed to more traditionally feminine values.

Volgy (1977) looked at the relationship between being in a feminist organization, type of employment, sex-role identification as measured on the BSRI, and psychological well-being. Feminists differed significantly from housewives and employed women on the BSRI. Feminists were least traditional, most assertive, and most masculine sex-typed. Professional women were most psychologically healthy on tests used.

Jordan-Viola, Fassberg, and Viola (1976) examined the relationship of participation in the feminist movement to androgyny as measured on the BSRI and manifest anxiety as measured on the Taylor Manifest Anxiety Scale. They tested 100 members of feminist organizations, 100 undergraduate women, 200 working women, and 80 unemployed housewives.

Feminists differed significantly from others on the BSRI (significant beyond the .001 level), scoring on the masculine side of zero while the other groups scored on the feminine side. University women were highest on manifest anxiety, and working women were more anxious than housewives. Positive correlations between anxiety and androgyny were attained for university women and working women. Negative correlations were found between anxiety and masculinity for feminists and university women.

Self/Ideal-Self and Self/Other Congruence

Rosenberg (1962) stated that the sciences of psychology, psychiatry and sociology have all become interested in the self-image with some theoreticians considering low self-esteem to be a basic element in neurosis. He suggested that if a "good self" is postulated as a universal value, then a negative self-image would be expected to be associated with signs of emotional disturbance.

Karen Horney (1945) proposed that a well-adjusted person accepts the real self, while visualizing an ideal to move toward. She suggested that this idealized image fills vital needs and stated a theory of a reciprocal relationship of the self/ideal concept in which lack of self-acceptance causes an unrealistic image of the idealized self. Attempts to reach this idealized image result in failure and rejection of the real self which causes the ideal to be even more elevated, with self and ideal becoming more disparate and causing more discomfort.

Congruence between self-concept and ideal self-concept has been viewed as important by Rogers (1951). He suggested that the discrepancy

between the two is a threat and a source of anxiety, and postulated that successful psychotherapy would increase the congruence between self and ideal.

Butler and Haigh (1954) discussed the self-concept as a conceptual pattern of the characteristics of the self that are admitted to awareness, determining the repression or recognition of experiences and affecting behavior. They stated the belief that a discrepancy between self-concept and ideal self-concept reflects a sense of self-dissatisfaction and a relatively low adjustment level and hypothesized that a self/ideal discrepancy is reduced as a result of therapy.

Carl Rogers and his group at the University of Chicago used a Q-sort (Stephenson, 1953) to look at self/ideal discrepancy in therapeutic movement. Butler and Haigh (1954), working with Rogers, stated that a scale measuring self/ideal discrepancy allows assessment of the value an individual puts on self-concepts by looking at the difference between the self scale and the ideal-self scale, yielding an index of self-value or self-esteem.

Taylor (1955) used a Q-sort self/ideal scale to have 120 college students classify themselves on statements rated as positive or negative by eight judges. Test-retest reliability after one week yielded a mean product-moment correlation of .79. The reliability coefficient for positive items was .95. Frank (1956) tested and retested 10 subjects drawn at random from a general psychology class on a self/ideal Q-sort and found test-retest reliability coefficients between .93 and .97. Dymond (1954) found the scores of the self/ideal Q-sort in a

control group to have a test-retest reliability of .86 at 6 month to one year intervals. Shlien (1964) measured self/ideal correlation and found that two control groups did not change with the passage of time.

Butler and Haigh (1954) used a self/ideal-self Q-sort with a group of clients seeking outpatient therapy and with an equivalent control group roughly matched on age, sex, socioeconomic status, and student-nonstudent status. Self/ideal correlation of the pretested therapy group was $-.01$ and that of the control group was $.58$. They concluded that there are distinct subclasses of populations on self/ideal congruence. Shlien, Mosak, and Dreikurs (1962) found self/ideal correlation for a group applying for therapy lower than that of a group not applying for therapy, at the $.001$ level of significance.

Chase (1957) looked at self/ideal congruence in veterans' hospital patients separate from the therapeutic situation. He found a group of psychotic, neurotic, and character-disordered patients lower in self/ideal congruence than a group of general medical patients. Dymond (1953), reporting on the development of the self/ideal Q-sort, found a group of patients beginning therapy were less congruent than a group not wishing therapy and never having been in therapy. Nahinsky (1966) compared four groups on self/ideal congruence on the Q-sort: controls divided into social groups, neurotic outpatients, psychotic outpatients, and psychotic inpatients. In each diagnostic group there was less self/ideal congruence than for controls.

Truax, Schuldt, and Wargo (1968) investigated the relationship between measures of anxiety and adjustment on the MMPI and the Anxiety

Reaction Scale and self/ideal congruence on the Q-sort. They found a negative relationship between high self/ideal congruence and high maladjustment on the other scales, most pronounced in outpatient neurotics and least pronounced in juvenile delinquents. They attempted to partial out social desirability on the Q-sort and still found substantial support for their results.

Block and Thomas (1955) gave MMPIs and self/ideal Q-sorts to college men and women and concluded that they supported Rogers (1951) contention that a large self/ideal discrepancy goes along with maladjustment on the MMPI.

There may be a difference between male and female self/ideal discrepancies. Guertin and Jourard (1962) found very different factors in looking at male and female self/ideal congruence and concluded that mixing of sexes in samples when looking at these discrepancies is indefensible. However, Turner and Vanderlippe (1958), Block and Thomas (1955), and Nahinsky (1966) reported no differences between male and female subpopulations of their samples.

Self/ideal congruence may be related to defensive style. High self/ideal congruence may not always be positive. Block and Thomas (1955) reported finding that individuals with very high self/ideal correlations tend to deny and suppress threatening feelings and cannot be considered healthy. Altrocchi, Parsons, and Dickoff (1960) found that "repressors," as judged by selected scales of the MMPI, had much smaller self/ideal discrepancies than "sensitizers." Friedman (1955), testing males, found that self/ideal correlation was significantly

higher in a normal group than in a neurotic group. A group of paranoid schizophrenics also had a significantly higher self/ideal correlation than the neurotic group, with no significant difference between the paranoid schizophrenic group and the normal group. Rogers (1958) found paranoid schizophrenics to have significantly higher self/ideal correlations than normals.

Bergin (1971) stated that the various self-concept measures such as those that measure self/ideal congruence probably have high inter-correlations, and personal preference may dictate the selection of a particular scale. He stated that the various scales are all basically ways of reporting subjective distress.

The Semantic Differential (SD) will be used in the present study to investigate self/ideal congruence, since it is much faster than the Q-sort both for subjects and scorers. The SD is a technique for measuring the meaning of concepts by rating them on a set of bipolar adjective scales. The distance between points on the scales is held to be roughly proportional to psychological affinity. Concepts from a particular domain will form a configuration of meaningful clusters (Hofman, 1967). A concept score can be calculated for any person by summing the ratings over the scales representing each factor (Maguire, 1973). The SD has been widely adopted by psychologists in a large number of research settings (Crockett & Nidorf, 1967).

Osgood and Suci (1952) developed the "difference" method to apply to semantic measurements in looking at semantic relationships. Osgood (1952) stated that semantic differential meanings vary in an unknown

number of dimensions. The method had its origin in research on synesthesia, a phenomenon characterizing experiences in one sense attached to experiences in another sense.

Osgood (1952) evaluated the SD and reported a reliability coefficient of .85 for repeated items. Heise (1969) questioned ratings of SD scales and concluded that the basic metric assumptions are not quite accurate but stated that violations are not serious enough to interfere with use of the instrument. Some metric errors will counteract others, when added together.

Oetting (1967) stated the belief that the relationship between response on the SD and personality characteristics, if it exists, is probably very complex.

The SD has been used by many researchers to look at self/ideal congruence.

Pervin and Lilly (1967) tested self/ideal discrepancy by having each subject rate him/herself and his/her ideal-self on a 4-point SD scale, including five evaluative factors, four activity factors, and four potency factors. Discrepancies between self and ideal-self were examined. Mueller (1966) used the SD for self and ideal-self and found that low anxious nonpatient male subjects saw themselves as significantly more active (p less than .01) and regarded themselves more highly (p less than .01) than high-anxious subjects.

Theorists have hypothesized that neurotics have faulty identification with their parents. Mowrer (1953) theorized that neurotics often identify with opposite-sex parents. Osgood (1952) and Lazowick

(1955) stated that the degree of similarity of meaning between self and model, such as mother or father, is a measure of identification and that the SD can be used to compare these concepts. Mother, father, man and ideal man will be used on an SD scale in the present study to compare the extent of identification of self with each concept.

Luria (1959) used three therapy groups and three control groups to compare "self" to several concepts on the SD. Concepts with high variance included "my mother" and "my father" and it was concluded that control groups can be distinguished from groups seeking therapy by SD meanings of self and parents. Therapy subjects value parental concepts less than controls. Normals tend to value both parents equally. Luria concluded that this process may be important for successful identification.

Mueller (1966) found that low-anxious females saw their fathers as more different from themselves than high-anxious females did. Beitner (1961) tested all male subjects using SD concepts including "me," "mother," and "father." Hospitalized paranoid schizophrenics, outpatient anxiety neurotics, tuberculosis patients, and Los Angeles businessmen were subjects. It was found that paranoid schizophrenics had poor identification with both parents as measured by distance on the SD from "me." Anxiety neurotics also had poor identification with parents, and appeared to identify with the opposite-sex parent -- mother, in this case.

Shell, O'Mally, and Johnsgard (1964) summarized the results of comparing the SD concepts of "myself," "my mother" and "my father."

Normal males have consistently inferred greater similarity to both parents than neurotic males have. Normal males have typically inferred greater similarity to "father" than to "mother." Normal females have often inferred greater similarity to parents than neurotic females have. Normal females have seldom inferred greater similarity to "mother" than "father." Shell et al. concluded that research has not found neurotic females to differ in a consistent way from normal females in extent of identification with parents. They stated that both neurotic and normal females have low identification scores. They also found large D-score differences between "self" and other positive concepts in both groups of females and concluded that "distance from positive" might be the measurement obtained rather than extent of parental identification.

The Hopkins Symptom Checklist

Derogatis, Lipman, Rickels, Uhlenhuth, and Covi (1974) stated the advantages of self-report measures including: reflection of the experience of the person reporting; economy of professional time; very easy scoring; and sensitivity to many treatment modalities. The disadvantages they reported for using self-report symptom and behavior measures include the possibility of distorting of symptoms and behaviors. Distortion due to social desirability has been mentioned by Edwards (1957) along with other possible response sets. Defenses may distort a self-report, acutely disturbed people may not report accurately, and the desire to please the investigator may bias self-report. Cattell (1972) stated that self-report measures have systematic errors

based on the subject's lack of self-knowledge, careless or dishonest responses, and lack of a true measurement continuum. He concluded that self-report data does have interest as a preliminary guide to further research and in clinical practice.

The Hopkins Symptom Checklist (HSCL) is a self-report measure used in the present study. It is a symptom checklist developed in an earlier form by Parloff, Kelman, and Frank (1954), at that time called the Discomfort Scale. The HSCL was developed by taking a set of symptoms from the Cornell Medical Index, supplemented by 12 items taken from a scale developed by Lorr (1952). Various forms of the HSCL have been used by numerous researchers, primarily with psychiatric outpatients having affective disorders such as anxiety states and depressive neuroses. Several minor variations of the scale have been developed. The basic scale consists of 58 items (Derogatis et al., 1974). The HSCL has been used in a 25-year study of psychotherapy at Johns Hopkins University School of Medicine -- The Psychotherapy Research Project (Frank, Hoehn-Saric, Imber, Liberman, & Stone, 1978).

Derogatis et al. (1974) investigated the reliability and validity of the HSCL on a sample of 1,435 outpatient anxious neurotics, 367 outpatient depressed neurotics, and 735 control subjects living in Oakland, California. The Oakland sample consistently had much lower symptom scores than the other samples. Test-retest reliability on 425 anxious neurotic outpatients had a stability of .75 to .84 on test administrations separated by one week. Interrater reliability was examined on 15 consecutive outpatients rated by pairs of highly trained

clinicians during a structured interview. Consistency was measured by calculating intraclass correlation coefficients for HSCL symptom dimensions. Correlations ranged from .64 for depression to .80 for interpersonal sensitivity. Internal consistency on 1,435 subjects had a coefficient alpha range from .84 to .87. Item-total correlations were all over .50, with most about .70, indicating substantial shared common variance among items.

Derogatis, Lipman, Covi, Rickels, and Uhlenhuth (1970) investigated construct validity of the HSCL, using factor analysis in an attempt to delineate the fundamental dimensions underlying various clinical entities. Twenty clinicians were asked to classify 64 HSCL items into four a priori symptom clusters: anxiety, depression, anger-hostility, and obsessive-compulsive-phobia. This was done twice with a two-week interval between ratings. Items assigned to a particular cluster by 70% of raters at both rating sessions were retained (31 items). Thirty-four psychiatrists rated 837 anxious neurotic outpatients applying for treatment. Ratings were based on information volunteered by the patient during a 30-minute interview. Females outnumbered males in the group 2:1 with a mean age of 34.2. The results were that the four transformed items isolated in factor analysis were highly congruent with four factors evolving from clinical experts. Derogatis et al. speculated that these factors may represent core dimensions of psychopathology. Results indicated validity for symptom constructs.

Lipman, Rickels, Covi, Derogatis, and Uhlenhuth (1969) factor

analyzed psychiatrists ratings of 837 patients (68.7% female) and found five stable and clinically meaningful factors underlying the HSCL ratings: somatization, obsessive-compulsive, interpersonal sensitivity, depression, and anxiety. Derogatis et al. (1974) found high internal consistency, test-retest reliability, and interrater reliability for all five factors.

Derogatis, Lipman, Covi, and Rickels (1971) used the HSCL with 837 anxious neurotic outpatients, obtaining self-ratings and independent psychiatrist's ratings. Two hundred twenty-nine patients were assigned to one of three social class groups in terms of the Hollingshead Two-Factor Index of Social Position. Substantial factorial invariance was found between classes and a high level of concurrence was obtained between psychiatrist and patient ratings. Little difference in factor structure was found whether analyzing female-only data or pooled male-female data in various social classes.

Prusoff and Klerman (1974) used the 58-item HSCL to rate and compare 364 depressed outpatient white women to 364 anxious neurotic outpatient women matched on race, sex, age, and social class using univariate and multivariate analysis. Results showed significant differences between the groups on levels and patterns of HSCL dimensions. The depressed group showed higher distress in general while the anxious group showed higher somatization and anxiety.

Rickels, Garcia, and Fisher (1971) used the 64-item HSCL with 144 women seeing a private gynecologist and with 135 anxious neurotic women seeking outpatient psychotherapy. Mean age of the gynecological

patients was 29.5, and of the neurotics, 39.7. Seventy-one per cent of the gynecological patients had 12 or more years of education, while 29% of the neurotic women had at least that much education. Other socioeconomic data did not differ significantly. There were notable differences on the HSCL between the gynecological group and the neurotic group, with F ratios significant beyond the .001 level. The conclusion was that the self-rated HSCL differentiates at high levels of significance between neurotics and non-neurotics. Thirty-nine of the gynecological patients took the HSCL again six months later, with little difference in scores. The test-retest correlation was .72.

Parloff et al. (1954) used the HSCL and a self/ideal Q-sort and found that high symptoms and low self/ideal congruence correlated at the beginning of treatment. They also found the staff's evaluation of a patient's discomfort and the patient's own report to be positively correlated ($r=.88$).

Kravetz (1978) compared 1,669 women in consciousness-raising (CR) groups to a clinic population. Eighty-five per cent of the women in CR groups said they were members of the feminist movement. The Life-Events Stress Scale and a 35-item version of the HSCL were used. Women from consciousness-raising groups and women from "growth centers" had significantly lower symptom scores than the clinic population, but higher symptom scores than a normative sample.

Lieberman and Bond (1976) used a 35-item HSCL to compare women entering therapy, women in consciousness-raising (CR) groups, women entering sensitivity groups, and a group of control women. Women

entering therapy had highest symptom ratings than all other groups. The other groups did not differ significantly from each other.

Hypotheses

In light of the previous research findings, several hypotheses have been advanced regarding the differences among the three groups of women -- women seeking therapy, feminists, and other women -- in the present study.

- 1) The feminist group will be more masculine sex-typed than other groups on the BSRI.
- 2) Clinic women will have lower self/ideal congruence on the SD than other groups.
- 3) Clinic women will have greater symptom distress than other groups as measured on the HSCL.
- 4) Low self/ideal congruence on the SD will correlate with high symptom distress on the HSCL.

METHOD

Subjects

Ten subjects were women seeking therapy at community mental health centers. Seven subjects were from the Loyola Guidance Center, an outpatient mental health center and training agency serving the Rogers Park area on the north side of Chicago. The mean age of women requesting service is 34 years (Walter, Note 1). The Rogers Park census of 1970 showed the population to be 90 per cent white with the median income of families to be \$11,439 (Chicago Association of Commerce and Industry, Research and Statistics Division and Oslo Financial Service Corporation, 1970). All women were asked at intake by the intake worker whether they would like to participate in research on women. Women who expressed interest were called and appointments made to fill out the questionnaire. Three subjects were from two different offices of the Will County Counseling Service, serving south suburban Cook County. Women were asked if they were interested in participating in research on women, and if interested were given the questionnaire by the intake workers. Intake workers were women. Ten women seeking therapy agreed to participate out of approximately twenty who were asked.

Results showed that the mean age of women entering therapy was 29.5 years. Sixty per cent were married and 22 per cent had been divorced or separated at some time. Thirty per cent reported having

been formerly involved in successful therapy. Forty per cent reported major stress in the past year (Table 1).

Another group of subjects was made up of 17 women who stated that they were feminists and that they had attended at least one meeting of a feminist organization. The researcher attended a meeting of the South Suburban National Organization of Women and asked for volunteers to participate in a research study on women. A notice was posted in the Women's Resource Center at Governors State University, and feminists volunteered through the Center. Another notice was posted on the Woman's Center board at Loyola University of Chicago, and feminists volunteered through that Center.

Results showed that the mean age of the feminist group was 34.41. Thirty-five per cent of the feminists were married, with 40 per cent reporting having been divorced or separated at some time. Twelve per cent reported parents divorced before the feminists were 20. Twelve per cent of feminists were black. Twenty-five per cent reported having been involved in successful therapy in the past, and 71 per cent reported major stress in the last year (Table 1). Seventeen feminists agreed to participate in the research out of approximately 30 asked if they wished to participate.

Control subjects were 15 undergraduate women students at Governors State University, a commuter university in Park Forest South, Illinois. The University is located in a suburb of Chicago, and has students that are at the junior and senior levels and Masters Degree Candidates. Seventy-nine per cent of students are from Cook County, an

TABLE 1

SUBJECTS

	<u>Controls</u>	<u>Feminists</u>	<u>Women Seeking Therapy</u>
Number	15	17	10
Age (mean)	34.8	34.41	29.5
Presently Married	47%	35%	60%
Divorced or Separated At Some Time	43%	40%	22%
Parents Divorced Before Subject Age 20	0	12%	30%
Black	7%	12%	10%
Involved in Successful Therapy in the Past for a Period of at Least 6 Months	13%	25%	30%
Reported Major Stress in the Last Year	53%	71%	40%

No significant differences among groups using Chi-squares.

urban county in Illinois which contains Chicago and many of its suburbs. The remaining students are from other counties in Illinois, Indiana, and Minnesota, and .01 per cent are from 47 different countries outside the United States. Thirty-four per cent of undergraduate women are full-time students. The rest are part-time students. Fifty-five per cent of women students are white Americans, 35 per cent black Americans, and the rest are of other racial origin or unspecified. Mean age of undergraduate women is 35.1.¹ Control volunteers were obtained when the experimenter attended classes in the College of Human Learning and Development, one of four colleges in the University, and asked if women would like to volunteer to participate in research on women. No credit was given for participation. Classes with an experiential format were excluded, as it was felt that this would interfere as a treatment variable.

From the results, it was found that the mean age of the control group was 34.8. Forty-seven per cent of this group were married, and 43 per cent reported having been divorced or separated at one time. None reported parents who divorced before the subject was 20. Seven per cent were black. Thirteen per cent reported having been involved in successful therapy that lasted over six months, at some time, and 53 per cent reported having experienced major stress in the last year

¹Personal Communication
Peter Ewell
Director, Title III Grant
Institutional Research and Planning
Governors State University
Park Forest South, Illinois

(Table 1). Fifteen control women agreed to participate out of approximately 35 asked if they wished to participate.

Three subjects, two controls and one feminist, were excluded due to the fact that they did not follow instructions in filling out forms.

Materials

Four instruments were used, stapled together as one questionnaire. First was a two-page face sheet of biographical information, based in part on the face sheet used by Orlinsky and Howard (1975) in their study of psychotherapy with women. Questions asked included: age; race; whether ever divorced; whether presently married; whether parents were divorced before subject was 20; whether subject had experienced great stress in the past year; and whether subject had ever been involved in therapy, and if so, how successful it was.

The Bem Sex Role Inventory (BSRI) was used, with each subject rating herself on one page of 60 personality characteristics (Appendix A). Directions were to put a number in the box after each characteristic, describing herself. Numbers 1-7 were used, ranging from "never or almost never true" (1) through "always or almost true" (7). Ratings for two major subgroups of characteristics were summed, one called "masculine" and one called "feminine" by Bem (1974). A social desirability score, used by Bem in standardization of the test, can also be computed but was not used in this research as it seemed not to be relevant. Means were computed for masculine and feminine characteristics, and masculine mean was subtracted from feminine and multiplied by 2.322 as directed by Bem (1974) to obtain the androgyny t-ratio.

Using the androgyny t -ratio, subjects were classified into sex role categories. Women with scores greater than 1 were classified as high-feminine, those with scores less than -1 classified as high-masculine, and those from -1 through 1, androgynous (Bem, 1974). Data was examined to determine whether any subjects had both masculine and feminine scores more than one standard deviation below the means for Bem's Stanford sample (1974). These were to be considered undifferentiated, as in Bem's later categories (Bem et al., 1976). No subjects scored in the undifferentiated range.

A two-page 58-symptom Hopkins Symptom Checklist (HSCL) was used (Appendix A). Written instructions were for subjects to rate themselves as to how they had been feeling during the past several days including the present day. Subjects rated each item from 1 (not at all) to 4 (nearly always). Responses to items were summed to arrive at a total symptom score for each subject (Derogatis et al., 1974).

The Semantic Differential (SD) was introduced by a page of instructions including an example, asking subjects to give their judgments on certain things. A single page with a noun on the top and 17 bipolar adjectives below was used to rate each concept (Appendix A). Scales were varied in polarity to prevent subjects from forming rigid response sets (Maguire, 1973). Of the 17 pairs of bipolar adjectives used, ten pairs are evaluative: happy/sad, good/bad, unpredictable/predictable, sociable/unsociable, ineffective/effective, cruel/kind, foolish/wise, beautiful/ugly, pleasant/unpleasant, and worthless/valuable. Four pairs reflect potency: soft/hard, dangerous/safe,

masculine/feminine, and strong/weak. Three pairs reflect activity: tense/relaxed, slow/fast, and active/passive. A 7-point scale was used, as is customary in SD research based on early research on methodology (Heise, 1969) and on Mueller's (1966) argument that not many more than seven discriminations can be made at one time. "Swan," "dog," and "elephant" were used as introductory concepts, and were examined in all subjects for extreme response sets. None were found. Other concepts used were "the ideal man," "mother," "myself as I'd like to be" (ideal self), "men," "myself," and "father." The "difference" method was used in scoring, a method developed by Osgood and Suci (1952) to look at semantic relations. All other concepts were compared to "myself." Distance from a particular adjective rating on "self" and on "ideal man," for example, were observed and squared (Osgood D^2). These were summed for each concept, to look at the discrepancy in identification between "self" and "ideal man," and all other concepts (Beitner, 1961). Summed D^2 s were entered in the computer for ease in computing. The square roots of the summed D^2 s are taken to obtain "Osgood D" scores.

Procedure

All subjects were told that participation in the research project was totally voluntary, and that they could discontinue participation at any time. It was explained to controls that grades did not depend on being involved in the research. Therapy subjects were told that participation was not part of their treatment, and that treatment would not be influenced by participation. Their therapists were not told if they

participated or not. Experimenters were women. Subjects were asked to read release forms and to sign two copies if they wished to be involved. Signatures were witnessed. One release form was given to the experimenter, and one was kept by the subject.

Subjects were then given a questionnaire and asked to fill it out. They were told if they had any questions in completing the form, they could ask the experimenter for an explanation. Occasionally questions were asked about specific directions, but most subjects filled out the questionnaire with no questions in 20 to 30 minutes. Subjects then turned in the questionnaire to the experimenter. They were told that an abstract of the results would be sent to them on completion of the research.

RESULTS

Since specific order was predicted by hypotheses, one-tailed tests were used in testing results.

A significant positive correlation ($r=.45$, p less than .01) between high Hopkins Symptom Checklist (HSCL) scores and low self/ideal-self congruence (high Osgood D scores) using a Pearson Product Moment Correlation. This supports Hypothesis 4, that stated that the two would be correlated.

Feminist, control, and therapy groups differed significantly (p less than .05, one-tailed) in total symptom distress scores on the HSCL, with women seeking therapy reporting highest symptom distress, using a one-way least square analysis of variance. This was as predicted by Hypothesis 3. Significant heterogeneity of variance was not found, with a Bartlett-Box F of .45. Table 2 shows the mean and standard deviations for the three groups.

Using a one-way least squares analysis of variance, feminists, controls, and the therapy group differed significantly in self/ideal-self congruence, but significant heterogeneity of variance was found (Bartlett-Box F , significant below the .001 level). A Kruskal-Wallis H test was not significant, nor was a 2x3 Chi-square contingency table (see Table 3). This finding did not support Hypothesis 2, stating that the groups would differ in self/ideal congruence.

Feminists, control, and therapy groups did not differ

TABLE 2
ANALYSIS OF VARIANCE
TOTAL SYMPTOM SCORES
HOPKINS SYMPTOM CHECKLIST

<u>Source</u>	<u>Degree of Freedom</u>	<u>Mean Squares</u>	<u>F Probability</u>
Between groups	2	1485.7031	less than .05, one-tailed
Within groups	39	514.6326	
	<u>No. of Subjects</u>	<u>Means</u>	<u>Standard Deviations</u>
Feminist Group	17	84.8	18.7
Control Group	15	97.9	26.0
Therapy Group	<u>10</u>	105.5	23.6
Total	42		

Note: No significant heterogeneity of variance was found (Bartlett-Box F ; $p=.45$; not significant).

TABLE 3

CHI-SQUARE CONTINGENCY TABLE

SELF/IDEAL-SELF CONGRUENCE

	<u>Feminist Group</u>	<u>Control Group</u>	<u>Therapy Group</u>	<u>Row Totals</u>
Below Median, Self/ideal Congruence	9	8	4	21
Above Median, Self/ideal Congruence	<u>8</u>	<u>7</u>	<u>6</u>	21
Column Totals	17	15	10	

Chi-square = .52549; df = 2; not significant

significantly in composition of high-feminine, high-masculine, and androgynous scores on the Bem Sex Role Inventory (BSRI) using a 3x3 Chi-square contingency table (see Table 4). This was contrary to Hypothesis 1, predicting that the feminist group would have more highly masculine scores.

Feminist, control, and therapy groups differed significantly (p less than .01) in self/ideal man congruence using a 3x2 Chi-square contingency table, with feminists having the highest self/ideal man congruence (low difference scores) and the therapy group having the lowest self/ideal man congruence (high difference scores) (see Table 5).

Feminist, control, and therapy groups were compared on self/mother congruence, self/men congruence, and self/father congruence using one-way least squares analyses of variance. None of the differences were found to be significant.

Groups classified as androgynous, high-masculine, and high-feminine on the BSRI were examined for differences in total HSCL symptom scores using one-way least squares analysis of variance. No significant differences were found. The same groups were also examined for differences in self/ideal congruence, using the same statistic, with no significant differences found.

All subjects were divided into two groups: those who reported having been involved at some time in successful therapy that went on for at least six months, and those who had not been so involved. These two groups were examined using a t test for differences between total symptom distress reported on the HSCL. Results showed $t_{40}=1.33$,

TABLE 4

CHI-SQUARE CONTINGENCY TABLE
BEM SEX ROLE INVENTORY CATEGORIES

	<u>Feminist Group</u>	<u>Control Group</u>	<u>Therapy Group</u>	<u>Row Totals</u>
Androgynous	6	4	3	13
Feminine	6	3	1	10
Masculine	<u>5</u>	<u>8</u>	<u>6</u>	19
Column Totals	17	15	10	

Chi-square = 3.6698; df = 4; not significant

TABLE 5

CHI-SQUARE CONTINGENCY TABLE

SELF/IDEAL MAN CONGRUENCE

	<u>Feminist Group</u>	<u>Control Group</u>	<u>Therapy Group</u>	<u>Row Totals</u>
Below Median, Self/ideal Man Congruence	13	6	2	21
Above Median, Self/ideal Man Congruence	<u>4</u>	<u>9</u>	<u>8</u>	21
Column Totals	17	15	10	

Chi-square = 8.96470; df = 2; p less than .01

not significant. The same two groups were also examined for differences in self/ideal congruence (low Osgood D scores=high congruence). Results showed $t_{40}=.42$, not significant.

All subjects were then divided into two other groups: those who reported having experienced significant stress in the last year, and those who did not. A t -test was used to examine differences in total symptom stress reported on the HSCL. Results showed $t_{40}=.07$, not significant.

No significant difference was found for age among the feminist, control, and therapy groups using a one-way least squares analysis of variance. Feminist, control, and therapy groups were then compared on several variables using 3x2 Chi-square contingency tables. Differences explored included percentage of blacks in each group, percentage of divorced persons, percentage who experienced successful therapy in the past, percentage who reported stress during the last year, and percentage who were presently married. None of these differences was significant. So few subjects reported parents who divorced before the subject was 20 that no analysis could be done on that data.

DISCUSSION

This study investigated personality characteristics of three groups of women: women seeking psychotherapy for themselves or their families in community mental health centers (therapy group), women who define themselves as feminists and report active involvement in the woman's movement (feminist group), and women who are neither feminists nor seeking therapy (control group). Four specific hypotheses were made, while other aspects of the study were exploratory. Predictions were partially confirmed by the results.

Results indicate that the three groups did not differ in age, racial composition, percentage having been divorced, percentage who had experienced successful therapy at some time in the past, percentage reporting severe stress in the past year, and percentage presently married. This indicates that differences in these areas did not account for statistically significant differences found among the groups, and increases the internal validity, since results indicate that these "plausible" rival hypotheses for differences were not particularly plausible.

A high positive correlation was found between high symptom distress as reported on the Hopkins Symptom Checklist (HSCL) and low self/ideal-self congruence, as was predicted by Hypothesis 4. If high symptom distress is accepted as a measure of anxiety, this supports Rogers (1951) view that low self/ideal congruence is associated with

feelings of threat and anxiety. It also supports Rosenberg's (1962) suggestion that the "good self" is a universal value, with a negative self-image in relation to the "good self" to be associated with signs of emotional disturbance (high symptom distress). Butler and Haigh (1954) stated their belief that a discrepancy between self-concept and ideal self-concept reflects a sense of self-dissatisfaction and a relatively low adjustment level, which could be reflected, in this case, in high symptom level. Parloff et al. (1954) also found a positive correlation between high symptoms on the HSCL and low self/ideal congruence. A limitation of accepting these views is that they all seem to assume that the lack of adjustment, and perhaps high symptom level, is caused by the low congruence between self-image and ideal self-image. Perhaps, on the contrary, high symptom distress and anxiety cause self-image to be lowered, thus creating low congruence between self-image and ideal self-image. The results of the present study show only a correlation between high symptom level and low self/ideal congruence. No cause-and-effect can be inferred.

Comparisons among the feminist, control, and therapy groups showed mixed results, with some differences highly significant and some differences not significant. Women seeking therapy reported higher symptom distress on the HSCL than the other groups (p less than .05, one-tailed). These results support Hypothesis 3. Rickels et al. (1971) also found that HSCL scores differentiated a group of women seeking therapy from a group not seeking therapy (gynecological outpatients). Derogatis et al. (1974) differentiated a control group from outpatient

anxious and depressed groups with the HSCL. Kravetz (1978) compared women attending an outpatient therapy clinic to other women, and found women in the clinic to have higher HSCL scores. Lieberman and Bond (1976) had similar results with a 35-item HSCL. These findings on validity, added to the other advantages of self-report measures described by Derogatis et al. (1974) such as economy of professional time and very easy scoring, indicate that the HSCL is a good, fast measure to differentiate psychotherapy clinic clients from other groups. A limitation of the present study is that it does not investigate whether symptoms change over time with or without therapy. A study now in progress by the author will speak to this limitation by looking at symptom change with and without therapy.

Feminists, controls, and the therapy group differed significantly in self/ideal congruence using the Semantic Differential (SD), using a one-way least squares analysis of variance, but there was significant heterogeneity of variance. Using a 2x3 Chi-square contingency table or a Kruskal-Wallis H test, results were not significant. Therefore it appears that the earlier significance was a result of the heterogeneity of variance among the groups, and not due to differences in group means. These results are contradictory to Hypothesis 2, predicting that clinic women would have lower self/ideal congruence. The correlation of self-ideal congruence with high symptom scores suggests that self-ideal congruence is important, but the lack of significance between groups indicates that it is at least not as sensitive as the HSCL in picking up differences among the groups.

Feminists, controls, and the therapy group could not be differentiated in composition of "high-masculine," "high-feminine," and "androgynous" subjects according to categories on the Bem Sex Role Inventory (BSRI). This is contrary to Hypothesis 1, which suggested that the feminist group would be more masculine sex-typed and contrary to the findings by Volgy (1977) and Jordan-Viola et al. (1976). Goldberg (1974) found results similar to those of the present study, with no significant difference in masculinity/femininity between feminists and controls. To look more closely at BSRI types, all subjects were regrouped as "high-masculine," "high-feminine," or "androgynous" based on BSRI scores. These groups were examined for differences on HSCL symptom ratings and self/ideal congruence. No differences were found among the groups. In the present study, high-feminine, high-masculine, and androgynous women could not be differentiated by symptom level or self/ideal congruence. This seems to be contradictory to many previous findings, including those by Pettus (1977), who found that androgynous women had lower trait anxiety and greater self-actualization. Schiff (1978) found that androgynous women and high-masculine women had greater self-esteem (if one can assume that self/ideal congruence is a self-esteem measure). Murray (1976) found that women who scored as androgynous on the BSRI had the highest "psychological health" ratings.

In the present study, it seems that the BSRI was not a useful measure to look at adjustment. It also appears that, if there are certain differences in BSRI groups, as has been found by other

researchers, these differences are not measured well by the HSCL or self/ideal congruence measured by a semantic differential.

Congruence with a model has been thought to indicate extent of identification with the model (Osgood, 1952).

A surprising difference among the feminist, control, and therapy groups was found in self/ideal man congruence. In the present study, feminists saw themselves as more congruent with "the ideal man" than controls or the therapy group. The three groups did not differ in self-congruence with "mother," "father," or "men." Contrary to these present findings, Luria (1959) looked at therapy and control groups and concluded that the two groups could be distinguished by SD meanings of self and parents. Mueller (1966) found that low-anxious females identified less with their fathers than high-anxious females.

Shell et al. (1964) summarized results of SD identification scores, and concluded that control females often inferred greater similarity to parents than those seeking therapy, but concluded that differences in identification were not consistent. They speculated that "distance from positive" might be the measurement obtained, rather than an identification measure. This theory might account for feminists and controls having greater congruence with "self" and "ideal man" than women seeking therapy. The therapy group may see themselves as less like any "ideal" concept because of low self-esteem or high anxiety from symptom distress.

All subjects were divided into those reporting successful therapy in the past and those who had not been so involved, and compared on

HSCL symptom level and self/ideal congruence. No significant differences were found. This indicates that successful therapy in the past is not reflected in low symptom scores or in high self/ideal congruence.

All subjects were then divided into those who reported significant stress in the last year and those who did not, and compared on HSCL scores. Results showed no differences between groups, which indicates that HSCL scores do not correlate with reported high stress.

There are many limitations to the present study. The control group is not ideal. All control subjects were undergraduates at a university. Although ages, racial composition, percentage having been divorced, percentage who had experienced successful therapy at some time in the past, percentage reporting severe stress in the past year, and percentage presently married did not differ significantly among the three groups, controls were students and may be different in certain characteristics, such as being more motivated, having less symptom distress, or having greater self/ideal congruence than a nonstudent population. They may be more like a group of professional women, and might have been more likely to score high in androgyny on the BSRI than nonstudents. A more "typical" control group, such as gynecological outpatients, might be a better choice for further research and increase generalizability of results.

Another limitation already mentioned is the fact that cause-and-effect should not be inferred from correlation between high symptom distress (HSCL scores) and low self/ideal congruence. These findings are correlated, but there is no indication that one causes the other,

though the literature seems to assume so. This causal association is based on the as yet untested assumption that low self/ideal congruence causes high symptoms. Retesting for change in the scores over time might help obtain some evidence for cause-and-effect relationships, if the relationship between the two concepts was traced.

High HSCL scores do not seem to be due to stress in the past year or successful therapy in the past, since groups did not differ statistically in reported stress or reported therapy in the past. It may be concluded that, of the instruments used in the present study, the HSCL best differentiates between groups seeking therapy and groups not seeking therapy. It is possible that the statement inquiring about stress in the past year was too general, and more specific inquiries about specific stress incidents might have resulted in a different outcome. A limitation of this study is that it is not known whether the HSCL scores are relatively constant, or measure change -- in other words, whether it is a state measure or a trait measure. An idea for further research now in progress by the present author is to give the HSCL to controls and persons entering therapy to see if it is stable in controls, and if it measures change in therapy.

As stated before, the high self/ideal man congruence found in feminists might be measuring distance from ideal concepts, rather than identification with the "ideal man" in particular. The groups not being differentiated on self/ideal-self congruence would indicate that this is not the case, but adding other "ideal" groups in further studies would check for this factor, particularly "ideal woman."

In sum, it can be concluded from the present study that three groups of women that were similar in composition of age, race, percentage having been divorced, percentage having experienced successful therapy in the past, percentage reporting stress in the past year, and percentage presently married, but differing in some aspects: one group defining themselves as feminists and having been active in a feminist organization; one group seeking outpatient psychotherapy; and one group being neither feminists nor seeking therapy, could be differentiated in some ways. The three groups could be differentiated by the HSCL, with the group seeking therapy reporting highest symptom distress, and feminists reporting least symptom distress. One could tentatively conclude that women seeking therapy have more symptoms than other women, and even hypothesize that they seek therapy to relieve these symptoms. If this is true, the HSCL might be one way to measure change in therapy. Used over time, the total symptom scores may decrease as therapy is successful. However, it might be that the control and feminist groups are more defended than the therapy group, and simply report fewer symptoms. MMPI "K" scores might be used in future research to check on defensiveness in subjects. Even if subjects are defensive, the HSCL symptom level reported seems to differentiate the groups. Since feminists report the least symptoms, one might conclude that they are more "psychologically healthy" than the other groups. Other studies indicate similar findings (Hjelle & Butterfield, 1974; Gump, 1972). Perhaps "feminist" women had more "ego strength" or less anxiety to begin with, and were able to critically examine traditional

sex roles, and this is why they define themselves as feminists. On the other hand, the very act of becoming involved in a feminist organization, including contact with other women questioning traditional sex roles and often including such activities as consciousness-raising groups, may reduce anxiety, and thus, symptom distress. If the latter is true, perhaps these contacts and groups should become a part of psychotherapeutic treatment of women, possibly combined with more traditional psychotherapeutic methods. This has been suggested by Brodsky (1973) and Holroyd (1976). Feminists might be examined using other instruments in further studies, such as with the Shostrom Personality Orientation Inventory (Hjelle & Butterfield, 1974), to further investigate differences between this group and other women. Time in group and type of group would have to be carefully controlled.

Low HSCL symptom distress and high self/ideal-self congruence are correlated, supporting the idea that low self-esteem (if that is what is measured by self/ideal congruence) and high symptom distress go together. However, the three groups could not be differentiated on just self/ideal congruence. One might conclude that the HSCL is a more precise instrument than the self/ideal semantic differential, and one could predict that change might be more easily measured with the HSCL.

The groups were differentiated on self/ideal man congruence with feminists rating "myself" most like "the ideal man" and the therapy group rating themselves least like "the ideal man." Yet the three groups did not differ on congruence of self with "men" or "father." They also did not differ on self/ideal congruence. The idea that

closeness of "self" to another semantic differential concept indicates identification with that concept is, to me, open to question. Closeness on a semantic differential may not reflect identification but some other factor. Shell et al. (1964) concluded after surveying the literature that results of studies examining differences using the semantic differential have not been consistent. Perhaps "ideal mother," "ideal father," and "ideal woman" should be tested to see if they differ in congruence from self/ideal man. However, perhaps feminists do identify more with the ideal man. Women's identification with male and female figures should be further investigated.

It was hoped that the BSRI would explore sex role identification differences among these three groups, yet no significant differences were found with this instrument. It was also hypothesized that results would reflect other findings relating "high-masculine" and "androgynous" sex role identification on the BSRI to psychological health, in this case measured by low HSCL scores and high self/ideal-self congruence. None of these findings were significant. It may be that other instruments would differentiate BSRI groups. Many measures said to differentiate BSRI groups seem to be rather general and nonreplicable, such as "psychological health ratings" (Pettus, 1977). Although there may be differences among BSRI groups, one can conclude that the instrument did not differentiate among the three groups in the present study. It may be simply that these three groups do not differ in sex role identification. Groups were combined, but still "high-masculine" and "androgynous" women could not be differentiated on HSCL symptom ratings or self/ideal congruence.

For the present purposes, it would appear that the HSCL is the most precise instrument to differentiate among such groups of women, and it may be useful in measuring change. This should be explored further. It seems that self/ideal-self congruence is correlated with symptom distress, but perhaps that is a "deeper," more slowly-changing personality construct. It appears that the BSRI is not useful in differentiating women seeking therapy from others, or women with high symptom distress from others. This, too, might be due to the fact that sexual identification is a very deep-seated, relatively slow-changing construct.

REFERENCE NOTE

Walter, J. Demographic and therapy variables of dropping-out of family therapy. Unpublished manuscript, 1978. (Available from Kay Bienemann, 18001 Baker Avenue, Country Club Hills, Illinois 60477).

REFERENCES

- Altrocchi, J., Parsons, O.A., & Dickoff, H. Changes in self-ideal discrepancy in repressors and sensitizers. Journal of Abnormal and Social Psychology, 1960, 6, 67-72.
- Bahn, A.K., Conwell, M., & Hurley, P. Survey of psychiatric practice. Archives of General Psychiatry, 1965, 12, 295-302.
- Beitner, M.S. Word meaning and sexual identification in paranoid schizophrenics and anxiety neurotics. Journal of Abnormal and Social Psychology, 1961, 63, 289-293.
- Bem, S.L. The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology, 1974, 42, 155-162.
- Bem, S.L. Sex role adaptability: One consequence of psychological androgyny. Journal of Personality and Social Psychology, 1975, 31, 634-643.
- Bem, S.L. On the utility of alternative procedures for assessing psychological androgyny. Journal of Consulting and Clinical Psychology, 1977, 45, 196-205.
- Bem, S.L., & Lenney, E. Sex typing and the avoidance of cross-sex behavior. Journal of Personality and Social Psychology, 1976, 33, 48-54.
- Bem, S.L., Martyna, W., & Watson, C. Sex typing and androgyny: Further explorations of the expressive domain. Journal of Personality and Social Psychology, 1976, 34, 1016-1023.
- Bergin, A.E. The evaluation of therapeutic outcomes. In A.E. Bergin & S.L. Garfield (Eds.), Handbook of psychotherapy and behavior change. New York: John Wiley & Sons, 1971, Pp. 217-270.
- Block, J.H. Conceptions of sex role: Some cross cultural and longitudinal perspectives. American Psychologist, 1973, 28, 512-526.
- Block, J., & Thomas, H. Is satisfaction with self a measure of adjustment? Journal of Abnormal and Social Psychology, 1955, 51, 254-259.
- Brodsky, A. The consciousness-raising group as a model for therapy with women. Psychotherapy: Theory, Research, and Practice, 1973, 10, 24-29.

- Broverman, I.K., Broverman, D.M., Clarkson, F.E., Rosenkrantz, P.S., & Vogel, S.R. Sex-role stereotypes and clinical judgments of mental health. Journal of Consulting and Clinical Psychology, 1970, 34, 1-7.
- Butler, J.M., & Haigh, G.V. Changes in the relation between self-concepts and ideal concepts congruent upon client-centered therapy. In C.R. Rogers & R.F. Dymond (Eds.) Psychotherapy and personality change. Chicago: University of Chicago Press, 1954, Pp. 55-75.
- Carlson, E.R., & Carlson, R. Male and female subjects in personality research. Journal of Abnormal and Social Psychology, 1960, 61, 482-483.
- Carlson, R. Understanding women: Implications for personality theory and research. Journal of Social Issues, 1972, 28, 17-32.
- Cattell, R.B. Description and measurement of personality, Yonkers-on-Hudson, N.Y.: World Book Company, 1972.
- Chase, P.H. Self concepts in adjusted and maladjusted hospital patients. Journal of Consulting Psychology, 1957, 21, 495-497.
- Derogatis, L.R., Lipman, R.S., Covi, L., & Rickels, K. Neurotic symptom dimensions as perceived by psychiatrists and patients of various social classes. Archives of General Psychiatry, 1971, 24, 454-464.
- Derogatis, L.R., Lipman, R.S., Covi, L., Rickels, K., & Uhlenhuth, E.H. Dimensions of outpatient neurotic pathology: Comparison of a clinical versus an empirical assessment. Journal of Consulting and Clinical Psychology, 1970, 34, 164-171.
- Derogatis, L.R., Lipman, R.S., Rickels, K., Uhlenhuth, E.H., & Covi, L. The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. Behavioral Science, 1974, 19, 1-15.
- Dymond, R.F. An adjustment score for Q-sorts. Journal of Consulting Psychology, 1953, 17, 339-343.
- Dymond, R.F. Adjustment changes over therapy from self-sorts. In C.R. Rogers & R.F. Dymond (Eds.), Psychotherapy and personality change. Chicago: University of Chicago Press, 1954, Pp. 76-84.
- Edwards, A.I. The social desirability variable in personality assessment and research, New York: Holt, 1957.

- Fabrikant, B. The psychotherapist and the female patient: Perceptions, Misperceptions, and Change. In V. Franks & V. Burtile (Eds.), Women in therapy: New psychotherapies for a changing society. New York: Brunner/Mazel, 1974, Pp. 83-109.
- Frank, G.H. Note on the reliability of Q-sort data. Psychological Reports, 1956, 2, 182.
- Frank, J.D., Hoehn-Saric, R., Imber, S.D., Liberman, B.L., & Stone, A.R. Effective ingredients of successful psychotherapy, New York: Brunner/Mazel, 1978.
- Friedman, I. Phenomenal, ideal, and projected conceptions of self. Journal of Abnormal and Social Psychology, 1955, 51, 611-615.
- Garai, J.E. Sex differences in mental health. Genetic Psychology Monograph, 1970, 81, 123-142.
- Garai, J.E., & Scheinfeld, A. Sex differences in mental and behavioral traits. Genetic Psychology Monographs, 1968, 77, 169-299.
- Gaudreau, P. Factor analysis of the Bem Sex-Role Inventory. Journal of Consulting and Clinical Psychology, 1977, 45, 299-302.
- Goldberg, C. Sex roles, task competence, and conformity. Journal of Psychology, 1974, 86, 157-164.
- Gove, W., & Tudor, J. Adult sex roles and mental illness. American Journal of Sociology, 1973, 78, 812-835.
- Guertin, W.H., & Jourard, S.M. Characteristics of real-self ideal-self discrepancy scores revealed by factor analysis. Journal of Consulting Psychology, 1962, 26, 241-245.
- Gump, J.P. Sex-role attitudes and psychological well-being. Journal of Social Issues, 1972, 28, 79-92.
- Gurin, G., Veroff, J., & Feld, S. Americans view their mental health, New York: Basic Books, 1960.
- Hefner, R., Rebecca, M., & Oleshansky, B. Development of sex-role transcendence. Human Development, 1975, 18, 143-158.
- Heilbrun, C.G. Toward a recognition of androgyny, New York: Knopf, 1973.
- Heise, D.R. Some methodological issues in semantic differential research. Psychological Bulletin, 1969, 72, 406-422.

- Hill, C.E. A research perspective on counseling women. Counseling Psychologist, 1976, 6, 53-55.
- Hjelle, L.A., & Butterfield, R. Self-actualization and women's attitudes toward their roles in contemporary society. Journal of Psychology, 1974, 87, 225-230.
- Hofman, J.E. An analysis of concept-clusters in semantic inter-concept space. American Journal of Psychology, 1967, 80, 345-354.
- Holroyd, J. Psychotherapy and women's liberation. Counseling Psychologist, 1976, 6, 22-28.
- Horney, K. Our inner conflicts, New York: Norton and Company, 1945.
- Jordan-Viola, E., Fassberg, S., & Viola, M.T. Feminism, androgyny, and anxiety. Journal of Consulting and Clinical Psychology, 1976, 44, 870.
- Kagan, J. Acquisition and significance of sex typing and sex role identity. In M. Hoffman & L. Hoffman (Eds.), Review of child development research: Volume I. New York: Russell Sage, 1964, Pp. 137-167.
- Kahn, L.G. Effects of sex and feminist orientation of therapists on clinical judgments. In Women's Educational Equity Communications Network, M. Butler, Director (Eds.), Resources in women's educational equity: Volume I. Washington, D.C.: U.S. Government Printing Office, 1977, P. 33.
- Kohlberg, L. A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E.E. Maccoby (Ed.), The development of sex differences. Stanford, California: Stanford University Press, 1966, Pp. 82-173.
- Kravetz, D. Consciousness-raising groups in the 1970's. Psychology of Women Quarterly, 1978, 3, 168-186.
- Lazowick, L. On the nature of identification. Journal of Abnormal and Social Psychology, 1955, 51, 175-183.
- Lieberman, M.A., & Bond, G.R. The problem of being a woman: A survey of 1700 women in consciousness-raising groups. Journal of Applied Behavioral Science, 1976, 12, 363-380.
- Lipman, R.S., Rickels, K., Covi, L., Derogatis, L.R., & Uhlenhuth, E.H. Factors of symptom distress: Doctor ratings of anxious neurotic outpatients. Archives of General Psychiatry, 1969, 21, 328-338.

- Lorr, M. The multidimensional scale for rating psychiatric patients, Washington, D.C.: U.S. Veterans Administration, 1952.
- Luria, Z. A semantic analysis of a normal and a neurotic therapy group. Journal of Abnormal and Social Psychology, 1959, 58, 216-220.
- Maguire, T.O. Semantic differential methodology for the structuring of attitudes. American Educational Research Journal, 1973, 10, 295-306.
- Mowrer, O.H. Psychotherapy: Theory and research, New York: Ronald Press, 1953.
- Mueller, W.J. Anxiety level, inferred identification, and response tendencies on a semantic differential. Journal of Counseling Psychology, 1966, 13, 144-152.
- Murray, B.O. Androgyny and sex role stereotypes: Women's real and ideal self perceptions and perceptions of psychological health in others. Dissertation Abstracts International, 1976, 37, 1444.
- Nalinsky, I.D. The self-ideal correlation as a measure of generalized self satisfaction. Psychological Record, 1966, 16, 55-64.
- National Institute of Mental Health. General hospital inpatient psychiatric services, Washington, D.C.: U.S. Government Printing Office, 1967. (a)
- National Institute of Mental Health. Outpatient psychiatric services, Washington, D.C.: U.S. Government Printing Office, 1967. (b)
- National Institute of Mental Health. Patient characteristics: Private mental hospitals, Washington, D.C.: U.S. Government Printing Office, 1967. (c)
- National Institute of Mental Health. Patients in state and county mental hospitals, 1967, Washington, D.C.: U.S. Government Printing Office, 1967. (d)
- National Institute of Mental Health. Veterans with mental disorders, 1963-1967, Washington, D.C.: U.S. Government Printing Office, 1967. (e)
- Oetting, E.R. The effect of forcing response on the semantic differential. Educational and Psychological Measurement, 1967, 27, 699-702.

- Olds, L.E. An exploratory study of androgyny: A sex role construct that integrates male and female polarities. In Women's Educational Equity Communication Network, M. Butler, Director (Eds.), Resources in women's educational equity: Volume I. Washington, D.C.: U.S. Government Printing Office, 1977, Pp. 19-20.
- Orlinky, D.E., & Howard, K.I. Varieties of psychotherapeutic experience: Multivariate analyses of patients' and therapists' reports, New York: Teachers College Press, 1975.
- Osgood, C.E. The nature and measurement of meaning. Psychological Bulletin, 1952, 49, 197-237.
- Osgood, C.E., & Suci, G.J. A measure of relation determined by both mean differences and profile information. Psychological Bulletin, 1952, 49, 251-262.
- Parloff, M.B., Kelman, H.C., & Frank, J.D. Comfort, effectiveness, and self-awareness as criteria of improvement in psychotherapy. American Journal of Psychiatry, 1954, 111, 343-351.
- Pervin, L.A., & Lilly, R.S. Social desirability and self-ideal self ratings on the semantic differential. Educational and Psychological Measurement, 1967, 27, 845-853.
- Pettus, J.P. Psychological androgyny: Construct validation and relationship to mental health and sex stereotypes. In Women's Educational Equity Communications Network, M. Butler, Director (Eds.), Resources in women's educational equity: Volume I. Washington, D.C.: U.S. Government Printing Office, 1977, P. 20.
- Prusoff, B.A., & Klerman, G.L. Differentiating depressed from anxious neurotic outpatients. Archives of General Psychiatry, 1974, 30, 302-309.
- Rice, J.K., & Rice, D.G. Implications of the women's liberation movement for psychotherapy. American Journal of Psychiatry, 1973, 130, 191-196.
- Rickels, K., Garcia, R., & Fisher, E. A measure of emotional symptom distress in private gynecological practice. Obstetrics and Gynecology, 1971, 38, 139-146.
- Rogers, A.H. The self-concept in paranoid schizophrenia. Journal of Clinical Psychology, 1958, 14, 365-366.
- Rogers, C.R. Client-centered therapy, Boston: Houghton-Mifflin, 1951.

- Rosenberg, M. The association between self-esteem and anxiety. Journal of Psychiatric Research, 1962, 1, 135-152.
- Rosenkrantz, P., Vogel, S., Bee, H., Broverman, I., and Broverman, D.M. Sex-role stereotypes and self-concepts in college students. Journal of Consulting and Clinical Psychology, 1968, 32, 287-296.
- Schiff, E. The relationship of women's sex role identity to self-esteem and ego development. In Women's Educational Equity Communications Network, M. Butler, Director (Eds.), Resources in women's educational equity: Volume II. Washington, D.C.: U.S. Government Printing Office, 1978, P. 80.
- Shell, S.A. Jr., O'Mally, J.M., & Johnsgard, K.W. The semantic differential and inferred identification. Psychological Reports, 1964, 14, 547-558.
- Sherman, J.A. Some psychological "facts" about women: Will the real Ms. please stand up? In J. Roberts (Ed.), Beyond intellectual sexism: A new woman, a new reality. New York: David McKay Company, 1976, Pp. 113-137.
- Shlien, J. M. Comparison of results with different forms of psychotherapy. American Journal of Psychotherapy, 1964, 18, 15-22.
- Shlien, J.M., Mosak, H.H., & Dreikurs, R. Effect of time limits: A comparison of two psychotherapies. Journal of Counseling Psychology, 1962, 9, 31-34.
- Spence, J.T., Helmreich, R., & Stapp, J. Ratings of self and peers on sex role attributes and their relation to self-esteem and conceptions of masculinity and femininity. Journal of Personality and Social Psychology, 1975, 32, 29-39.
- Steinmann, A. Cultural values, female role expectancies, and therapeutic goals: Research and interpretation. In V. Franks & V. Burtle (Eds.), Women in therapy: New psychotherapies for a changing society. New York: Brunner/Mazel, 1974, Pp. 51-82.
- Stephenson, W. The study of behavior, Chicago: University of Chicago Press, 1953.
- Taylor, D.M. Changes in the self concept without psychotherapy. Journal of Consulting Psychology, 1955, 19, 205-209.
- Traux, C.B., Schuldt, W.J., & Wargo, D.G. Self-ideal concept congruence and improvement in group psychotherapy. Journal of Consulting and Clinical Psychology, 1968, 32, 47-53.

Turner, R.H., & Vanderlippe, R.H. Self-ideal congruence as an index of adjustment. Journal of Abnormal and Social Psychology, 1958, 57, 202-206.

Volgy, S.S. Sex-role orientation and measures of psychological well-being among feminists, housewives, and working women. In Women's Educational Equity Communications Network, M. Butler, Director (Eds.), Resources in women's educational equity: Volume I. Washington, D.C.: U.S. Government Printing Office, 1977, Pp. 6-7.

Weisstein, N. Psychology constructs the female. In V. Gornick & B.K. Moran (Eds.), Women in sexist society: Studies in power and powerlessness. New York: Basic Books, 1972, Pp. 133-146.

APPENDIX A

BEM

INSTRUCTIONS: Please fill in a number (1-7) after each item, stating how often this is true for you according to the scale below:

1	2	3	4	5	6	7
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE	OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE

Self reliant	
Yielding	
Helpful	
Defends own beliefs	
Cheerful	
Moody	
Independent	
Shy	
Conscientious	
Athletic	
Affectionate	
Theatrical	
Assertive	
Flatterable	
Strong personality	
Loyal	
Unpredictable	
Forceful	
Feminine	
Happy	

Reliable	
Analytical	
Sympathetic	
Jealous	
Has leadership abilities	
Sensitive to the needs of others	
Truthful	
Willing to take risks	
Understanding	
Secretive	
Makes decisions easily	
Compassionate	
Sincere	
Self-sufficient	
Eager to soothe hurt feelings	
Conceited	
Dominant	
Soft-spoken	
Likable	
Masculine	

Warm	
Solemn	
Willing to take a stand	
Tender	
Friendly	
Aggressive	
Gullible	
Inefficient	
Acts as a leader	
Childlike	
Adaptable	
Individualistic	
Does not use harsh language	
Unsystematic	
Competitive	
Loves children	
Tactful	
Ambitious	
Gentle	
Conventional	

H S C L

INSTRUCTIONS: How have you been feeling during the past several days, including today? Please answer by marking after each item a number (1-4) from the scale below:

1 _____ 2 _____ 3 _____ 4 _____
 Not at all Sometimes Often Nearly always

1. Headaches	
2. Nervousness or shakiness inside	
3. Being unable to get rid of bad thoughts or ideas	
4. Faintness or dizziness	
5. Loss of sexual interest or pleasure	
6. Feeling critical of others	
7. Bad dreams	
8. Difficulty in speaking when you are excited	
9. Trouble remembering things	
10. Worried about sloppiness or carelessness	
11. Feeling easily annoyed or irritated	
12. Pains in the heart or chest	
13. Itching	
14. Feeling low in energy or slowed down	
15. Thoughts of ending your life	
16. Sweating	
17. Trembling	
18. Feeling confused	
19. Poor appetite	
20. Crying easily	
21. Feeling shy or uneasy with the opposite sex	
22. A feeling of being trapped or caught	
23. Suddenly scared for no reason	
24. Temper outbursts you could not control	
25. Constipation	
26. Blaming yourself for things	
27. Pains in the lower part of your back	
28. Feeling blocked or stymied in getting things done	
29. Feeling lonely	

H S C I

1 2 3 4
 Not at all Sometimes Often Nearly always

30. Feeling blue	
31. Worrying or stewing about things	
32. Feeling no interest in things	
33. Feeling fearful	
34. Your feelings being easily hurt	
35. Having to ask others what you should do	
36. Feeling others do not understand you or are unsympathetic	
37. Feeling that people are unfriendly or dislike you	
38. Having to do things very slowly in order to be sure you are doing them right	
39. Heart pounding or racing	
40. Nausea or upset stomach	
41. Feeling inferior to others	
42. Soreness of your muscles	
43. Loose bowel movements	
44. Difficulty in falling asleep or staying asleep	
45. Having to check and double check what you do	
46. Difficulty making decisions	
47. Wanting to be alone	
48. Trouble getting your breath	
49. Hot or cold spells	
50. Having to avoid certain places or activities because they frighten you	
51. Your mind going blank	
52. Numbness or tingling in parts of your body	
53. A lump in your throat	
54. Feeling hopeless about the future	
55. Trouble concentrating	
56. Weakness in parts of your body	
57. Feeling tense or keyed up	
58. Heavy feelings in your arms or legs	
If you have problems not included on this list, please write them in and rate them below:	
59.	
60.	
61.	

APPROVAL SHEET

The thesis submitted by Kay Bienemann has been read and approved by the following committee:

Dr. Alan S. DeWolfe, Director

Professor of Psychology

Dr. J. Clifford Kaspar

Professor of Psychology

Director, Loyola Guidance Center

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

12/4/79
Date

Alan S. DeWolfe
Director's Signature