Mental Health Professionals, Counselor Educators, and Counselors In-Training: A Comparative Study of Sex-Role Stereotypic Attitudes Toward Women

Judith Yonover Housos
Loyola University Chicago

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MENTAL HEALTH PROFESSIONALS, COUNSELOR EDUCATORS, AND COUNSELORS-IN-TRAINING: A COMPARATIVE STUDY OF SEX-ROLE STEREOTYPIC ATTITUDES TOWARD WOMEN

by

Judith Yonover Housos

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

November

1979
I wish to express my appreciation to Dr. John Wellington, Director of my committee. From this caring professor and mentor, I have learned to face the struggle for self-actualization and self-fulfillment.

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A special wish for my daughters, Lisa, Julie, and Stephanie; that you may have the courage to grow to be androgynous women-persons, and find meaningful authenticity and freedom in your lives.

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TO SHANA:

YOU ARE ALWAYS THERE.
The author Judith Yonover Housos, was born on November 7, 1936 in Chicago Illinois.

After completion of her elementary and secondary education, she continued her academic pursuits and received the Bachelor of Education degree in 1959 from Chicago Teachers College.

The years 1959 through 1963 were devoted to professional education wherein she taught elementary school in the Chicago and Markham, Illinois school systems.

Her professional career was temporarily postponed from 1963 to 1970 as she chose to remain home to rear her three daughters. Combining her dual roles as career woman and mother, she returned to the classroom until 1974 when her personal objectives led her to do graduate work in counseling at Loyola University of Chicago.

As her career goals and aspirations became focused, advanced study beyond the Master's degree that she received in June 1976, was required. Her doctoral studies commenced at Loyola in the department of Guidance and Counseling in June 1977, and she was awarded a teaching/research assistantship for two years.
Presently, the author is completing her Clinical Internship at Madden Mental Health Center in Hines, Illinois.

Ancillary to her formal training in academia, she has a broad range of field and supervisory experience including: private practice under the supervision of a registered psychologist, psychometrics, group facilitator, crisis intervention, alcoholism counseling, supervisor for master's level practicum, research consulting (methodology and statistics), high school counseling, career development, consultation for in-service training for CETA counselors, and counseling in the community college setting.

Her research, work, and writing have focused primarily on the Psychology of Women, and she has adopted a feminist perspective.
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CHAPTER I

INTRODUCTION

The foundation for sex-role stereotyping originates in the cultural definitions of femininity and masculinity.\(^1\) Traditional sex-role stereotypic attitudes of appropriate behaviors and attributes, although outdated, are still used to characterize women and men.\(^2\)

In the article "Sex Role Stereotypes: A Current Appraisal," Inge Broverman and her associates wrote: "Sex role standards can be defined as the sum of socially designated behaviors that differentiate between women and men."\(^3\) Traditionally, psychologists have been undiscriminating in their acceptance of sex roles as essential to personality development; therefore, the positive values of sex-role standards had rarely been questioned. The results of recent investigations allowed Broverman\(^4\) to express


\(^4\)Ibid., p. 67.
concern over the possible detrimental effects of sex-role stereotyping. The evidence indicates the existence of pervasive and persistent, clearly defined sex-role stereotypes. The findings further suggest that these existing stereotypes between women and men are not only approved of, they are even idealized by large segments of society.

In addition, Broverman's research demonstrates that since more feminine traits are negatively valued than are masculine traits, women tend to have more negative self-concepts than do men. There is also the tendency for women to denigrate themselves, which is evidenced by the powerful social pressures to conform to the sex-role standards of society.

Society's sex-role definitions and expectations result in differing basic self images, or sexual identities. Identity is defined as the image one has of the self as a female or male, as well as convictions about what membership in that group implies. Sex-role identification, the individual's basic sex-typed image, is built up gradually from infancy, and is the result of learned conceptions about the self as female or male. Yorburg suggests these conceptions are transmitted in the form of different expectations of prescribed roles for women and men.

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5 Ibid., p. 75.

Feminine and masculine ideals (or sexual identities) are part of the values and social customs that are held in common by society, and communicated to humans at the time of birth. Sex-role identity includes the beliefs about how one ought to think, act, and feel, by virtue of having been born female or male. These stereotypic roles include learned ideals of feminine and masculine behavior, as well as the authority relationships between the sexes. The research of Boslooper and Hayes indicated the cultural ideals of femininity and masculinity have provided societal standards for judging emotions, behaviors, privileges, and limitations, and these ideals result in evaluations of the self as good, bad, inferior, superior, desirable or undesirable.

In many ways, female and male roles have been defined in our culture as polar opposites. Women are believed to be more emotional, intuitive, erratic, less persistent, and weaker. Women are placed in subservient positions by stereotyped differences, and according to Tennov,

7 According to Gordon in "Counselors and Changing Sexual Values," our culture has insisted on the idea that men should be aggressive, worldly, strong, rational, and dominant, while women should be passive, domestic, weak, emotional and submissive. p. 362.


these are cultural assertions to women's inferiority.

Female and male are defined as biological categories, while the terms femininity and masculinity have become cultural and social definitions. The ideals of femininity and masculinity, as defined by our culture, and as learned by females and males, result in sex-typed identities. These learned behaviors and attitudes have become the derivation of sex-role stereotyping.

During the past few years, there has been an increase in research which has focused on the investigation of sex-bias in society in general, and more specifically, sex-role stereotypic attitudes in the helping professions. The ideal standards of mental health for women and men maintained by mental health clinicians have been found to parallel the stereotypic sex differences that have been assumed by society.

Broverman's research has shown that the clinical standards for mentally healthy, mature individuals, sex unspecified, and for mentally healthy mature men are virtually identical. The clinical standards of the ideal for the mentally healthy woman were described as more submissive, more easily influenced, less independent, less adventurous, less competitive, less objective, and more easily

---

hurt than mentally healthy men.

These standards, as described by practicing mental health clinicians, are seen as a function of the sex of the person, and illustrate a double standard of mental health. What is accepted as mature and healthy is the norm for men; the expectations for women are considered immature. In essence, this double standard views mental health as something different for women than for men.

Femininity is defined as passivity, as emotional dependence, physical weakness, and as reaction instead of action. The qualities necessary for success in today's culture of competitiveness, aggressiveness, and the desire to achieve are considered unwomanly. According to Boslooper and Hayes¹¹ as long as women are locked into a gender role that defines "normal" as physical frailty and social passivity, those women who seek to break out of this role are seen as deviates.

The tendency of sex-role stereotypes to ascribe greater social value to masculine than to feminine behaviors

¹¹Boslooper and Hayes in The Femininity Game, p. 173, contend that as long as men are programmed to perform the masculinity "rite" those who refuse to conform will be considered deviates, too. It seems that rigid gender roles are responsible for much of what is called deviant behavior, both sexual and social. The definition of "deviant" varies directly with the definition of "normal."
has been suggested by the research of Rosenkrantz\textsuperscript{12} and his colleagues. Sex-role stereotyping may articulate for the individual the sex-role behaviors that others expect.

**Statement of the Problem**

The problem which this investigation addresses concerns the sex biases of mental health professionals, counselor educators, and counselors-in-training. The problem may be clarified by asking the following questions:

1. Do these three groups differ in their level of sex bias, or do they all possess the same level of sex bias?

2. Are levels of sex bias influenced by a person's age, sex, or group classification, or some unique interaction of these three variables?

3. Among mental health professionals, are levels of sex bias influenced by the subject's age, sex, or specific professional title, or by some unique interaction of these three variables?

4. Among counselor educators, are levels of sex bias influenced by the subject's age and sex, or some unique interaction of the two variables?

5. Among counselors-in-training, are levels of sex bias influenced by the subject's age, sex or year in

program, or by some unique interaction of these three variables?

6. Are there differences among the subjects in the assessed level of sex bias when the subjects are classified according to their theoretical orientation?

7. Is there a relationship between a subject's perception of women and the personal attributes that a subject stereotypically assigns to women?

The literature is clear in its assertion that the values and belief systems, particularly in practicing mental health professionals and counselor educators, are in all likelihood transmitted to their client systems.

Sex-role stereotyping, historically and currently, is detrimental to both female and male clients, particularly the female client. The emerging counselor-in-training is influenced by the professionals and educators who are charged with the responsibility for their training and development. If the deleterious effect of sex-role stereotyping is to be minimized, mental health professionals, counselor educators, and counselors-in-training, need to become aware of their own sex biases, and how these biases have an effect on their client systems.

Although the literature is rife with assertions concerning sex-role stereotypic attitudes of mental health professionals, counselor educators, and counselors-in-training, little systematic research has been done to
quantify sex bias and none attempts to explicate relative differences between the groups in this study.

This research attempts to gather and analyze data of an empirical nature to supplement the theoretical arguments of the negative effects of sex-role stereotyping. Although similar to society in their stereotypic attitudes toward women, these subject groups were selected for this investigation because they are in the distinctive position of imparting these biases directly with both student and client population and/or minimizing the effects of sexism. The quantification of sex stereotypic attitudes brings a new dimension to self-awareness.

**Purposes and Objectives of the Study**

The purpose of this investigation is two-fold; to examine differences in sex-role stereotypic attitudes among mental health professionals, counselor educators, and counselors-in-training, and to test the contention that a double standard of mental health for women and men exists.

This research has several objectives:

1. To show that mental health professionals, counselor educators, and counselors-in-training have differing levels of sex bias.

2. To discuss the implications of these differences relative to their effects on client systems.

3. To highlight differing sex-role stereotypic
attitudes between psychiatrists, psychologists, social workers, counselor educators, master's level counselor trainees, and doctoral level counselor trainees.

4. To demonstrate that the sex, age, and group classification of the subjects influence their assessed level of sex bias.

5. To illustrate that there is an association between a person's attitudes toward women and the attributes that a person will assign to women.

6. To present further evidence of the existence of a double standard of mental health for women and men.

Statement of Hypotheses

To meet the purposes and objectives of this study, the following hypotheses, stated in the null form, will be investigated:

$H_1$: There will be no significant differences in the level of assessed sex bias between the three subject groups.

$H_2$: There will be no significant differences among the three subject groups in levels of assessed sex bias when the subjects are classified by sex, age, and subgroup classification.

$H_3$: There will be no significant differences in the level of assessed sex bias between Mental Health Professionals when the subjects are classified by sex, age, and professional title.
H_4: There will be no significant differences in the level of assessed sex bias between Counselor Educators when the subjects are classified by sex and age.

H_5: There will be no significant differences in the level of assessed sex bias between Counselors-in-Training when the subjects are classified by sex, age, and school program.

H_6: There will be no significant differences in the level of assessed sex bias within Mental Health Professionals, Counselor Educators, and Counselors-in-Training when the subjects are classified by theoretical orientation.

H_7: The data will suggest no level of association between the subject’s scores on the Attitudes Toward Women Scale and the second Personal Attributes Questionnaire.

H_8: There will be no significant differences in the perceptions of Mental Health Professionals in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

H_9: There will be no significant differences in the perceptions of Counselor Educators in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

H_{10}: There will be no significant differences in the perceptions of Counselors-in-Training in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.
Rationale

Evidence of sex bias among the helping professions as indicated by the Broverman\textsuperscript{13} research suggested that inasmuch as clinicians are reflecting stereotypic attitudes, they are, therefore responsible for perpetuating them.

Although it has been presumed that counselors and therapists support equality for both women and men, Williams\textsuperscript{14} has documented that mental health professionals do possess sex biases and stereotypic attitudes similar to societal stereotypes, and these biases are both reflected and reinforced in the counseling and therapeutic relationship.

Hawley, Thomas and Stewart\textsuperscript{15} have researched stereotypic attitudes of clinicians, and report conclusive findings of the existence of a double standard of mental health among clinicians. These studies confirm the contentions regarding the sex bias of counselors and therapists.

\textsuperscript{13} Broverman, "Sex-Role Stereotypes and Clinical Judgments," pp. 6-7.


Dewey\textsuperscript{16} wrote: "Traditionally, the counseling profession has perpetuated society's stereotypes and myths through counselor bias." She also contended that sex-role stereotypes and sexist behavior have had the destructive effect of limiting the psychological development and potential contributions of women, and the existence of sexism in the counseling or therapeutic relationship implies a negative evaluation of women.

Seymour Halleck, in his book, \textit{The Politics of Therapy} expounded on psychiatry's attitudes toward women:

The writings and teachings of psychiatry have helped provide a rationale for keeping women in a subservient position. The founders of psychoanalysis saw women as basically masochistic and passive--as needing a certain degree of masculine domination in order to feel more comfortable and whole. Many outstanding psychiatrists still refer to women in terms of their needs for passivity, to be companions to men or to be mothers; little mention is made of their need to be active contributors to the larger society. A woman who enters psychotherapy will usually be exposed to a system of values that emphasizes the virtues of passivity; if she rejects these values her therapist may interpret her attitude as immature.\textsuperscript{17}

Foxley\textsuperscript{18} indicated that it is doubtful that those in the mental health professions have been able to evade


\textsuperscript{18} Foxley, \textit{Nonsexist Counseling}, pp. 21-38.
societal indoctrination which has perpetuated stereotypic roles and sexist attitudes; as they, also, have received the same sex-role socialization as their clients. Therefore, they, as representatives of society, are also subject to the pervasive influence of sex-role stereotypes, according to Foxley and these attitudes, values, expectations, and beliefs that are possessed by the professional will be influential in work with clients.

When discrimination occurs by the mental health profession, the behaviors are attributable to the kinds of people they are. Holroyd's contention is that one of the difficulties that confronts the helping professionals in attempting to change their attitudes is that they, as all humans, are victims of their attitudes.

Preconceived attitudes and beliefs play an unconscious part in making judgments about what is appropriate behavior for different groups of people; these prejudgments have an influence on the behavior of others, and these biases could conceivably have adverse consequences for the client population.

19 Ibid.

Recent studies have shown how much sex-role values impact the entire helping process. The widespread occurrence of sexist counseling has resulted from a belief in traditional sex-roles. Okun\textsuperscript{21} expressed the belief that when the mental health professional uses her or his own ideology, either covertly or overtly, sexist counseling may occur.

In their investigations on sex-role stereotyping, Violet Franks, Vasanti Burtle, Vivian Gornick, and Barbara Moran\textsuperscript{22} have found that counselors and therapists possess and impart sex biases through the therapeutic interview which is perceived by the female client as reinforcing and maintaining the stereotypic inferiority of women. There are significant data available that allow the assumption to be made that the higher the level of sex bias possessed by the counselor or therapist, the greater will these biases be reflected. Gilbert and Waldroop's\textsuperscript{23} research has shown that neither the sex, nor the age of the traditional professional is a variable; that is, both females and males


in varying ages reinforce and transmit these stereotypic images to the detrimental effect upon the client. The investigators demonstrated that it becomes quite evident that sex-role attitudes influence the practice of sex-fair counseling in both the goals and the process of the helping relationship.

Gardner's research has suggested that both counselor educators and counselors-in-training possess sex biases and stereotypic attitudes as have been found among mental health professionals and society at large, and they also, will reflect these attitudes in their counseling approaches.

Wells reflected:

Regardless of whether you are male or female therapists, it is likely that you carry sex-role values from your own upbringing which are reinforced by most contacts with our daily culture. Your professional training was almost certainly affected by beliefs held by your professors.

Acknowledgment, then, is given to the fact that mental health professionals, counselor educators, and counselors-in-training are as susceptible as the general public to sex-role stereotypic attitudes. The significant role of the helping relationship may be the unwitting basis

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for the deleterious reinforcement of sex bias.

An important consideration which would need to be addressed is the issue of the counselor educator who has the responsibility for providing the counselor trainees with the necessary information and training that will enable them to have a broader understanding and awareness of sexism and sex-role issues, as well as enable them to become non-sexist practitioners.

The importance of the education of the counselor-in-training was predicted almost twenty years ago when Kemp emphasized the counselor trainee's awareness of her/his personality dynamics and inner attitudes. Ten years later, additional significance was placed upon counselor education when Island proposed:

Graduate schools can--and counselor education programs must--provide the conditions in which students can see social, educational, political, psychological, and economic contradictions in the environment. Then, as an educated elite they may be able to act effectively against the oppressive elements they encounter.

As traditionally prescribed roles are no longer acceptable to women, their needs from the mental health profession require re-evaluation. The therapeutic encounter must increasingly address the issue of sex-role

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bias, since today's woman is more aware and sensitive to the bias of others, particularly the person from whom she is seeking help. The sexist attitudes that are transmitted in the therapeutic or counseling process have had considerable detrimental outcomes for the female client.

The National Advisory Council on Women's Educational Programs has charged that: "Counselor's theoretical underpinnings, the materials they use, and the culture in which they live, are all found to be sex biased." 28

Osmond, Franks, and Burtle 29 defined psychotherapy as a form of educational activity aimed at promoting psychological and social skills in people. In order to promote the psychological well-being of women, Fabrikant 30 postulated that the helping professions, (and then, eventually society) need to perceive women as healthy individuals, sharing equally with men.

In their publication, Sex Discrimination in


Guidance and Counseling, the National Advisory Council stated that sexism still reigns in the educating and counseling of men and women—and in the education of counselors. The American Psychological Association's Task Force on Sex Bias and Sex-Role Stereotyping identified four areas of sex bias in psychotherapy and counseling:

1. Fostering traditional sex roles,
2. Bias in expectations and devaluation of women,
3. Sexist use of psychoanalytic concepts, and
4. Responding to female clients as sex objects, including seduction.

The helping professions have the obligation to assess their own experiences, biases, and beliefs that pervade their attitudes and values. All members of counselor education faculties and members of the mental health professions are in a unique position to develop new directions in order to facilitate changes in restrictive stereotyping that has limited the individual potential of women.

Definition of Terms

This section will present definitions of the


principle terms of the dissertation.

**ATWS:** The Attitude Toward Women Scale (see p. 111).

**Client Systems:** That group of individuals who are the target population for the services rendered by mental health professionals (clients, patients), and counselor educators (students).

**Counselor Educator:** Faculty members who are involved in the graduate training of students in counseling programs.

**Counselors-in-Training:** Those individuals whose primary role is that of student in counseling at either the master's or doctoral level of graduate study.

**Feminist Therapy:** A therapy which does not adhere to a specific set of therapeutic techniques, but incorporates different schools of psychotherapy and counseling. Feminist therapy also incorporates the values of nonsexist therapy (see p. 21). The roots of feminist therapy are based on the concepts of social thinking provided by the women's movement, the allegations by women against sexist bias among psychotherapists, and the research on women that the feminist movement has brought to psychology. The values and assumptions of feminist therapy as classified by Rawlings and Carter\(^{33}\) are as follows:

1. The inferior status of women is due to their having less political and economic power than men.

2. A feminist therapist does not value an upper or a middle class client more than a working class client.

3. The primary source of women's pathology is social, not personal, external, not internal.

4. The focus on environmental stress as a major source of pathology is not used as an avenue of escape from individual responsibility.

5. Feminist therapy is opposed to personal adjustment to social conditions: the goal is social and political change.

6. Other women are not the enemy; men are not the enemy either.

7. Women must be economically and psychologically autonomous.

8. Relationships of friendship, love, and marriage should be equal in personal power.

9. Major differences between "appropriate" sex-role behaviors must disappear.

**Group Classification**: The particular group to which the subject belongs in its broadest definition, i.e., Mental Health Professional (psychiatrist, psychologist, social worker); Counselor Educator (faculty members); and Counselors-in-Training (master's and doctoral graduate students).
Mental Health Professional: Subjects identified as maintaining a private practice in counseling or psychotherapy (i.e., psychiatrist (M.D.), psychologist (Ph.D.), or social worker (M.S.W.).

Nonsexist Therapy: The following values and assumptions are incorporated and defined by the term nonsexist therapy: 34

1. The therapist is aware of her/his expectations for female-male behavior, she/he is aware of cultural values and discards those which are inconsistent with her/his values and a nonsexist philosophy.

2. The nonsexist therapist will help clients make decisions about their behavior based on what they want for themselves, and does not adhere to prescribed sex-role behaviors.

3. The nonsexist therapist does not feel that sex-role reversals are pathological, but is more concerned that people are able to work out behavioral styles and assignment of tasks satisfactorily.

4. Marriage, in nonsexist therapy, is not regarded as any better an outcome for a female than for a male.

5. The nonsexist therapist believes that the best emotional balance is achieved by a person, female or male, who has a blend of assertiveness and tenderness. In this

34 Ibid., pp. 54-58.
way, females are expected to be as autonomous and assertive as males, and males are expected to be as expressive and tender as females.

6. Nonsexist therapists reject theories of behavior which are based on anatomical differences.

Norms: Norms are ways of behaving which are typical for a group, and which reflect its attitudes about what is right and wrong, good and bad. Normative behavior is behavior which is within the limits that are defined as normal. Norms are also value judgments which have been implicitly agreed upon by that society, and serve as guidelines for the socialization of children.

PAQ-1: The first Personal Attributes Questionnaire (see p. 113).

PAQ-2. The second Personal Attributes Questionnaire (see p. 113).

Psychotherapy: The term is applied to the use of psychological techniques by trained persons to alleviate mental and emotional problems in daily living. It implies a personal consultation between a therapist and a client, and implicit in the practice of psychotherapy is the goal in the client, that is, change in behavior, attitudes, beliefs, feelings, approach to life, well being, and mental health. Subsumed under this title are all therapeutic approaches and theoretical orientations.

Sexism in Counseling: Sexist counselor behavior
is any behavior on the part of the counselor which only encourages the expression of feelings, thoughts, attitudes, and behaviors on the part of the client, (counselee) that are in line with traditional sex-role stereotypes, and who actively discourages non-sex-role feelings, thoughts, attitudes, and behaviors. Sexist counselor/therapist behavior may be overt or covert, i.e., verbal behavior which indicates approval or disapproval or non-verbal cues which give the same messages.

**Sexist Therapist:** A therapist who accepts the traditional and cultural definitions of women as being essential to an adequate sexual identity, and as the norms for mental health. The structure is based on a patriarchal model where women are encouraged to be helpless and dependent. In sexist therapy, the blame for women's problems is placed on intrapsychic factors, and solutions for these problems is an adjustment to the "status quo."

**Sexual Identity:** The total conception that people have of who they are. This includes all the beliefs that make up the individual's concept of "who I am." It includes the beliefs that people have about their worth as human beings, and beliefs that determine self-confidence and self-esteem.

**Stereotype:** A belief or attitude consistently held to be true by a person or a group of persons about a segment of the population with insufficient data to maintain the
validity or continuation of that belief or attitude.

**Subgroup:** That specific group to which the subject belongs, which is subsumed under one of the three group classifications, i.e., psychiatrist, psychologist, social worker (Mental Health Professional); Counselor Educators, (Educators); master's and doctoral students, (Counselors-in-Training).

**Theoretical Orientation:** The set of theories or constructs in counseling psychology which an individual accepts as explicating the nature of humankind, and influences the individual's mode of counseling or therapy.

**Delimitations of the Study**

The scope and focus of this investigation have been restricted by the following delimitations:

1. **Geographical Area:** The geographical area of this study has been specifically restricted to the Chicago metropolitan area for those subjects who comprised both the Mental Health Professional sample and the Counselors-in-Training sample. The subjects in the Counselor Educator sample were obtained from the faculties of various universities in the state of Illinois which offer graduate programs in counseling.

2. **Student Sample:** This investigation was delimited to only students in counseling or counseling psychology programs because one of the major foci of this
research targeted counselors-in-training, and did not purport to study students in any other programs.

3. Mental Health Professional: This classification was delimited to those individuals engaged in private practice; therefore, all school counselors were intentionally excluded.

**Limitations of the Study**

There were limitations of this research that the investigator was unable to control or neutralize. These limitations included:

1. The Voluntary Nature of the Sample: This precludes the ability to draw a true random sample from the population; therefore, generalizations based upon the results of this work should be viewed with caution. Replication of this study, if supportive of these findings would add validity to the generalized statements.

2. Lack of Laboratory Controls: Lacking laboratory controls, the actual effect of the environmental and social factors, although assumed to be neutralized, cannot be tested, nor eliminated with certainty.

3. Geographic Residence of Student Sample: Although the study was restricted to the metropolitan Chicago area, the permanent geographic area of the counselors-in-training could not be determined. If the students live in a different geographic area, but attend
graduate school in this area, it must be assumed that other geographic variables affect the results, the degree to which cannot be controlled or measured. In these cases, the assumption of randomization of environmental and social influences is invalidated.

**Summary and Overview of Remaining Chapters**

Chapter One presented an introduction to the problem, provided a statement of the problem, highlighted the purpose and objectives, rationale, and hypotheses of the study, as well as the delimitations and limitations of the research.

Chapter Two will develop relevant literature which establishes the research foundation for this study.

Chapter Three will present the methods and procedures of the study. For the purpose of presentation, the chapter will be divided into seven sections: restatement of the problem, description of the subjects, description of the procedure, statement of the null hypotheses, description of the variables, description of the research instrumentation, and treatment of the data.

Chapter Four will present the results of the statistical analyses of the data. The hypotheses-analyses-summary format will be used.

Chapter Five will consist of a presentation of the following:
1. restatement of the problem;
2. restatement of the null hypotheses;
3. a condensed statement of the methodology;
4. the results of the research;
5. conclusions; and
6. recommendations.
CHAPTER II

SURVEY OF LITERATURE

Personality Theory

Recent reviews of pertinent research suggest that there is an imbalance in concepts of personality theory. Personality theories, whether psychoanalytic, social learning, cognitive-developmental, or humanistic, have presented a universalistic, masculine view of personality.

The ancestry of the field of psychology of women is differential psychology, the study of individual difference in behavior. According to Hyde and Rosenberg\textsuperscript{35} the differences between females and males, both descriptively and theoretically have been the subject of scientific study for the last century.

Historically, the psychology of women, which includes psychodynamic processes and personality development, has its roots in three major theoretical paradigms, each proposing explanations of the female psyche. The three theories, psychodynamic, social learning, and cognitive-developmental, operate from vastly different assumptions

and provide different explanations as to the nature of female development and the acquisition of a sexual identity.

A cursory review of each of the theories is necessitated in order to establish the basic tenets of each theory in reference to the psychology of women.

Psychodynamic, Social Learning, and Cognitive-Developmental Theories

Psychodynamic theory has stressed the importance of penis envy on the part of the female, which leads to the Oedipal complex and is, in turn, never fully resolved. According to psychodynamic theory, characteristics of women, which are retained throughout life, are passivity, masochism, and an immature superego.

Social learning theory is based on the premise that female and male development run in parallel, and motivation for learning sex-role identity occurs at first by reinforcement from the mother, and secondly from others. Acquisition of further sex-typed behaviors come from imitation and observational learning.

Cognitive-developmental theory has as its underlying principle the idea that both the female and the male child acquire a concept of sex identity. The attachment to the same sex parent brings about modeling of sex-typed behaviors, this acquisition of sex identity is, then, largely
an intellectual cognition process.  

Psychodynamic theory, originating with Freud, was one of the first theories of psychology which attempted to add validity to the cultural myths and sex stereotypic attitudes surrounding the role and status of women, prevalent in Freud's time. Freudian and neo-Freudian theories continue to exert enormous influence on our understanding of personality dynamics. 

Both the theory of Freud, as well as the vocabulary, assume the male to be the prototype of humanity the female is understood in relationship to him. Carlson interpreted Freud's biological determinism theory of women as based on the dichotomy established between the cognitive and affective dimensions of human functioning, where the positive valuation of cognitive or rational behavior and the less positive or negative valuation of affective or sensual behavior paralleled the positive valuation of men over women. 

Freud's concepts of femininity portray women as defective (inferior to males), since they are born without a penis; motherhood, then, becomes a compensation for this defect.  

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36 Ibid., p. 47. 

deficiency. Shainess\textsuperscript{38} has documented Freud's position that women were naturally masochistic, and had weaker super-egos than men; women were considered neurotically sick (aggressive behavior being a symptom) who claimed to suffer from penis envy and masculine protest. Deckard's\textsuperscript{39} work reiterated Freud's concepts of women who resisted femininity, that is, feminine temperament, status, and role, as thought of as inviting neurosis, for as much as anatomy was her destiny, femininity was thought to be her fate.

One of Freud's disciples, Erik Erikson\textsuperscript{40} concluded that while women are biologically different than men, they are not necessarily inferior. He argued that the psychology of women was determined by their "productive inner space" (the womb), which conditions them to be nurturant. In contrast, men, because of their external genitalia, exploit and manipulate the world.

Weisstein\textsuperscript{41} has researched proponents of


\textsuperscript{40}Erik Erikson, "Inner and Outer Space: Reflections on Womanhood," \textit{Daedalus} 93 (1964): 582-606.

psychodynamic theories in regard to their views of the nature of women.

Bruno Bettelheim reported: "We must start with the realization that, as much as women want to be good scientists or engineers, they want first and foremost to be womanly companions to men and to be mothers."  

Erik Erikson explained:

Much of a young woman's identity is already defined in her kind of attractiveness and in the selectivity of her search for the man (or men) by whom she wishes to be sought . . . mature womanly fulfillment rests on the fact that woman's somatic design harbors an inner space designed to bear the offspring of chosen men, and with it, a biological, psychological, and ethical commitment to take care of infancy.  

Joseph Rheingold, a psychiatrist, viewed the acceptance of a woman's role by women as a solution to societal problems. He wrote:

Woman is nurturance, anatomy decrees the life of a woman. When women grow up without dread of their biological functions and without subversion by feminist doctrine, and therefore enter upon motherhood with a sense of fulfillment and altruist sentiment, we shall obtain the goal of a good life and a secure world in which we live.

The three theories, psychodynamic, social learning, and cognitive-developmental have marked distinctions.

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43 Erik Erikson, "Inner and Outer Space," p. 584.

Cognitive-developmental theory is seen as an intellectual, rational process, motivated by cognitive factors. In comparison, the motivations of social learning theory are pain-avoiding and reward-seeking, while psychodynamic theory adheres to the precepts of incest-sexual-motivations.

Both cognitive-developmental and social learning theory assert that female and male children actively seek to acquire sex-role identity, which is quite different from psychodynamic theory which views children, female and male, as passive recipients of anatomical determinants.

Hyde and Rosenberg have observed that there is more experimental evidence supporting social learning and cognitive-developmental theories, in regard to empirical verification of theories that support children actively seeking to acquire sex role identity, and the importance of social and cultural components of the development, than empirical studies supporting psychodynamic theory of sex-role identity development.

Developmental theorists, from Freud to modern role theorists, have given considerable attention to the observed sex differences between females and males in their behavior. Despite the long standing interest in sex differences, the male has been viewed as the normative model, and the female has been treated as a deviation from the norm. Major

45 Hyde and Rosenberg, Psychology of Women, p. 48.
theorists, whether female or male, have been affected by societal and cultural dominant masculine values; therefore, almost every major theory of human nature has been a theory of mankind. Heilbrun has declared that it has been the pattern to assume that with the understanding of men, the primary concern, women's behavior, could be predicted as a deviation from the normative male model. Heilbrun continues that the need to investigate women, their experiences, natures and perceptions were largely ignored because of the assumption of the automatic predictions of the behavior of women from the understanding of men.

The study of women had been rarely included as one of the topics that comprise the field of psychology. Of thirty-five introductory textbooks in social psychology published between 1940 and 1970, Watson found only one containing a full chapter on women.

The contention exists that theoreticians of personality have been clinicians and psychiatrists who have written the bulk of the literature on personality. The major support for their theories have been years of intensive clinical experience, rather than empirical evidence.


Weisstein\textsuperscript{48} has indicted the psychoanalytic tradition for not considering it necessary to have evidence in support of their theories. She has concluded that clinical psychological theories are not based on scientific evidence; empirical studies that do exist have ignored the different cultural expectation and social contexts for women and men.

As a discipline, the social sciences have been male oriented; this is demonstrated by the fact that empirical and experimental studies have dealt primarily with men. This limitation in psychology has excluded and ignored women; if female subjects were included, investigators ignored sex differences. Therefore, results could not be applicable to women. Daniels\textsuperscript{49} has concluded that the treatment of women has been as incomplete and neurotic versions of the male sex, which have been the theoretical basis of the dominant schools of psychology.

Writers have been cognizant of the extent to which culture sets and reinforces normal behaviors for deviance. D'Andrade and Kessler\textsuperscript{50} have studied women from an

\textsuperscript{48} Weisstein, "Fantasy World of the Male Psychologist," p. 360.


anthropological, cultural, and psychological point of view. D'Andrade pointed out that psychology tends to consider sex differences as differences in personal characteristics, while anthropology, on the other hand, generally conceives sex differences as social and cultural institutions.

The writings of Rawlings and Carter are in accord with the theory of sex differences as having socially and culturally based frame of references as opposed to theories in psychology which have as their foundation biological differences between females and males. The authors have concluded that both Erikson and Freud used data from observations, rather than empirical studies to substantiate their case histories. They have cited the fact that Erikson presented data to establish his theories based on observations of ten year old girls and boys. By this age, children have already been socialized into gender roles. Freud's views were also based on observations he made about his female patients. Neither Freud nor Erikson had any empirical, scientific substantiation for their hypotheses. In the case of Freud, observations of people who present themselves for therapy are not generalizable to normal nonpatient populations.

Weisstein drew the following conclusions:

While evidence is mounting that what a person does, and how a person feels, will be determined by the

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expectations and behavior of people in the environment, psychotherapists, clinical psychologists, and psychiatrists remain entrenched in biased and misogynist viewpoints.52

In this context, the psychoanalytic literature on female development has been accused of articulating myths about women through scientific language. Freud postulated a theory about females who believe themselves to be castrated, based on his mythical image of the female genitals as a wound. The scientifically sounding, immature superego, was contingent upon image of woman as sinful and depraved. De Beauvoir53 has concluded Freud simply translated females into castrated males; this phallocentrism is an example of the male-as-normative model.

The derogation of women in psychological and psychiatric literature has not been confined to male theoreticians and writers. Melanie Klein, Helen Deutsch, Maria Bonapart, and Mary Chadwick54 are some of the women writers who have contributed to antifemale psychiatric literature.

Helen Deutsch55 largely adhered to Freudian theory

52 Weisstein, "Psychology Constructs the Female," p. 71.


in her writing. Among her beliefs about the female personality were that (a) instinct and intuition are very important, and (b) in order to be a woman, one must develop a feminine core which included the traits of narcissism, masochism and passivity.

Despite the fact that Deutsch's books contained case histories to illustrate major tenets of the psychoanalytic view of women, she was considered more of an observer and analyst, than a theorist. She believed that female passivity was a result of anatomy and biological functioning, typical of psychodynamic theory. Hyde and Rosenberg\(^56\) were among critics of her work who commented that she had confused cultural and biological forces, and failed to recognize cultural assignments of the female role.

Psychologist Judith Bardwick\(^57\) has replicated many of the conceptions that have proven so damaging to women. Tennov\(^58\) also noted that Bardwick made frequent admissions that her assertions were hunches, guesses, or based on intuition, when she made pronouncements about what is "normal" or "abnormal."

The majority of psychotherapists, psychoanalysts,


and theorists, whether female or male, have accepted the stereotypical conceptions of their professional heritage. However, Miller has acknowledged those professionals who have emphasized cultural factors in female psychology.

Clara Thompson and Karen Horney are two examples of psychoanalysts who rejected Freud's biological explanation of feminine character in favor of socioculture theory. They contended that the psychological attributes Freud observed in women were not due to women's biological inferiority but represented the outcome of cultural prejudices against women and their inferior social status. In their opinion, penis envy was merely symbolic of women's envy of male prerogatives and privileges in society. Thompson and Horney explained the presence of such personality traits as passivity, masochism, and narcissism in terms of women's inferior social status, economic dependency on men, and the social inhibition of sexual and aggressive behavior, rather than accepting these traits as being innate in women.

Both Drs. Thompson and Horney opposed Freud's position which equated behavior with inherited innate qualities.


Two radically different phenomena, feminine biology and feminine status had been joined; through the inference that feminine status is the product of feminine biology, and therefore inevitable, rather than dependent on the social situation. The impression was conveyed that the status of women is merely what nature had planned for her.

Horney\textsuperscript{61} had pointed out that Freudian notions articulate the childish views boys have of girls, and that Freud's psychological theory of women had been phallocentric. Her chief disagreement with Freud concerned his notion that penis envy was the critical factor in female development.

Alfred Adler's contribution to the psychology of women as noted by Hyde and Rosenberg\textsuperscript{62} was his recognition that Freud has mistaken the reasonable female envy of the male's political and economic power to be female envy of the male anatomy. Tennov\textsuperscript{63} has claimed it is evident that the psychoanalytic orientation, which has dominated clinical psychology, psychiatry, and social work for decades, is one which views women as biological, intellectual, social and moral inferiors of men.

Women, in psychological theory have been


\textsuperscript{62}Hyde and Rosenberg, \textit{Psychology of Women}, p. 38.

\textsuperscript{63}Tennov, \textit{Psychotherapy}, pp. 200-225.
characterized as: inconsistent, emotionally unstable, lacking in a strong conscience or super ego, weaker, nurturant, rather than productive, and intuitive rather than intelligent. Hacker summarized the accepted psychological position of women when she reiterated societal expectations for women: "If they are at all normal, they know their place, which is in the home, where they are really quite lovable, happy, childlike, loving creatures." She concluded that this description adds up to a typical minority group stereotype of inferiority.

Weisstein extrapolated on the acceptance of sexist norms of our culture by psychologists and psychiatrists. She feels they have not seen beyond the superficial conception of female nature, and has argued that these fantasies of childish dependence and servitude lack any evidence to support the actual true potential of women. Dr. Weisstein places the accountability for these norms on clinicians, as she feels it is they who are responsible for limiting human potential through their disregard for the evidence that societal contexts have provided. In summary, she contends that until expectations and respect for both women and men are equal, psychology has nothing to offer but the reflections of prejudices.

Hyde and Rosenberg expressed goals for the study of the psychology of women, and the discovery of new phenomena that had formerly been ignored. They also questioned the many existing assumptions in the light of new research on the psychology of women.

Carlson has questioned: "How is it possible that psychology seems to have abandoned its central concern with the experience and behavior of the individual?" The relevance of personality theory becomes questionable when generalizations which seek to explain the behavior of humans, both women and men, is in terms of "man."

Shields has asserted that most personality theories are theories of men, and that it is incorrect to assume that the psychology of women exists as a separate specialty within the discipline of psychology.

If these personality theories are the rationale upon which the professionals base their theoretical orientation for helping clients, and if these theories raise serious questions as to their appropriateness for women, Doherty contends it then becomes necessary to question

67 Rae Carlson, "Understanding Women."
therapeutic and/or counseling methods and approaches which have their basis in these theories.

Concomitant with the growth of feminism, the role of the helping professions in relationship to women has received increased examination. Of late, the surge of interest in sex-role stereotypic attitudes has drawn increased attention to the appreciable part that sex bias may play in the therapeutic or counseling situation. The allegations and tentative evidence of sexist bias among mental health professionals have charged that the biased belief system of clinicians is the attributing factor that may seriously affect counseling efficacy. This, then, has become the impetus for looking at what has been excluded from the research and study of the psychology of women.

**Influence in Psychotherapy**

Rawlings and Carter⁷⁰ maintain the values of those in the helping professions profoundly effect the treatment of women in therapy and counseling. Influential sources of values and beliefs include: the personality theory adopted by the counselor/therapist (her/his view of human nature); the models of psychopathology (what problems should be treated); and the models of mental health (the goals of treatment).

Bart\textsuperscript{71} had stated that value-free psychotherapy is a myth. Halleck\textsuperscript{72} acknowledged that all systems of psychotherapy contain implicit value systems. Rosenthal\textsuperscript{73} demonstrated and confirmed that clients who were considered the most improved in therapy had adjusted their values to more closely adhere to those of their therapists/counselors. The clients who were not considered improved, showed greater differences in values than those of their therapist/counselor.

In addition, Rokeach maintained that value shifts were a crucial aspect of psychotherapy:

\ldots the aim of psychotherapy can be conceptualized, at least in part, as an attempt to bring about change or value reeducation in a client or patient. \ldots If therapy is to be successful, it surely must be manifested as changes or rearrangement of value priorities and as changes in the degree of integration of the client's or patient's value system.\textsuperscript{74}

The values and goals underlying the treatment process reflect what is considered normal by society; to this extent, therapy also reflects these standards, the same


pervasive sexist characteristics of society. Cox\textsuperscript{75} has stressed that just as women's sex role identities have been identified by men, psychotherapy and mental illness have also been defined by men, both in practice and theory.

Tennov\textsuperscript{76} has written that psychotherapy is a male enterprise, and the misogyny of the literature is carried over into practice. Although the majority of clients and patients are women, personality theory is still male oriented. Psychiatric writings exhibit male bias with the use of terms such as "man," and "mankind," rather than terms which refer to members of both sexes, as "person," or "people."

Psychotherapy for women has been viewed from a male point of view. It may seem understandable in this traditionally man's society; however, as it has been pointed out, the greatest number of clients are women, while the majority of therapists that are consulted are men. Osmond, Franks, and Burtle\textsuperscript{77} have drawn the following conclusion: If therapy is carried out primarily by men in a male-oriented society, therapy, as it now exists, may fail to take into account the special needs of women.


\textsuperscript{76}Tennov, \textit{Psychotherapy}, p. 208.

In a report in the APA Monitor in 1973, the data presented indicated that 76 percent of all psychologists, and 89 percent of all psychiatrists were male. The percentage of women social workers was high; however, very few women social workers conduct autonomous private practices. The following year, a report was published in the APA Monitor, indicating that of 27,530 APA members questioned, 76 percent of those designated as "service providers" (those who spend some proportion of their time in providing direct services) were male. These results clearly indicate that the majority of mental health professionals in private practice are male psychologists and professional psychiatrists, which demonstrates the disproportionate female representation among therapists.

Studies completed by Chesler have shown that the majority of psychiatrists and psychologists are middle-aged, married men, while social workers are predominantly female, younger, and in less well-paying positions. The male clinician has been said to be involved in a political institution that has taken a traditional view of women.


Much has been written about the values and techniques of psychotherapy. Psychotherapy has been defined as patriarchal (covertly and overtly), autocratic, as well as coercive. Freud (and women have always been the main consumers of psychotherapy from Freud's era onward) believed that the psychoanalyst-patient relationship must be that of a superior and a subordinate.

Psychotherapy and marriage have been classified as the two major socially approved institutions for white, middle class women. According to Chesler, both institutions provide a similar function for women, and that is, as vehicles for personal salvation. Whether in marriage, or in therapy, this is accomplished through an understanding, benevolent, male authority figure. For females, in our culture, not being married, or being unhappily married, is experienced as an illness. Therapy can hopefully cure this.

Both Fabrikant and Williams have observed that although therapists (middle class, middle-aged, married

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males) and women in therapy (white, educated, middle class, housewives and mothers) vary widely, they both have been socialized within the traditional female-male relationship model, and are likely to share the values and attitudes inherent in that model. Not only is this a female-male interaction, the therapist is perceived by the patient (woman) as being able to help her with her problems, through his knowledge, power, authority, and control. In this way, according to the authors, the therapeutic relationship is much like marriage, as women have been conditioned to value these attributes in the male. Fransella and Frost have reported that for most women, psychotherapy becomes their answer, as the therapist can become a surrogate father, husband, lover, or priest confessor for her. This role interaction is both complimentary and respectable, and Fabrikant's study suggested women state a preference for a male therapist.

Chesler maintains that in the course of psychotherapy, the patient (woman) is encouraged (directed) to talk by her traditional therapist, who is expected by her, or perceived by her, to be superior, and controlling. The

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85 In Fabrikant's study, 67 percent of the women had male therapists.

therapist's primary focus is to bring the patient to terms with her role as a female, to an admission and acceptance of her dependency, which substantiates his insensitivity to the objective facts of female oppression.

It has been this enforcement of traditional beliefs about the roles of women as well as the ways in which women's problems are dealt with by the mental health profession which has been responsible for the increasing numbers of women who seek help. Yet, Chesler[87] found that women continue to seek psychotherapy, for their unhappiness is very real. They enter therapy just as they enter marriage with a sense of urgency and despair, and are implicitly encouraged by clinicians to either blame themselves, or to take responsibility for their unhappiness in order to be cured. Fabrikant's[88] study reported reasons for women seeking therapy. It was shown that many women suffer from dissatisfaction either with the role of wife and mother, or from a conflict between this role and the strong desire for a life style of her own. He also found that male therapists thought that the majority of women could be fulfilled by being a wife and mother while female therapists disagreed. The results of Fabrikant's study suggest that women are in a predicament, as it is possible that the answers

[87] Ibid., pp. 362-392.
they seek will not be provided for in therapy.

Fabricant's 89 1974 study did support the conclusions of an earlier study in 1972 by Broverman and her colleagues. Data from the Broverman 90 study suggested that both female and male clinicians share a negative assessment of women, and women in treatment tend to be in twice as long as men. Evidence from Fabrikant's research provided conclusions that females in therapy are victimized by a social structure and therapeutic philosophy which keeps them dependent as long as possible. Fabrikant's results differed from the Broverman study in that Fabrikant had concluded that there were differences in the perceptions and attitudes toward women by female and male clinicians.

The American Psychological Association's Task Force on Sex Bias 91 investigation was precipitated due to findings of previous research. The primary purpose of this investigation was to examine sex bias and sex-role stereotyping in psychotherapeutic practice. The subjects of the study were women psychologists who were asked to respond to a questionnaire in regard to actual incidents and circumstances in psychotherapy with women clients who had identified sexist attitudes among clinicians with whom they

89 Ibid., pp. 83-111.
91 APA, "Task Force on Sex Bias," pp. 1169-1175.
had formerly been in treatment. Responses indicated the following areas of sexist behaviors which were held in common: fostering traditional sex roles; bias in expectations and devaluation of women; sexist use of psychoanalytic concepts; sexual exploitation of female clients; and viewing women as sex objects. The Task Force arrived at the conclusion that women in therapy were having alien values imposed upon them.

The accusation has been made by Wycoff\textsuperscript{92} that contemporary psychological theory and practices reflect and influence our societal, cultural, and political lack of understanding of women. Women who have exhibited the inability to adjust or to be contented with the traditional feminine roles have received emotionally cruel treatment. Female unhappiness has been viewed as well as treated as pathological; women have been considered deviate from their natural roles, by men who have ignored the oppressive conditions and criticisms of those roles.

Chesler\textsuperscript{93} has documented that the psychotherapeutic relationship becomes for most women one more power relationship in which they submit to a dominant authority figure. Many women, who had grievances against the social order, were considered to be and considered themselves to be


psychologically ill. Diagnosis by their therapists as described by Tennov\textsuperscript{94} interpreted their difficulties to be a cause of internal pathology, rather than a reaction to oppressive social forces.

Although the literature addresses itself largely to the bias of the male therapists, there exists a number of women who have considered themselves part of this unique elite. Heilbrun\textsuperscript{95} has attributed this, in part, to the lack of role models available to women. For some women, the adoption of the male role model has meant achieving success through the male model of achievement; and therefore, thinking of themselves as honorary males. To remain within the male establishment, echoing masculine theories, meant remaining biased against women. They have remained committed to the male club they have joined; and show an inability to identify with women. There is no need for them to rebel against the social structure set up by the male dominated culture. There also is no need to be dissatisfied with the female designated stereotypic culture, as for them, it is nonexistent. These women consider themselves exceptional.

These women who have opposed the tenets of the women's movement as not being applicable to them have been

\textsuperscript{94}Tennov, \textit{Psychotherapy}, p. 205.

\textsuperscript{95}Heilbrun, \textit{Reinventing Womanhood}, p. 107.
designated "Queen Bees" by Rawlings and Carter. They consider themselves to be very special as they have worked very hard to achieve their success, and it would be very threatening to them to advocate equality and nondiscriminatory policies for other women. It is the possession of their unique qualifications that the Queen Bee attributes to her success, and constant reinforcement of this idea is necessary for self-esteem.

Staines, Tavris, and Jayaratne have expounded upon the Queen Bee syndrome. The authors maintain that these women have rejected a major assumption underlying the women's movement, which is the premise that women's problems are external in origin. They are admittedly as uncomprehending of women's conditions as their male colleagues. Their attitudes consist of thinking that (a) women are either inferior to men, or (b) women are not motivated to succeed.

Insights gained in recent years in regard to psychotherapy as it affects women, have enabled critics to view therapy as reflecting and reinforcing traditional values, beliefs, and attitudes about women and their roles.

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Williams\textsuperscript{98} has affirmed that the most critical scrutiny has been by feminists, who have accused traditional therapy for women as failing to see the real problems of women, which are those inherent in their traditionally subservient and powerless roles.

The three major paradigms in personality theory, psychodynamic, social learning, and cognitive-developmental, although different in their assumptions of sexual identity and female development, have comparable views in reference to the psychology of women. These theories have as a basis, a masculine view of personality.

Since the proliferation of research on sex differences, and the appearance of textbooks devoted to the study of women, the psychology of women is becoming accepted as an academic entity. Nevertheless, Shield's\textsuperscript{99} claims there remains today, an almost universal ignorance of the psychology of women. Due to the emphasis of biological differences, the major theories were indifferent to the study of social sex roles and cultural concepts of feminine and masculine and according to the author, behavior had been defined, social forces were not recognized, and little meaningful research in female psychology was being conducted.

Psychoanalytic theory provided psychology with the

\textsuperscript{98}Williams, \textit{Psychology of Women}, pp. 82-88.

first comprehensive theoretical explanation of sex differences. Other major paradigms in their acceptance and respect aided in its assimilation. Sex difference theories and acceptance of social sex roles soon came to be perceived as an indication of one's mental health, as evidenced by Maccoby and Jacklin. 100

Present day refutations of the adequacy of the major theories, psychodynamic, social learning, and cognitive-developmental, have come to the recognition of researchers who have proclaimed the inadequacy of the psychological explanation of women's behavior and nature inherent in the basis of sex differences in personality.

Recently, the strict adherence to sex differences in personality theory has diminished, whether based on social learning orientations and/or cognitive styles. Questions pertaining to femininity, masculinity, and adaptation to sex roles have presented unexamined value problems relative to the counseling and therapeutic encounter with women. Two basic problems which are central to the psychology of women and to the issue of sexism in psychotherapy and counseling women are: (1) The question of values in psychotherapy, and (2) the therapist's or counselor's knowledge of the psychological processes in women.

100 Maccoby and Jacklin, Psychology of Sex Differences, pp. 32-41.
In reply to these problems, the APA Task Force on Sex Bias\(^{101}\) has made the recommendation that formal criterion and procedures are needed to evaluate the education and training of psychotherapists in the psychology of women, sexism in psychotherapy and counseling, and other related issues.

Williams\(^{102}\) attributes the growing awareness of the deleterious effect on women by sexist assumptions and biases, as the precipitating factor leading to the introduction of feminist values into counseling and psychotherapy with women.

Feminist therapy has attempted to provide the professional community with a guide to psychotherapeutic treatment which encourages women to develop as complete human beings. In feminist therapy, the word therapy as interpreted by Rawlings and Carter\(^{103}\) is used in a broad sense to connote not only symptom removal, but also the positive growth and development of full human functioning.

A primary goal of feminist therapy would be to help clients become aware of the historically traditional social context of their oppression as being the basis for their psychological problems. Feminist therapy emerged from

\(^{101}\)APA Task Force on Sex Bias.


\(^{103}\)Rawlings and Carter, Psychotherapy for Women, Chapter 1.
an identification with the humanistic movement in psychology. Williams\textsuperscript{104} has outlined the primary emphasis of feminist therapy: (1) individual growth; (2) awareness of one's feelings and their expression; (3) the defining and experiencing of goals for oneself, rather than pursuing goals defined by others as being valuable; and (4) self-nurturance, giving attention to the needs of oneself, as opposed to allowing oneself to always be influenced by the needs and expectations of others, due to fears of the consequences of another's displeasure or the loss of love from a significant other.

An important aspect of feminism is for a client to begin to see the extent to which external forces have shaped her behavior and are controlling the course of her life. Heilbrun\textsuperscript{105} is emphatic in stating that a woman (client) does not necessarily become a feminist herself, however, or adopt the value system of her therapist. She will probably continue in a conventional marriage, for example, but under different conditions, such as greater personal freedom and greater involvement in activities outside the home without feeling guilty. Under these circumstances, Yale\textsuperscript{106} highlighted the goal of feminist therapy as helping

\textsuperscript{104} Williams, \textit{Psychology of Women}, p. 78.
\textsuperscript{105} Heilbrun, \textit{Reinventing Womanhood}, p. 102.
the client grow into the whole person she can be and to have the kind of life which is fulfilling to her, within the context of her personal circumstances and the framework of society.

The Double Standard of Mental Health

The literature reveals that clinicians appear to propagate a double standard of mental health, which promotes a negative assessment of women. Broverman's\textsuperscript{107} data revealed that mental health professionals use different norms to define healthy women and healthy men. The mentally healthy adult female has been defined by the negation of the standards for the mentally healthy male (more submissive, passive, dependent, less objective, more easily influenced, more emotional, more susceptible to having their feelings hurt). The standards or attributes of the mentally healthy male, constitute the criteria for the mentally healthy adult, sex unspecified. Women, are seemingly caught in a double bind; how do they manifest traits considered healthy for a mentally healthy female and a mentally healthy adult simultaneously?

Concomitant with male domination in the therapeutic

relationship Barrett, Berg, Eaton, and Pemeroy\textsuperscript{108} have studied the employment of masculine criteria of mental health in the treatment of women. Whiteley\textsuperscript{109} reiterated that underlying these criteria is the implicit acceptance of the culturally prescribed feminine sex-role, as well as prescribed masculine sex-role ideals, which are viewed as more socially desirable than feminine ones. Research by Rice and Rice\textsuperscript{110} presented evidence that pathology in women has been interpreted by psychologists as dissatisfaction with the traditional feminine sex-role ideology. Women, who conform to the traditionally circumscribed roles are seen as more healthy than women who do not.

There are two basic models which have been used as a theoretical basis for pathology. The first is the mental illness model which is comprised of biologically based theories leading to causes of pathology within a person. The mental illness model (the medical model) as clarified by Rawlings and Carter sees clients as "victims of internal impulses which they should learn to master"


through psychotherapy."\(^{111}\) Insight, in psychodynamic psychotherapy assumes causation to lie within the patient. Tennov\(^{112}\) has expounded on traditional insight therapy conforming to a disease or medical model; in the psychotherapeutic encounter the client is considered to be a patient who is sick and pathology is of internal origin.

The second is the environmental model, consisting of socially based theories leading to sources of pathology within the environment. According to Szasz,\(^{113}\) the environmental model is concerned with a "problems in living" approach. Advocates of the medical model encourage women to think of their anger and unhappiness as an emotional illness. In this way, those therapists and counselors who subscribe to this model are able to exert social control of women, for this reinforces the existing power structure, and social contexts are ignored. Lundberg and Franham\(^{114}\) have indicated that the rebellion of women against restrictive and stultifying roles is dismissed by proponents of this model as a projection of woman's personal inadequacies and further proof of illness.


Brown\textsuperscript{115} has concluded that the implications of the medical model for pathology are particularly harmful for women since the labelling of women as mentally ill, results in women becoming societal scapegoats, and the roots of their oppression remain unexamined. The major difference between this model and the environmental model is that in the environmental model the individual is encouraged to function with responsibility for her/himself, and pathology is viewed as having external origins.

Three standards of mental health, which have defined treatment that women have received in therapy are: The normative, the androcentric, and the androgynous model of mental health.

The normative model of mental health has as its basis, the definition of behavior for women and men according to the sex-role prescriptions designed by societal standards. This model implies a double standard of mental health for women and men, since cultural role prescriptions for women and men are different.

The counseling readiness scale, a subscale of the Adjective Check List\textsuperscript{116} (which was empirically derived) demonstrates an existing double standard of mental health. Women who did see themselves in need of counseling used


\textsuperscript{116}Harrison Gough and Alfred Heilbrun, Jr., \textit{The Adjective Check List Manual} (Palo Alto, Calif.: Consulting Psychologists, 1965).
such self-descriptive adjectives as: assertive, dignified, enterprising, independent, individualistic, intelligent, serious, and thorough, to name a few. Although these adjectives appear to describe a person who would feel equal in status with others, they are not descriptions of the cultural stereotype for women. Therefore Gough and Heilbrun\textsuperscript{117} concluded women who describe themselves in this manner, fail to fit societal expectations and would perceive themselves as emotionally unsound.

The self-descriptions of women who did not see themselves in need of therapy indicated items such as: energetic, honest, jolly, patient, peaceable, slow, sociable, suggestive, trusting, wholesome. These items were considered appropriate in terms of the sex-role stereotype for women; yet the list is more suggestive of a person with childlike qualities.

The widely quoted study of Braverman\textsuperscript{118} and her associates has provided data that most psychotherapists operate on a double standard of mental health for women and men. The subjects of the study were seventy-nine actively functioning clinicians (33 women and 46 men) who were sent a 122-item questionnaire, with one of three sets of instructions: describe a healthy, mature, socially

\textsuperscript{117}Ibid., p. 9.

\textsuperscript{118}Braverman, "Sex-Role Stereotypes and Clinical Judgments," pp. 1-7.
competent (a) adult, sex unspecified, (b) man, and (c) woman.

This investigation hypothesized that (a) clinical judgments about the characteristics of healthy individuals would differ as a function of the sex of the person judged, and (b) behaviors judged healthy for an adult, sex unspecified, which are presumed to reflect an ideal standard of mental health, would resemble behaviors judged healthy for men, but differ from behaviors judged healthy for women.

Both hypotheses were confirmed. The judgments of healthy women, according to the investigators, seemed to be an "unusual way of describing mature, healthy individuals." The results of their investigation did confirm that there is a double standard of mental health in existence by both female and male psychotherapists; that is, the general standard of mental health is applied only to men.

It had been suggested by Broverman et al.\(^{119}\) that the acceptance of an adjustment notion of mental health is the basis for the double standard. This means that women must conform to behavioral norms for the culture feminine sex role, regardless of the fact that they are less socially desirable and less healthy by generalized adult standards. Keller\(^{120}\) observed that the treatment of women is geared

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\(^{119}\) Ibid., pp. 5-6.

toward improving women's capacity to live up to the cultural definition of mental health, rather than challenging them.

The second model of mental health is the andro-centric, or male-centered model, which is a single model of mental health for both sexes, the male model. Block's work suggested that possessing the traits of a healthy man is considered beneficial for career women; and these women are not considered emotionally disturbed, although psychotherapists do consider them neurotic.

In their research, Rawlings and Carter found that feminists have rejected the androcentric model as, they result the bias in society that has interpreted masculine associated activities and traits as superior and denigrates whatever is feminine; they do not feel this leads to enhanced mental health in women or men. In discussing the feminist point of healthy behavior, Silveria has made the inquiry:

Where is the ability to interact positively with others? Where is gentleness, love, awareness of others, the ability to express feelings, empathy? ... I am saying that a major version of mental health, advanced by psychology for years reveals a lack of understanding


122 Rawlings and Carter, Psychotherapy for Women, p. 27.
of what makes for a full and human life. 123

The third model of mental health is the androgynous model. The basis is one in which women and men possess the best of both female-associated and male-associated characteristics and are not restricted by societal role prescriptions, nor valuation dependent upon one's gender.

The double standard of mental health clearly reflects role typing and sexual stereotypes. In summary, it holds the criteria for judging normal or abnormal, as well as different behaviors for women and men. The norm for healthy adults are the male traits which are more highly valued in this society. Women are faced with a dilemma: if feminine, by definition of the double standard, she is negatively valued due to her traits; if masculine, the behavioral norms assigned to her sex are violated, and she is seen as a deviate. The identification of this double standard is largely attributable to concepts held by both society and the mental health professions and tend to become perpetuated.

**Sex-Role Stereotyping**

The terms "sex-roles" and "gender-traits" have been used to refer to the patterns of behavior in which females

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and males have been socialized (sometimes encouraged and in other cases coerced) into adopting. Vetterling-Braggin, Elliston, and English\textsuperscript{124} have identified these behaviors as ranging from "sex-appropriate" personalities and extending to interests and professions. Boys get rewards for developing the accepted masculine characteristics, while girls undergo training to be feminine.

The question has been raised: Is there anything wrong with sex-role stereotyping? The most basic objection to sex-role assignments as discussed by Trebilcot\textsuperscript{125} is that sex-roles limit the personal freedom to develop any personality or interests that one chooses. If one would try to justify sex-role stereotyping, one would not only need to prove that some definite social purpose has been served (such as producing happiness, efficiency, or stability), but also that these results provide more valuable benefits than the freedom that has been lost. Vetterling-Braggin et al.,\textsuperscript{126} maintain that on the basis of this approach, sex roles can be considered wrong, unless the happiness produced by them outweighs the happiness lost.


\textsuperscript{126}Vetterling-Braggin et al., Feminism and Philosophy, p. 40.
Justification for the acceptance of sex-roles has been rejected by philosophers, namely, John Rawls. According to Rawls\textsuperscript{127} theory, the loss of basic liberty or equal opportunity cannot be compensated for, not even by any amount of efficiency or happiness.

The roles of women, and "women's place" in our culture has been socially defined. A particular belief system has been set up which determines not only their nature, but also appropriate behavior. In order to understand why people, and especially women, act as they do, it is necessary to know how they see themselves, and how they ascribe to a particular social framework.

Fransella and Frost\textsuperscript{128} adhere to the premise that women share common understandings, which are implicit, as well as external roles which have been imposed on them. The qualities of the groups to which they belong are self-assigned; it has been surmised that they want to do what is expected of them, as socially recognized goals are valued. Basic reasons have been cited by Fransella and Frost\textsuperscript{129} as preventing women from seeing new possibilities for their lives. Evidently these basic assumptions that are made about women's roles are not explicitly verbalized.


\textsuperscript{129} Ibid., pp. 174-205.
Therefore, it is exceedingly difficult to question norms which have not been articulated.

Another problem that has prevented women from changing basic ways of looking at things is the structure of society. Society has been organized according to a particular set of beliefs. The majority of people act in accordance with society's belief system; not only is it difficult to see things in another way, it is more difficult to behave differently. The authors concluded that in order to change basic ways of looking at things, the structure of society would need changing.

The "sex-role system" has been attacked by feminists who feel that assigned and restricted roles for females and males are the basis for oppression of women. Papachristou\textsuperscript{130} has credited the categorization of women as an inferior class, based upon their sex, as providing the impetus for revision of the institutions that have reinforced the sex-role system.

For some, the accountability for women's identity has been placed on women, rather than ascribing the responsibility solely to roles set by society. Sharma has stated:

Women's destiny is not just to be attractive, to be able to find a smart, rich husband, and to be a good housewife and mother. She can be all of these if she chooses to be. But first and foremost she is a person, and she should be treated like one. As a person,

she also has the responsibility to acquire maximum potential and self-actualization. The process of defining herself and her identity is her own responsibility and should not be exclusively dictated by society and its expectations, although society can set some guidelines.131

Another consequence of standards of sex-roles is the designation of certain expectations for women in regard to success, which results in a double bind. Horner's132 study revealed results that women worry about both failure and success in achievement orientated situations. If a woman fails, she is not living up to her own standards of performance; yet, if she is successful, she is not living up to societal expectations about the female role. Men in our society do not experience the kind of ambivalence that women do; they are encouraged (not only permitted) to succeed. Horner did conclude that some legal and educational barriers have been removed in recent years, but it is still clear that psychological barriers to women in terms of success and achievement remain.

Bem and Bem133 examined the "unconscious ideology"


of the nature of the female sex. This is an ideology which results in construction of the emerging self-image as well as aspirations of the female child from the very beginning. Their scrutiny of the concept of mental health which has been distorted by the culture's sex-role stereotypes was in agreement with the well known and much quoted Broverman study. The Bem and Bem research also revealed that our own profession of psychology has different concepts for mental health for women and men. According to their investigation, clinicians stated that a woman is to be regarded as healthier and more mature if she is: more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more susceptible to hurt feelings, more emotional, more conceited about her appearance, less objective and more antagonistic toward math and science. Yet, this was the same description which the clinicians used to characterize an unhealthy immature man or an unhealthy immature adult (sex unspecified). The conclusions of the Bem investigation summarily equated the mature woman with the immature adult.

In summarizing their implications, the Bems's position is that society has dictated and controlled choices for women. If women aspire toward challenging and fulfilling careers and professions, the traits needed are the

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positive ones which have been assigned to men. If a woman possesses the same traits, because she is a woman, she elicits disapproval. Her motivation has been controlled by society's sex-role ideology. Her so-called freedom consists of two options: (1) succeed and have her femininity questioned; or (2) behave in the prescribed feminine manner, and accept the secondary class status as an adult and as a professional.

Scarf\(^{135}\) has held that an adverse aspect of the designated sex-roles females and males are taught from the moment of birth onward, is that in our culture girls and women are expected to show higher dependency needs than boys and men. The significant and pervasive effect of needing approval from others will exist throughout womanhood; whereby being female has the connotation of never being encouraged to become a self-sufficient individual. The "normally feminine, normally dependent" woman has no independent sense of self. Her feelings of worth, esteem and well-being occur only to the extent she feels liked/loved/significant to someone else. If she feels a sense of failure in an interpersonal relationship, she then equates this with being a total failure. The ensuing outcome is depression. The loss of the significant other, whom she has vitally depended on, becomes transformed into something

that can be viewed as pathological, a clinical depressive illness.

Evidence from studies done by Scarf\footnote{Ibid., pp. 44-54.} have indicated that more women than men enter psychological treatment as women are more depressed than men. The data revealed that two to five times as many women as men are likely to be diagnosed as depressed. The reasons given are:

1. Women, consistent with standard cultural ideals of femininity, assume "sex-appropriate behavior," i.e., the sick and dependent role when under stress; and

2. Being "feminine" requires going to the doctor, which seems to be the particular societal way to cope (60 percent of all patient visits are female).

Unfortunately, the women are too readily given medication, either tranquilizers and/or anti-depressants. The use of medically prescribed, mood-altering drugs is a very widespread phenomenon, and the majority of those using them (70 percent) are women. When asked his view on the use of psychoactive drugs in treating depression, Dr. Silvano Arieti,\footnote{Silvano Arieti, "Roots of Depression: The Power of the Dominant Other," \textit{Psychology Today} 12 (1979).} a psychiatrist, stated that many drugs are able to alter the proper functions of the nervous system. However, a biochemical substance has prevented the organism
from feeling the depression; the circumstances have not changed, and the person is not given the chance to work her way out of the depression.

Since our social institutions rest on the basic assumptions that women not only are restricted, but should be restricted to particular traditional roles, Sharma\textsuperscript{138}\ asserted changes that are attempted by women are subject to the stereotypical constraints of society.

The literature reveals that sex-stereotypes do exist, in terms of personality characteristics and role expectations. Data have also shown that many women have expressed anger in regard to these mandated roles. Fransella and Frost\textsuperscript{139} have raised the question: It therefore seems reasonable to ask why don't women give up these stereotypic expectations of themselves?

Conclusive evidence has shown that women have colluded with these stereotypic images of themselves. Brown, Cox, and Williams\textsuperscript{140} concur that women have accepted traditional sex biases about women; social roles, personality stereotypes, self-images, and cultural tradition have been

\begin{itemize}
  \item \textsuperscript{138}Sharma, "Continuing Education and Counseling for Women," p. 102.
  \item \textsuperscript{139}Fransella and Frost, On Being a Woman, pp. 195-205.
  \item \textsuperscript{140}Brown, Radical Psychology, pp. 2-18; Cox, Female Psychology, pp. 303-316; Williams, Psychology of Women, pp. 190-210.
\end{itemize}
organized to make stereotypes seems reasonable and justifiable.

Mental Health Professionals

Although counselors and clinicians have been exposed to the problems concerned with sex-role stereotyping and sexism both in the media and professional literature, Foxley's research is indicating that there has been no change in behavior or attitudes toward clients due to this awareness.

Empirical evidence accumulated in 1970 by the Broverman investigation demonstrated that women and men were perceived as differing in personality characteristics by both women and men social workers, psychologists, and psychiatrists. In reviewing that data, Foushee, Helmreich, and Spence noted that clinicians are neither immune to the exaggerated stereotypes of society, nor are they necessarily perfect judges of the perceptions of others.

The 1974 study of Fabrikant reported that male therapists rated 70 percent of the female attributes as

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141 Foxley, Nonsexist Counseling, p. 277.


negative, and 71 percent of male attributes as positive. Women therapists' ratings for attributes of females were 68 percent negative; whereas, their ratings for males were 67 percent positive.

On the basis of 1978 study Hayes and Walleat concluded that female and male clients who have similar problems, are seen as possessing different stereotypic personality attributes and traits, by counselors of both sexes. For example, males who were rated as more dominant were considered to be less in need of therapy or counseling than females, who when rated as dominant, were considered to be more in need of therapy or counseling. There was agreement between both female and male counselors on these observations. These perceptions were unaffected by the sex of the rater.

Thomas and Stewart investigated whether secondary school counselors respond more positively to female clients with stereotypically traditionally feminine (conforming) goals than those with stereotypically masculine (deviate) goals. Audiotapes of high school girls were presented to 64 practicing counselors. The responses were analyzed according to the sex of the counselor. The findings


146 Thomas and Stewart, "Counselor Responses to Female Clients," p. 352.
reported that:

1. Female counselors gave higher acceptance scores to both deviate and conforming clients than male counselors;
2. Counselors, regardless of sex, rated conforming goals as more appropriate than deviate; and
3. Counselors, regardless of sex, rated female clients with deviate career goals to be more in need of counseling than those with conforming goals.\textsuperscript{147}

Numerous studies have indicated that females and males in the helping professions do not differ in their tendencies to stereotype by sex; it is this evidence, along with the institutional and social barriers that have impeded the growth of women.

Regardless of the fact that no single research study has shown conclusively that sexism in therapy is prevalent, the cumulative data do support this viewpoint. Foxley\textsuperscript{148} has been adamant in pointing out that it is not enough to dismiss these investigations by conceding that mental health professionals, as counselor educators, and counselor trainees have been reared and educated in a society which has not only encouraged, but has perpetuated stereotyped roles for girls and women, boys and men, as the evidence of sex-role stereotyping among the helping professions is too alarming.

\textbf{Counselor Educators}

Graduate training programs in counseling would

\textsuperscript{147} Ibid., p. 353.
\textsuperscript{148} Foxley, \textit{Nonsexist Counseling}, p. 31.
appear to be a sound modality for the exposing and working through of sexist activity and sex-role stereotyping during the process in which the counselor-in-training develops his/her professional identity. Toward this end, the counselor educator has a pivotal role. Yet, it appears that counselor educators have not perceived sex stereotyping as a relevant issue. The literature is essentially void of publications by counselor educators in support of the inclusion of some form of training for prospective counselors which addresses the issue of sex bias in the counselor/client interview.

The most well-known personality theories and counseling theories are taught in counselor education programs as core courses. Yet, feminist or nonsexist theoretical approaches have yet to be included in counselor curricula programs.

The lack of literature involving sex-role stereotyping and stereotypic attitudes among counselor educators, suggests that there are few opportunities provided the counselor-in-training to explore her/his own biases; to study formally the alternative therapeutic modalities for women, or to use the university environment as a vehicle to greater awareness of gender issues. It has been suggested by Foxley\textsuperscript{149} that the same traditional views of women and men and their roles and status in society, are

\textsuperscript{149}Ibid., pp. 30-34.
promulgated in the educational institutions without abatement.

The nucleus of the mental health delivery system is the training and education of persons who will ultimately join their established colleagues. The counselor educator has enormous accountability and responsibility in providing students with a broad based, yet comprehensive educational experience. It appears that this comprehensive training is lacking, since the entire area of the new psychology of women has been virtually ignored by the educators.

Counselor educators, because of their important role in the training of counselors, need to be aware of their own biases and stereotypic attitudes. Among their recommendations for further research, Hayes and Walleat suggested areas to be addressed. Salient questions to be studied are:

1. Do counselor educators support a double standard of mental health for women and men?

2. Do counselor educators possess the traditional views of the status and role of women, as the literature has charged as being true of mental health professionals?

3. Do counselor educators transmit their biases and values to students through their teaching techniques?

4. Why is it that counselor educators generally

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have not recommended courses which focus on and address the issues of sex bias in the helping relationship?

5. Why is it that specific personality theories of women are not taught in graduate programs, whereas traditional theories are exposed to students?

Counselors-in-Training

In a replication of a previous study, Hawley\textsuperscript{151} found that there is a significant relationship existing between careers women choose and their beliefs regarding men's views of the feminine ideal. This investigation compared female counselors-in-training with female teachers-in-training; Hawley's research suggested that the female counselors-in-training allowed a wider range of educational and career choices than the teachers-in-training who adhered to a more traditional, stereotypic view of women's careers.

Pietrofesa and Schlossberg\textsuperscript{152} tested the hypothesis that counselors were biased against women entering a traditional stereotypic masculine occupation. The subjects for the study were counselor trainees enrolled in a counseling practicum. The group consisted of 13 females and 16 males (N=29). Subjects interviewed a coached female counselee

\textsuperscript{151}Hawley, "Perceptions of Male Models of Femininity Related to Career Choice," pp. 308-313.

\textsuperscript{152}John J. Pietrotesa and Nancy K. Schlossberg, Counselor Bias and the Female Occupational Role (Detroit: Wayne State University, 1970) ERIC Documents CG 006056.
who was trying to decide between a "masculine" and a "feminine" occupation. Each interview was taped; the tapes were then reviewed and tabulated as to their bias. A biased or prejudicial statement on the part of the counselor trainee included any statement or rejection, positive or negative bias in regard to the counselor's expressed interest in career choice.

The following conclusions were drawn by the researchers:

1. Counselors display more bias against females entering a so-called "masculine" occupation than for females entering a so-called "feminine" occupation.

2. Female counselors display as much bias against females as male counselors.

Content analysis of bias statements indicate that major stress is placed upon the "masculinity" of the occupation.

Pietrofesa and Schlossberg\textsuperscript{153} indicated that the results of the study strongly reinforce the conclusion that counselors-in-training are biased against women entering masculine fields. Female counselors-in-training were found to display as much bias as male counselors-in-training.

The research by Pietrofesa and Schlossberg, Thomas

\textsuperscript{153}Ibid., p. 2.
and Stewart, and Hawley\textsuperscript{154} has shown that counselors, both female and male, have biases about female counselees. An early publication in the literature by Westervelt\textsuperscript{155} focused on the need for counselor education programs to accept counselor bias as a fact and help counselors-in-training bring biased feelings into the open in order to become aware of their harmful effect in human encounters.

Westervelt\textsuperscript{156} emphasized the importance of the counseling practicum or internship experiences for counselor trainees as the opportune time to identify, understand, work with, and gain insights into psycho-social sex differences.

Maslin and Davis\textsuperscript{157} conducted a study on counselors-in-training in order to examine whether female and male counselor trainees differ in the attributes of behavioral characteristics they assign to healthy and competent persons.

The subjects for this study were 90 counselors-

\textsuperscript{154}Pietrofesa and Schlossberg, "Counselor Bias;" Thomas and Stewart, "Counselor Responses;" and Hawley, "Perceptions of Femininity."


\textsuperscript{156}Ibid., pp. 26-28.

\textsuperscript{157}Audrey Maslin and Jerry L. Davis, "Sex-Role Stereotyping as a Factor in Mental Health Standards Among Counselors-in-Training," \textit{Journal of Counseling Psychology} 22 (March 1975): 87-91.
in-training, 45 females and 45 males, who were selected randomly from full time graduate students in programs in counseling. Of this sample, 22 were doctoral students and 68 were in a master's program.

The instrumentation used was a shortened version of Rosenkrantz' Sex-Role Stereotyped Questionnaire. The results of this study confirmed the research findings cited by Broverman that mental health clinicians were in accord with societal stereotypes regardless of sex. Females and males agreed that mentally healthy adults and mentally healthy males were approximately the same in degree of stereotypic masculinity-femininity perceptions.

However, this research found (unlike the previous research), that females and males disagreed in their expectations of the mentally healthy female. Females expected a mentally healthy female to be approximately the same as the sample's standard for mentally healthy males and mentally healthy adults, whereas males expected a healthy female to be more stereotypically feminine. There was a clear difference between female and male expectations of females. The results of this suggest that stereotypic expectations of females are held more by male counselors-in-training than by female counselors-in-training.


By way of explanation, Maslin and Davis\(^{160}\) attribute the difference in findings to the effect of the feminist movement upon women and men. In other words, the increased attention and support of the women's movement in the last few years has had an effect on the stereotypic images women held about the mentally healthy woman, but men still sustain these stereotypes to some degree.

One of the recommendations of the American Psychological Association Task Force on Sex Bias\(^ {161}\) was in relationship to the training and educating of future counselors. The problem stated was the values and beliefs of counselors as the core of sex bias in the counseling relationship.

Since this time, and regardless of the need for counselor education programs to include training on the issues of sex-role stereotyping in the helping relationship, Kenworthy, Koufas, and Sherman\(^ {162}\) noted that few graduate programs have provided instruction or enlightenment in this area of study.

Gilbert and Waldroop\(^ {163}\) conducted research to test the effectiveness of an experimental counseling course.

\(^{160}\) Maslin and Davis, "Sex-Role Stereotyping."

\(^{161}\) APA Task Force on Sex Bias, pp. 1169-1175.


designed specifically to increase sex-fair counseling. In this study, 25 volunteer students were randomly assigned to either a treatment or control section of the course in individual counseling.

Prior to the class, all subjects completed questionnaires; the only measure experimentally used was the Attitudes Toward Women Scale. After the completion of the course, the same instrument was again filled out. Additional measures utilized were videotaped vignettes, depicting the sex-role stereotyping of female clients, according to the four areas of perceived sex bias identified by the APA Task Force:

1. fostering traditional sex roles
2. bias in expectations and devaluation of women
3. sexist use of psychoanalytic concepts
4. responding to women as sex objects.

The findings of this study as summarized by Gilbert and Waldroop clearly indicated that training procedures designed to increase sex-fair counseling can be effective. There were, however, gender differences in the findings. There was a tendency on the part of the males in the study

165 APA Task Force, "Sex Bias," p. 1172.
to support role expansion of women (i.e., the fulfillment of traditionally appropriate female roles before pursuing nontraditional roles), more than role transcendence (i.e., the pursuit of nontraditionally appropriate female roles without prior fulfillment of traditional roles). This tendency is consistent with other research on males' reaction to the changing roles of women.

The investigators concluded their discussion with the awareness that this particular training procedure, although effective in changing the attitudes of students toward the role of women, as well as increasing their awareness and sensitivity to sex bias (in videotaped counseling vignettes), was only a first step; and suggested that future research in this area is still needed.

Additional research has been completed, utilizing college populations, other than the counselors-in-training samples, in order to assess stereotypic perceptions of the women and men within this approximate age distribution. It has been hypothesized that the younger women and men may have different perceptions of women, due to their exposure to the women's movement.

The 1968 research of Rosenkrantz\(^\text{167}\) which studied the extent to which sex-role stereotypes influence the self-concepts of women and men revealed that both college women

\(^{167}\)Rosenkrantz, "Sex Role Stereotypes and Self-Concepts," p. 293.
and men are in agreement as to clearly defined sex-role stereotypes for women and men. The results also indicated that the behaviors which are stereotypically associated with masculinity are more socially desirable than those associated with femininity.

The Broverman experiment was replicated again in 1973 by Nowacki and Poe\textsuperscript{168} who conducted their research with psychology students. Here also there were significant discrepancies among women and men in their ratings of the attributes of the mentally healthy female and the mentally healthy male. The authors maintain that further research is needed in this area to determine the extent of stereotypic discrimination. They have also suggested that forthcoming studies include counselor educators in an attempt to discover if there is a prevalence of sex-role stereotyping among the instructors of counselor trainees. In this way, if such attitudes are found to be pervasive, effective ways of eliminating sex bias can be encompassed in counselor training programs, and into faculty in-service workshops.

There has been little specific research designed to investigate whether or not sex-role stereotyping exists among students in counselor education programs and the need

exists for research to focus on the investigation of a possible relationship between attitudes toward women and sex-role orientation among students in counselor education programs as they currently exist in universities today.

**Research on Sex-Stereotypic Attitudes**

One of the most frequently used psychometric instruments in the research literature on attitudes toward women is the Sex-Role Stereotype Questionnaire (SRSQ) developed by Rosenkrantz, Vogel, Bee, Broverman and Broverman.¹⁶⁹

Much of the work of Rosenkrantz et al. has been previously cited in the survey of literature. The usefulness of the SRSQ has been amply demonstrated. However, as Spence, Helmreich and Stapp¹⁷⁰ have pointed out, the instrument, with its 122 items, each with a 60 point response range is cumbersome to administer and score.

To minimize these disadvantages, a shorter version of the SRSQ in terms of the number of items and a much smaller response range was desired. Beginning with the original 122 items of the SRSQ plus an additional 16 items added by the authors, the Personal Attributes Questionnaire (PAQ) was developed. The PAQ is a 55-item questionnaire


which retains the data gathering power of the original SRSQ while simplifying the administration and scoring of the instrument. For most research uses that require the use of a Sex-Role Stereotype Questionnaire, the PAQ and the SRSQ are interchangeable.

Spence, Helmreich and Stapp\textsuperscript{171} administered the PAQ to 248 male and 282 female students who attended the University of Texas at Austin. The authors were investigating the following assumptions: that both male and female subjects, when asked to rate the characteristics of the mentally healthy male and the mentally healthy female would rate them differently and that the characteristics of the healthy adult sex unspecified would parallel the ratings given by the subjects for the mentally healthy adult male.

Analysis of the data produced some interesting implications. The data suggested that the mean stereotype scores of the males was significantly higher than that for the females (p<.01). The data also suggested that both men and women tended to rate themselves in the same stereotypic direction that they rated the mentally healthy adult male and female. The final implication of the data was that both men and women, when asked to rate the characteristics of the ideal female and male, attributed to both sexes those characteristics previously stereotypically attributed to the mentally healthy adult male. In other

\textsuperscript{171}Ibid., p. 17.
words, the characteristics attributed to the healthy adult male were seen as more desirable than those characteristics attributed to the healthy adult female.

This research was replicated in the spring of 1974 using a sample of 56 men and 108 women. The findings of this study supported the results of the previous investigation.

One of the objectives of this research is to determine if a double standard of mental health, defined as significant differences in the attributed characteristics of the mentally healthy adult male and the mentally healthy adult female with the adult male characteristics being the more desirable, exists. The PAQ has demonstrated its ability to garner such data as indicated in the work of Spence, Helmreich and Stapp. Based on this research, this author has selected the PAQ as one of the two instruments to be used in this research. It provides the necessary data to address several of the hypotheses of this study.

The second instrument selected by this author for this research is the Attitude Toward Women Scale (ATW) developed by Spence and Helmreich. This instrument was designed to determine if women and men perceive the

characteristics of females differently. At the time of the development of the ATW there was an absence of standardized, psychometrically sound instruments for surveying the attitudes which members of society have about the role of women.

Gilbert and Waldroop\textsuperscript{173} in their research concerning sex-fair counseling used the ATW to gather their data. The results of this study suggest that among counselors, differences in sex-role stereotypic attitudes were prevalent. Men tended to support the view that women should adhere to and accept their traditional stereotypic roles, prior to establishing any independent (outside the home) role, whereas women stressed the value of independence and autonomy over traditional stereotypic roles. Thus, a clear split along gender lines was determined in terms of the counselors perception of the role of women in society.

In 1972, Spence and Helmreich\textsuperscript{174} administered the ATW to 420 men and 529 women. They found that the mean stereotypic score for men was significantly lower (more traditional) than that for the women (p<.001).

The research of this author involves potential gender differences among mental health professionals, counselor


\textsuperscript{174}Spence and Helmreich, "The Attitudes Towards Women Scale."
educators and counselors-in-training in terms of their differences in perception of the status and roles of women in society. Based on the work of Gilbert and Waldroop as well as Spence and Helmreich, this author has selected the ATW as an appropriate instrument for gathering the required data needed to address several of the hypotheses specified in this study.

Recapitulation

The literature has focused on the traditional stereotypic definitions of female sexuality and role behavior, in conjunction with the nature of the psychotherapeutic relationship. In addition, the impact of the socialization process, wherein sex-role stereotypes are learned and reinforced, has been addressed.

Furthermore, psychotherapy has been charged with being a form of social control, by means of the oppression of women. The traditional medical model, which is reported to be unequal and hierarchical, has been shown to be operative in the beliefs and constructs of mental health professionals.

The pronouncement that more women than men are seen as having psychological problems is not an innocuous allegation. The therapist, female or male, who has traditional assumptions about sex-roles, and who has trained in an approach which has its criterion for restoration of mental
health, the client's ability to function in conformity with society's expectations, has goals of therapy/counseling formulated to feature adjustment to a designated place in society.

Some evidence has been presented that suggests the potential for mental health professionals, counselor educators and counselors-in-training, to support and transmit sex-stereotypic attitudes exist. Some of the feminist literature goes further and states that mental health professionals, counselor educators and counselors-in-training espouse sex-role stereotypic attitudes. There is little definitive evidence to support extreme accusations, although the evidence is more substantial that if mental health professionals, counselor educators or counselors-in-training are stereotypically biased, there is a good probability that these attitudes will be transmitted to their respective client systems.

The literature has laid the responsibility for sex bias on a number of doorsteps including the following:

1. In the United States 90 percent of the psychiatrists and 84 percent of the clinical psychologists are men. This is seen as lending credence to the criticism that Psychiatry and Psychology are masculine disciplines controlled by men to the detriment of women.

2. There is a much greater proportion of educators in institutions of higher learning, particularly in graduate
programs who are men.

3. Among counselors-in-training, women, as opposed to men, have perceived the changing roles of women to encompass less stereotypic bias, and a higher degree of egalitarianism.

Some advocates for equality have raised what they consider to be salient issues: How are women to become free from the dictates of a sexist society, if her therapist/counselor possesses sexist values? How are counselors-in-training to acquire a multi-disciplinary approach to cognitive and affective learning about human behavior if their professors incorporate sexist attitudes into the counselor education curricula being offered?

How does the process of empathy permeate effective counseling practices when a female therapist or counselor who is male-oriented, and biased toward women, is unaware that she, too, is oppressed as a woman? Where is the validation for this woman-therapist/counselors who views marriage and children as sufficient fulfillment for all women--except herself?

The importance of attacking the irrational myths about women, becoming sensitive to societal changes, and taking the initiative to help eliminate continuing sex-role stereotypic attitudes is seen as critical.
CHAPTER III

METHODOLOGY

The purpose of Chapter Three is to present the methods and procedures of this investigation. For clarity of presentation, this chapter has been divided into seven sections, namely, restatement of the problem, description of the subjects, explication of the procedure, statement of the null hypotheses, description of the variables, description of the research instrumentation, and treatment of the data.

Statement of the Problem

The problem which this investigation addresses concerns the sex biases of mental health professionals, counselor educators, and counselors-in-training. This research was designed to examine the differences in sex-role stereotypic attitudes toward women among mental health professionals, counselor educators, and counselors-in-training, and to test the contention that a double standard of mental health exists for women and men.

Description of the Subjects

The subjects of this study are mental health
professionals, counselor educators, and counselors-in-training.

The mental health professionals were a random selection of therapists in private practice from the Chicago metropolitan area. The counselor educators were randomly selected from the faculty lists of universities with graduate school programs in counseling in the state of Illinois. The counselors-in-training were randomly selected from the graduate enrollment lists of two major universities in the Chicago metropolitan area. The subjects were selected from the general population of Mental Health Professionals, Counselor Educators, and Counselors-in-Training, and chosen for solicitation using the table of random numbers.

A total of 136 subjects participated in this study. There were 30 mental health professionals, which included 7 psychiatrists, 15 psychologists, and 8 social workers; 30 counselor educators, and 76 counselors-in-training, including 30 master level graduate students, and 46 doctoral level graduate students. (See Table 1.)

The subjects ranged in age from 22-65 years of age. Table 2 presents a summary of the ages of the subjects by subgroup. Age intervals of 5 years have been established for reporting the data.

Of the 136 subjects, there were 80 females and 56 males. In Table 3 is presented a summary of the sex of the subjects by subgroup.
Table 1

Heading and Classification of Subjects by Group and Subgroup

<table>
<thead>
<tr>
<th>Number of Subjects</th>
<th>Mental Health Professionals</th>
<th>Counselor Educators</th>
<th>Counselors-in-Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td>15</td>
<td>Counselor Educators</td>
<td>Master's = 30</td>
</tr>
<tr>
<td>Social Workers</td>
<td>8</td>
<td>30</td>
<td>Doctoral = 46</td>
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<tr>
<td>Total = 136</td>
<td>30</td>
<td>30</td>
<td>76</td>
</tr>
<tr>
<td>Age Intervals of Subjects</td>
<td>Mental Health Professionals</td>
<td>Counselor Educators</td>
<td>Counselors-in-Training</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------</td>
<td>---------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>Psychiatrists</td>
<td>Social Workers</td>
<td></td>
</tr>
<tr>
<td>22 - 25</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26 - 30</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>31 - 35</td>
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<td>4</td>
<td>2</td>
</tr>
<tr>
<td>36 - 40</td>
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<td>1</td>
<td>3</td>
</tr>
<tr>
<td>41 - 45</td>
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<td>2</td>
</tr>
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<td>46 - 50</td>
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Table 2 (cont'd.)

<table>
<thead>
<tr>
<th>Age Intervals of Subjects</th>
<th>Mental Health Professionals</th>
<th>Counselor Educators</th>
<th>Counselors-in-Training</th>
<th>Total Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrists</td>
<td>Psychologists</td>
<td>Social Workers</td>
<td>Counselor Educators</td>
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<tr>
<td>51 - 55</td>
<td>0</td>
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<td>0</td>
<td>3</td>
</tr>
<tr>
<td>56 - 55</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Total in Subgroup</td>
<td>7</td>
<td>15</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Mean Age</td>
<td>46.43</td>
<td>41.34</td>
<td>41.25</td>
<td>45.84</td>
</tr>
<tr>
<td>Total Ss</td>
<td>30</td>
<td>30</td>
<td></td>
<td>76</td>
</tr>
<tr>
<td>Mean Age</td>
<td>41.4</td>
<td>45.84</td>
<td>34.7</td>
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</table>
Table 3
Sex of Subject by Group and Subgroup Classification

<table>
<thead>
<tr>
<th>Sex of Subjects</th>
<th>Mental Health Professionals</th>
<th>Counselor Educators</th>
<th>Counselors-in-Training</th>
<th>Total Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrists</td>
<td>Psychologists</td>
<td>Social Workers</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>11</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Subgroup Total</td>
<td>7</td>
<td>15</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Subject Total</td>
<td>30</td>
<td>30</td>
<td></td>
<td>76</td>
</tr>
</tbody>
</table>
In Table 4 is presented a summary of the marital status of the subjects by subgroup. Of the 136 subjects, 90 were married, 28 were single, 11 were divorced, 1 was a widow, 2 were separated, and 4 were cohabiting.

In Table 5 is a presentation of the ethnic background of the subjects by subgroup.

The theoretical orientation of the subjects according to subgroup is presented in Table 6. The orientations included were: eclectic, humanistic, feminist or nonsexist, analytic, existential, client-centered, behavioralist, other, and undecided.

Description of the Procedure

A research packet was prepared for each subject and contained the following:

1. A letter of explanation and solicitation for participation in the research (see Appendix D, p. 241).
2. A personal demographic questionnaire (see Appendix C, p. 235).
3. Instructions for completion of ATWS (see Appendix A, p. 219).
4. The Attitude Toward Women Scale.
5. Instructions for completing the first PAQ (see Appendix B, p. 225).
6. The Personal Attributes Questionnaire (first).
7. Instructions for completing the second PAQ.
Table 4
Marital Status of the Subjects By Group and Subgroup Classification

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Mental Health Professionals</th>
<th>Counselor Educators</th>
<th>Counselors-in-Training</th>
<th>Total Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrists</td>
<td>Psychologists</td>
<td>Social Workers</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>5</td>
<td>11</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>Single</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cohabit</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>15</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Subject Total</td>
<td>30</td>
<td>30</td>
<td>76</td>
<td>136</td>
</tr>
</tbody>
</table>
Table 5

Ethnic Background of the Subjects by Group and Subgroup Classification

<table>
<thead>
<tr>
<th>Ethnic Background</th>
<th>Mental Health Professionals</th>
<th>Counselor Educators</th>
<th>Counselors-in-Training</th>
<th>Total Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrists</td>
<td>Psychologists</td>
<td>Social Workers</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>7</td>
<td>14</td>
<td>7</td>
<td>128</td>
</tr>
<tr>
<td>Black</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Spanish</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Oriental</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Subgroup Total</td>
<td>7</td>
<td>15</td>
<td>8</td>
<td>136</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>30</td>
<td>76</td>
<td>136</td>
</tr>
</tbody>
</table>
Table 6
Theoretical Orientation of Subjects by Group and Subgroup Classification

<table>
<thead>
<tr>
<th>Theoretical Orientation</th>
<th>Mental Health Professionals</th>
<th>Counselor Educators</th>
<th>Counselors-in-Training</th>
<th>Total Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrists</td>
<td>Psychologists</td>
<td>Social Workers</td>
<td></td>
</tr>
<tr>
<td>Eclectic</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Humanistic</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Feminist or Nonsexist</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Analytic</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Existential</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Client-Centered</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Behavioralist</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Undecided or Other</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Subgroup Totals</td>
<td>7</td>
<td>15</td>
<td>8</td>
<td>136</td>
</tr>
<tr>
<td>Totals</td>
<td>30</td>
<td>30</td>
<td>76</td>
<td>136</td>
</tr>
</tbody>
</table>
8. The Personal Attributes Questionnaire (2nd).

The packets were mailed to 90 mental health professionals, 90 counselor educators, and 179 counselors-in-training. Of this number, 30 mental health professionals, 30 counselor educators, and 76 counselors-in-training provided usable responses.

The subject was first asked to complete a personal data questionnaire. Upon completion, the Ss were asked to complete the Attitude Toward Women Scale, and were told that this survey describes the attitudes toward the role of women in society which different people have. The Ss were asked to express their own feelings about each statement. Next, the Ss were asked to complete the first Personal Attributes Questionnaire. For each of the items the Ss were asked to rate how they viewed the mentally healthy adult male on a bipolar dimension.

The third, and final questionnaire, was a Personal Attributes Questionnaire identical to the first one, except for the instructions for completing the instrument. The Ss were asked to rate each of the items, on a bipolar dimension for a mentally healthy adult female.

These three instruments provided the necessary data to meet the purposes and objectives of this study.

A total elapsed time of six weeks was encountered
between the mailing of the packets and the cut-off date for returns. There was no follow-up solicitation for additional subjects.

This survey method precludes control of environmental influences or test time for the subjects.

A usable response contained the following minimal data:

1. Age
2. Sex
3. Title: as indicated on the demographic questionnaire
4. Completion of the ATWS and PAQ-1 and PAQ-2.

Missing data were treated appropriately in the data analysis.

Upon receipt of the packet, the ATWS and both PAQs were scored (see Instrumentation, Chapter 3, page 107). Demographic information was extracted and reported.

Statement of the Null Hypotheses

This research poses the following hypotheses stated in the null form:

\( H_1: \) There will be no significant differences in the level of assessed sex bias between the three subject groups.

\( H_2: \) There will be no significant differences among the three subject groups in levels of assessed sex bias.
possessed by the mentally healthy adult female and the mentally healthy adult male.

\( H_{10} \): There will be no significant differences in the perceptions of Counselors-in-Training in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

**Description of the Variables**

A total of eight variables, two independent, three dependent, and three control, were under study in this research.

**Independent Variables:**

1. Group Classification
2. Subgroup

**Dependent Variables:**

1. ATW score
2. PAQ-1 score
3. PAQ-2 score

**Control Variables:**

1. Age
2. Sex
3. Theoretical Orientation

Table 7 presents a summary of each variable by name, description, and source.

**Description of Research Instrumentation**

The instrumentation used for the data collection
Table 7
A Summary of Independent, Dependent and Control Variables, and Levels of the Variables

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of Variable Levels</th>
<th>Variable Name</th>
<th>Variable Description</th>
<th>Variable Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>3</td>
<td>Group Classification</td>
<td>The group in which a particular S was assigned</td>
<td>The classification is mandated by each Ss primary role. Each Ss was assigned to one and only one of three groups: Mental Health Professionals, Counselor Educators, and Counselors-in-Training</td>
</tr>
<tr>
<td>Independent</td>
<td>6</td>
<td>Subgroup</td>
<td>That specific group, subsumed under group classification in which each Ss has her/his primary identification</td>
<td>The subgroup is mandated by each Ss primary role. Each S is assigned to one and only one subgroup: Psychiatrist, Psychologist, Social Worker, Counselor Educator, Counselor-in-Training (Master's level), Counselor-in-Training (Doctoral level)</td>
</tr>
</tbody>
</table>
Table 7 (cont'd.)

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of Variable Levels</th>
<th>Variable Name</th>
<th>Variable Description</th>
<th>Variable Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent</td>
<td>1</td>
<td>ATW score</td>
<td>The summated score of a 55 item questionnaire</td>
<td>The Attitude Toward Women Scale (Spence, Helmreich, 1972) (see p. 111)</td>
</tr>
<tr>
<td>Dependent</td>
<td>1</td>
<td>PAQ-1 Score</td>
<td>The summated score of a 55 item questionnaire</td>
<td>The Personal Attributes Questionnaire (Spence, Helmreich, and Stapp, 1974) (see p. 113)</td>
</tr>
<tr>
<td>Dependent</td>
<td>1</td>
<td>PAQ-2 Score</td>
<td>The summated score of a 55 item questionnaire</td>
<td>The Personal Attributes Questionnaire (Spence, Helmreich, and Stapp, 1974) (see p. 102)</td>
</tr>
<tr>
<td>Control</td>
<td>2</td>
<td>Age</td>
<td>Age of S</td>
<td>Data provided by S when completing demographic questionnaire</td>
</tr>
</tbody>
</table>
Table 7 (cont'd.)

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of Variable Levels</th>
<th>Variable Name</th>
<th>Variable Description</th>
<th>Variable Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>2</td>
<td>Sex</td>
<td>Sex of S</td>
<td>Data provided by S when completing demographic questionnaire</td>
</tr>
<tr>
<td>Control</td>
<td>8</td>
<td>Theoretical Orientation</td>
<td>Theoretical Orientation</td>
<td>Data provided by S when completing demographic questionnaire</td>
</tr>
</tbody>
</table>
portion of this investigation are:

The Attitude Toward Women Scale (Spence Helmreich) and The Personal Attributes Questionnaire (Spence, Helmreich and Stapp). 175

For this investigation, sex-stereotypic attitudes are being measured across three dimensions:

1. Attitudes Toward Women--a measure of the subject's perception of the role of women in the home, business and society.

2. The attributes that the subjects perceived as being possessed by the mentally healthy adult male.

3. The attributes that the subjects perceived as being possessed by the mentally healthy adult female.

The instruments and their applications will be discussed separately.

The Attitudes Toward Women Scale

The Attitudes Toward Women Scale (ATWS) (see Appendix A, p. 219) contains 55 items. Each item consists of a declarative statement for which there are four response alternatives: agree strongly, agree mildly, disagree mildly, disagree strongly.

disagree strongly. Each item is given a score from 1 to 4, with 1 representing the most traditional, conservative attitude, and 4 the alternative, reflecting the most liberal, pro-feminist attitude. Since the statement contained in some of the items is conservative in content, and others liberal, the specific alternative given a score of 1 (agree strongly or disagree strongly), varied from item to item. Each subject's score, (assessed level of stereotypic attitudes) is obtained by summing the values for the individual items, the range of possible scores going from 55 (most traditional or biased) to 220 (most liberal or pro-feminist).

The ATWS items are concerned with the vocational, educational, intellectual roles of women, as well as their freedom and independence, dating, courtship and etiquette, sexual behavior, and marital relationships and obligations.

The score of the ATWS may be utilized in two ways:

1. The total raw score obtained by summing the 55 items which represents an overall measure of sex-stereotypic attitudes; or

2. The items may be clustered into 8 groupings, each grouping representing a focused area of sex-stereotypic attitudes.

Normative Data for the ATWS

The ATWS was given to 529 women and 420 men enrolled
in an introductory psychology course at the University of Texas (Austin), during the fall semester of 1971. During the spring semester of 1972, the instrument was administered to 239 women and 293 men.

Table 8 presents a summary of selected statistics from the two samples of women and men, as well as from the two samples combined. For a detailed explanation of the normative data see Spence, Helmreich and Stapp.176

The normative data suggest that there is no significant difference in response level between women and men, but differences are expected between generations, i.e., age variables.

In this study, a sex stereotypic score, or measure was obtained for each subject, i.e., attitude toward women. This score was one of the three dependent variables previously specified. The independent variables (their effects) in influencing this score as well as the interaction of the independent variables were tested.

The authors of the ATWS did not provide reliability and validity data.

The Personal Attributes Questionnaire

The Personal Attributes Questionnaire (PAQ) (see Appendix B, p. 225) is a 55-item scale developed by Spence, 176

---

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 1971</td>
<td>Spring 1972</td>
</tr>
<tr>
<td>Mean</td>
<td>86.748</td>
<td>92.863</td>
</tr>
<tr>
<td>Median</td>
<td>84.125</td>
<td>91.250</td>
</tr>
<tr>
<td>Skewness</td>
<td>.452</td>
<td>.390</td>
</tr>
<tr>
<td>Range</td>
<td>37-155</td>
<td>46-156</td>
</tr>
<tr>
<td>N</td>
<td>420</td>
<td>293</td>
</tr>
</tbody>
</table>
It is a modification of the Sex-Role Stereotypic Questionnaire (SRSQ) developed by Rosenkrantz, Vogel, Bee, Broverman, and Broverman, 1968.

The scale presents 55 bipolar adjectives, each having a score range of 1 through 5, with the traditional masculine receiving a score of 5. A subject's score is obtained by summing the responses to the 55 items. Thus, the range of scores on the PAQ is 55 to 275.

Normative Data for the PAQ

The scale was administered to 122 women and 82 men who were introductory psychology students in the spring semester, 1973 at the University of Texas. The instructions were to rate the typical adult male and female. A second sample of 112 women and 92 men were given the scale and instructed to rate the typical college student. A third sample of 108 women and 93 men were given the scale and instructed to rate the ideal female and male.

In Table 9 a summary of items which were significantly different for rating of adults, students, females, and males is presented.

In this study, the PAQ is administered twice with

177 Ibid., p. 12.
Table 9

Number and Percentage of Items for Which Occurred Significant (p<.05) Differences Between Mean Ratings of Typical Adult, Typical Student, and Significant Differences Between Mean Self-Ratings of Male and Female Subjects

<table>
<thead>
<tr>
<th></th>
<th>Typical Peer</th>
<th>Typical Adult</th>
<th>Ideal Individual</th>
<th>Self-Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Males</td>
<td>84</td>
<td>64.1</td>
<td>100</td>
<td>76.3</td>
</tr>
<tr>
<td>Females</td>
<td>98</td>
<td>74.8</td>
<td>112</td>
<td>85.5</td>
</tr>
</tbody>
</table>

Note: Significant t's differing in direction between the sexes or between instructional conditions were found for seven items. These items were difficult to classify and not included in the tally above. Percentages were therefore computed on the basis of 131 rather than 138 items.
differing instructions. On the first PAQ, the subject is asked to rate the mentally healthy adult male, and on the second PAQ, the subject is asked to rate the mentally healthy adult female.

Two scores are then obtained for each subject. One score is the subject's view of the attributes of the mentally healthy adult male, and the second score is the subject's view of the mentally healthy adult female.

Cross Validation

The PAQ was given to a second sample of introductory psychology students (108 women and 56 men) in the same semester as the original sample. Significant stereotypes were found for both sexes on all items.

Internal Consistency and Test-Retest Reliability

An alpha coefficient was computed for the stereotype as a measure of internal consistency. The values were .91 and .90 for men and women respectively, thus, the scale shows satisfactory reliability.

Test-retest data were available from 31 Ss who retook the PAQ after an interval of thirteen weeks. The r values were .92 and .98 for men and women respectively.

Treatment of the Data

There were three research instruments utilized in this research. Each instrument was analyzed separately
using the appropriate statistical paradigm.

The following is a presentation of the hypothesis number, and the statistical procedure used to test it.

- **H₁**: One Way Analysis of Variance
- **H₂**: 2x2x5 Factorial Analysis of Variance
- **H₃**: 2x2x3 Factorial Analysis of Variance
- **H₄**: 2x2 Factorial Analysis of Variance
- **H₅**: 2x2x2 Factorial Analysis of Variance
- **H₆**: Chi-Square ($\chi^2$) for Independence
- **H₇**: Pearson Product Moment Correlation Coefficient
- **H₈**: t Test for Paired Samples
- **H₉**: t Test for Paired Samples
- **H₁₀**: t Test for Paired Samples

For all analyses, a significance level of $\alpha \leq 0.05$ has been established.

**Sample Statistical Models**

**One Way Analysis of Variance**

This variance model is used to test for significant difference between two or more groups on a single dependent variable.

This model requires that between group variance and within group variance be determined, and the F ratio calculated by dividing the between group's mean square by the within group's mean square.

Formulas:
\[ C = \frac{(\Sigma x_1)^2}{N} \quad \text{Total } Sx = \Sigma x_1^2 - C \]

\[ \text{Between } = \frac{(\Sigma x_{A_1})^2}{n_{A_1}} + \frac{(\Sigma x_{A_2})^2}{n_{A_2}} \]

\[ \text{Within } = \text{Total } - \text{Between} \]

The analysis of variance paradigm assumes that the groups being tested are drawn from the same population and their mean scores do not differ significantly. In this research an \( \alpha < .05 \) allows for the rejection of this assumption. As previously stated, one-way ANOVA tests for significant differences between two or more groups on a single dependent variable. Two-way analysis of variance involves two independent variables (or factors) and is utilized to compare groups which differ from one another along two dimensions. Factorial analysis of variance denotes any ANOVA in which there are two or more factors (independent variables or dimensions). The three-way ANOVA involves three independent variables (factors or dimensions). The categories or subgroups of each factor are designated levels.

Three-Way Factorial Analysis of Variance

This procedure allows for the analysis of the variance between three independent variables across three levels:

1. The amount of variance each independent variable alone accounts for in the data (main effects).
2. The additive effects of any pair of independent variables which accounts for variance in the data (first order or two-way interactions).

3. The additive effects of the three independent variables which accounts for variance in the data (second order or three-way interactions).

Three-way ANOVA always asks seven research questions, three concerning the main effects, three concerning the first-order effects, and one concerning second-order effects.

For example: A researcher is interested in knowing the additive effects of the variables sex, age and subgroup classification and the score obtained on the Attitudes Toward Women Scale.

The seven research questions to be asked are:

**Main Effects**

1. **Main effect of sex of subject.** Does the sex of the subject lead to equal subject ratings on the ATWS, when all data associated with the sex of each S are combined with the age of each S, and the subgroup classification of each subject?

2. **Main effect of age of subject.** Are ratings given by the subjects in each age group equal when all data associated with age subgroups are combined with the subgroup classification of each subject?

3. **Main effect of the subgroup classification**
of subject. Do all the subjects in the study (disregarding sex of subject and age of subject) rate the same on the ATWS?

First Order Interactions

4. Sex of subject by age of subject interaction. Do the subjects in each sex of subject subgroup (in over 35 and under 35 groups combined) have a similar trend or pattern of ratings on the ATWS?

5. Sex of subject by subgroup classification of subject interaction. Is the trend of the ratings by subjects classified according to subgroup classification similar for both males and females?

6. Age of subject by subgroup classification of subject interaction. Is the difference between overall ratings on the ATWS for the subjects classified by subgroup classification of the same magnitude within each of the subgroups? A significant interaction here would indicate the degree to which the subjects over 35 and under 35 differ depending upon the subject's subgroup classification.

Second Order Interaction

7. Sex of subject by age of subject by subgroup classification of subject interaction. Is the rating on the ATWS for any subgroup influenced by the unique combination of the sex of the subject, the age of the subject,
and the subgroup classification of the subject?

In interpreting the ANOVA table the second-order interaction effect is inspected first. If significance is not found, the first-order interactions are inspected. If significance is not found the main effects are inspected. Should significance be found in second-order interactions, the results of first-order interaction effects are disregarded. Should significant interaction effects be found in first-order interactions, the results of the main effects are disregarded.

As with one-way analysis of variance, three-way ANOVA assumes that there are no significant second-order effects, significant first-order effects, or significant main effects.

ANOVA Solutions

When all the cells of a design have the same frequencies, the design is said to be balanced, or orthogonal. In an orthogonal design, the effects of each independent variable (main effects), will be orthogonal to (independent of) the effects of all other factors and, in addition, the interaction effects will be orthogonal to the main effects.

If the frequencies in each cell are not equal, but are proportional to the marginal frequencies of each factor, only the main effects will be orthogonal.

This research is a non-orthogonal design. ANOVA
provides three different approaches to composing the variation in a dependent variable. These are: the classical experimental approach, the hierarchal approach, and the classic regression approach.

Any of the three approaches may be used, but for non-orthogonal designs, the hierarchal approach is most appropriate. That is, a conceptual hierarchy is assigned to the various main effects before partitioning the sum of squares into component parts.

In the hierarchical approach, the main effects are partitioned according to the established hierarchy. That is, higher priority is assigned to one of the independent variables and the variable is allowed to explain all of the variation in the dependent variable that it can. A second variable is then allowed to explain any variation that remains, and so on.

In this research, the following hierarchy has been established: sex, age, followed by group classification, and title equally.

This hierarchy is used for all two-way and three-way factorial analyses.

Multiple Classification Analysis

Inspection of the multiple classification analysis shows the additive effects of each category expressed as deviation from the grand mean. These coefficients may be
used to describe the pattern of differences that exist, or alternatively, from this information and knowledge of the grand mean, a table of additive means can be readily constructed. Since the effects of each category are deviations from the mean, the additive means for a particular category or subcell can be computed by adding the appropriate category effects to the grand mean.

The ETA statistic is associated with each independent variable and summarizes the relationship between the independent variable and that factor operating alone. It is equivalent to a regression multiple $r$ with dummy variables. When squared, ETA indicates the amount of variation in the dependent variable which can be "explained by" the additive effect (main effect) of the independent variable. ETA, in other words, is defined as the designated weight of the variable. It is the relative weight of any single variable or factor compared to all other factors in the analyses. The most important ETA weight is the highest, as the higher the coefficient, the more important is that factor in determining the variation of the scores.

The coefficients under the column labeled "adjusted for independence deviation" show the effects of each category (expressed as deviations from the grand mean) when other factor(s) are adjusted for. BETA is interpreted as a standardized partial regression coefficient and indicates the importance of a factor after the effects of other
factors have been removed (but cannot be interpreted in terms of "explained variation" like ETA). BETA is an expression of the amount of variance in the data that a particular given variable accounts for; the decimal figure indicates the percentage of variance in the data which is accountable by that variable.

The multiple $r$ and multiple $r^2$ squared statistics summarize the total additive effects of all independent variables. Multiple $r$ is a regression multiple $r$ with dummy variables. Multiple $r^2$ squared is interpreted as the amount of variation in the dependent variable which can be "explained by" the additive effects of the independent variables.

For clarification, the term additive refers to the Linear Additive Model associated with Analysis of Variance. This model, in essence, states that a person's score is equal to: $1$ (the grand mean) $+$ (that factor associated with a subject's membership in a particular group) $+$ (that factor that is idiosyncratic to the subject).

All three-way ANOVAS performed in this investigation should be interpreted within these guidelines.

Chi Square for Independence

To test for significant difference between the subjects on the ATWS, the first PAQ (attributes of the mentally healthy adult male), and the second PAQ (attributes of the
mentally healthy adult female) a series of contingency tables or cross breaks were prepared. To test for significance of the cells of the contingency table, a simple Chi Square Analysis will be formed. The formula for Chi Square is:

\[ x^2 = \sum \frac{(o_e - e_e)^2}{e_e} \]

where \( o_e \) = observed frequencies.
\( e_e \) = expected frequencies.

This simple analysis tests for significance of the number of subjects occupying each cell of the contingency table. The question is: Are the observed frequencies of subjects in each cell different from the expected frequencies in each cell of the contingency table? The assumption of \( x^2 \) is that the cells are independent and there is no association between them.

**Pearson Product Moment Correlation Coefficient**

Pearson \( r \) is a useful statistic for determining the degree of association between two interval level variables that are free to vary. The assumption of the Pearson \( r \) is: \( r = 0.00 \), i.e., there is no level of association between the two variables. In other words, to what degree will the scores of variable B vary as the scores of Variable A vary (positively or negatively)? The formula for Pearson \( r \) is:
\[ r_{xy} = \frac{n \sum x_i y_i - (\sum x_i)(\sum y_i)}{\sqrt{n \sum x_i^2 - (\sum x_i)^2}[n \sum y_i^2]^2} \]

**t Test for Paired (Correlated) Samples**

This t test is appropriate in any situation in which each of the data observations in the first group is logically tied to one of the scores in the second group. The formula for the t test for paired (correlated) samples is:

1. To calculate the standard error of the differences of the means

\[ SE_{M_{A1} - M_{A2}} = \sqrt{SE_{M_{A1}}^2 + SE_{M_{A2}}^2} \]

2. Then:

\[ t = \frac{M_{A1} - M_{A2}}{SE_{M_{A1} - M_{A2}}} \]

The t test may only be used to test significant difference between means when only two groups are involved in the analysis. Three or more groups require analysis of variance. It should be noted, however, that with two groups the t test and analysis of variance will produce the same results. The relationship of the F ratio to the t ratio is: \( \sqrt{F} = t \)
CHAPTER IV

RESULTS

Introduction

This chapter presents the statistical analysis of the data. The hypothesis-analysis-summary style of presentation will be followed. In this form, each hypothesis will be stated, followed by a presentation of statistical analysis and results, tables, and relevant discussion.

A distribution of scores for the subjects (N = 136) on the three instruments, The Attitudes Toward Women Scale, the first Personal Attributes Questionnaire (Attributes of the Mentally Healthy Adult Male), and the second Personal Attributes Questionnaire (Attributes of the Mentally Healthy Adult Female) is presented in Table 10.

Data Analysis

Hypothesis 1

There will be no significant differences in the level of assessed sex bias among the three subject groups.

Results

The calculated F-ratios for the difference between the subjects on the Attitudes Toward Women Scale (ATW),
Table 10

Distribution of Scores on the Attitude Toward Women Scale, the First Personal Attributes Questionnaire, and the Second Personal Attributes Questionnaire by Group and Subgroup Classification

<table>
<thead>
<tr>
<th></th>
<th>Mental Health Professionals</th>
<th>Counselor Educators</th>
<th>Counselors-in-Training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>15</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor Educators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master's</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctoral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under T ATW PAQ-1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>150 PAQ-2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>151 T ATW PAQ-1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>160 PAQ-2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>8</td>
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<tr>
<td>161 T ATW PAQ-1</td>
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<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>11</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>170 PAQ-2</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>171 T ATW PAQ-1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>7</td>
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<tr>
<td>180 PAQ-2</td>
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<td>6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>181 T ATW PAQ-1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
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<td></td>
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<td>0</td>
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<tr>
<td>190 PAQ-2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 10 (cont'd.)

<table>
<thead>
<tr>
<th>Mental Health Professionals</th>
<th>Counselor Educators</th>
<th>Counselors-in-Training</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>15</td>
<td>8</td>
<td>30</td>
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<td>30</td>
<td>30</td>
<td>46</td>
<td>136</td>
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<td></td>
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<tr>
<td>Physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>15</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>200 PAQ-2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>201 T ATW</td>
<td>1</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>210 PAQ-2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>211 T ATW</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>+ PAQ-2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>45</td>
<td>24</td>
</tr>
<tr>
<td>Mean T ATW</td>
<td>180.43</td>
<td>192.47</td>
<td>192.13</td>
</tr>
<tr>
<td>Mean PAQ-1</td>
<td>175.00</td>
<td>166.73</td>
<td>163.25</td>
</tr>
<tr>
<td>Mean PAQ-2</td>
<td>161.43</td>
<td>168.23</td>
<td>163.25</td>
</tr>
<tr>
<td>Mean Score Groups</td>
<td>T ATW 189.57</td>
<td>182.47</td>
<td>186.86</td>
</tr>
<tr>
<td>PAQ-1 167.73</td>
<td>168.50</td>
<td>168.72</td>
<td></td>
</tr>
<tr>
<td>PAQ-2 165.37</td>
<td>161.17</td>
<td>161.17</td>
<td></td>
</tr>
</tbody>
</table>
Table 10 (cont'd.)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Population Total</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATW</td>
<td>N = 136</td>
<td>186.485</td>
<td>190.500</td>
<td>192.000</td>
<td>16.464</td>
</tr>
<tr>
<td>PAQ-1</td>
<td>N = 136</td>
<td>168.456</td>
<td>168.500</td>
<td>174.000</td>
<td>9.917</td>
</tr>
<tr>
<td>PAQ-2</td>
<td>N = 136</td>
<td>162.118</td>
<td>163.167</td>
<td>163.000</td>
<td>12.670</td>
</tr>
</tbody>
</table>
the first Personal Attributes Questionnaire (PAQ-1), and the second Personal Attributes Questionnaire (PAQ-2), were 1.4478, .1062 and 1.2707 respectively. None of these ratios were significant at the .05 level, therefore, the null hypotheses is accepted for all three measures. The results of the one-way ANOVAS are presented in tables 11, 12, and 13.

Discussion

The lack of significance determined for each of the measures, the ATW, the PAQ-1 and the PAQ-2 indicate that Mental Health Professionals, Counselors Educators, and Counselors-in-Training do not differ in their perceptions of the role and status of women in society, or in their perceptions of the attributes of the mentally healthy adult male and the attributes of the mentally healthy adult female.

The implications of the data appear to reflect the relative equality of the perceptions of the subjects and suggest that on these three dimensions (1) the subject's level of assessed sex bias is not influenced by her/his membership in a given group, and (2) levels of assessed bias would appear to be a function of a broader variable or set of variables of which the total subject population are exposed. What is being suggested is that socialization and culturalization play a major role in the formulation
Table 11

One Way Analysis of Variance with Multiple Comparison (Range) Test of the Three Subject Groups on The Attitudes Toward Women Scale

<table>
<thead>
<tr>
<th>Source</th>
<th>d.f.</th>
<th>S.S.</th>
<th>M.S.</th>
<th>F Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>779.73</td>
<td>389.86</td>
<td>1.4478</td>
<td>.2388+</td>
</tr>
<tr>
<td>Within Groups</td>
<td>133</td>
<td>35,814.24</td>
<td>269.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>36,593.97</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multiple Range (Comparison) Test (LSD Procedure)

Ranges for the .050 level, 2.80

<table>
<thead>
<tr>
<th>Subset 1</th>
<th>Group</th>
<th>Group 3</th>
<th>Group 2</th>
<th>Group 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>182.47</td>
<td>186.86</td>
<td>189.57</td>
</tr>
</tbody>
</table>

+ α>.05
Table 12

One-Way Analysis of Variance with Multiple Comparison (Range) Test of the Three Subject Groups on the First Personal Attributes Questionnaire (Attributes of the Mentally Healthy Adult Male)

<table>
<thead>
<tr>
<th>Source</th>
<th>d.f.</th>
<th>S.S.</th>
<th>M.S.</th>
<th>F Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>21.17</td>
<td>10.59</td>
<td>.1062</td>
<td>.8893+</td>
</tr>
<tr>
<td>Within Groups</td>
<td>133</td>
<td>13,254.56</td>
<td>99.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>13,275.73</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multiple Range (Comparison) Test (LSD Procedure)

Ranges for the .050 level, 2.80

Subset 1

<table>
<thead>
<tr>
<th>Group</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>167.73</td>
<td>168.50</td>
<td>168.71</td>
</tr>
</tbody>
</table>

$+ \alpha > .05$
Table 13

One-Way Analysis of Variance with Multiple Comparison (Range) Test of the Three Subject Groups on the Second Personal Attributes Questionnaire (Attributes of the Mentally Healthy Adult Female)

<table>
<thead>
<tr>
<th>Source</th>
<th>d.f.</th>
<th>S.S.</th>
<th>M.S.</th>
<th>F Ratio</th>
<th>F Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>406.35</td>
<td>203.18</td>
<td>1.2707</td>
<td>.2840+</td>
</tr>
<tr>
<td>Within Groups</td>
<td>133</td>
<td>21,265.76</td>
<td>159.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>21,672.12</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multiple Range (Comparison) Test (LSD Procedure)

Ranges for the .050 level, 2.80

Subset 1

<table>
<thead>
<tr>
<th>Group</th>
<th>Group 3</th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>161.17</td>
<td>161.21</td>
<td>165.37</td>
</tr>
</tbody>
</table>

+ α>.05
and development of the individual's value and attitude system. A person's level of sex bias is brought to the groups and the institutions to which they eventually become part, by the individual. It is further suggested that within these broader institutions, the individual's stereotypic attitudes toward people, and in particular, women, become reinforced and maintained.

It is acknowledged that these implications do not have the support of empirical evidence sufficient to substantiate these speculations.

Hypothesis 2

There will be no significant differences among the three subject groups in levels of assessed sex bias when the subjects are classified by sex, age and subgroup classification.

Results

The three-way factorial ANOVAS indicate different results for the subjects across the three measuring instruments. On the ATW, an F-ratio of 16.204, α<.01 was found for the main effect of sex of subject. A significant triple interaction effect was found, F-ratio of 6.526, α<.01 (sex x age x subgroup classification) for the subjects on the PAQ-1. For the PAQ-2, the main effect of sex of subject was found to be significant, F-ratio of 10.921, α<.01. These data suggest that (1) for the ATW, the hypothesis is
accepted for the variables age and subgroup classification, but rejected for the variable sex; (2) for the PAQ-1, the hypothesis is rejected for all of the variables; and (3) for the PAQ-2, the hypothesis is accepted for the variables age and subgroup classification, but rejected for the variable sex.

The results of the three-way factorial ANOVAS for the ATW, the PAQ-1, and the PAQ-2 are presented in tables 14, 15, and 16.

Discussion

The implications of the data are three-fold. First, the subjects differ in their perception of the role and status of women along gender lines. The inspection of the Multiple Classification Analysis of Table 14 reveals that on the ATW, males were significantly more traditional in their views of the status and roles of women in society when compared with the scores of the female subjects. This result suggests that males are more supportive of the traditional stereotypic view of women, while scores for female subjects have suggested an inclination to diverge from the traditional stereotypic viewpoint of women. Furthermore, this gender difference is found throughout group and subgroup classifications and is reflected by the total population sample of females and males.

The second implication of the data concerns the
### Table 14

Three Way Factorial Analysis of Variance: (ATW) Attitude Toward Women x Sex x Age x Subgroup Classification

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Effects</strong></td>
<td>5,355.66</td>
<td>6</td>
<td>892.61</td>
<td>3.750</td>
<td>.002</td>
</tr>
<tr>
<td>Sex</td>
<td>3,851.16</td>
<td>1</td>
<td>3,851.76</td>
<td>16.180</td>
<td>.001*</td>
</tr>
<tr>
<td>Age</td>
<td>603.49</td>
<td>1</td>
<td>603.49</td>
<td>2.535</td>
<td>.114</td>
</tr>
<tr>
<td>Subgroup Class.</td>
<td>901.02</td>
<td>4</td>
<td>225.25</td>
<td>.946</td>
<td>.440</td>
</tr>
<tr>
<td><strong>2-way Interactions</strong></td>
<td>2,371.95</td>
<td>9</td>
<td>263.55</td>
<td>1.107</td>
<td>.363</td>
</tr>
<tr>
<td>Sex-Age</td>
<td>268.46</td>
<td>1</td>
<td>268.46</td>
<td>1.128</td>
<td>.290</td>
</tr>
<tr>
<td>Sex-Subgroup Class.</td>
<td>2,145.56</td>
<td>4</td>
<td>536.49</td>
<td>2.254</td>
<td>.067</td>
</tr>
<tr>
<td>Age-Subgroup Class.</td>
<td>636.76</td>
<td>4</td>
<td>159.19</td>
<td>.669</td>
<td>.615</td>
</tr>
<tr>
<td><strong>3-Way Interactions</strong></td>
<td>780.09</td>
<td>2</td>
<td>390.05</td>
<td>1.639</td>
<td>.199</td>
</tr>
<tr>
<td>Sex-Age-Subgroup Classification</td>
<td>780.09</td>
<td>2</td>
<td>390.05</td>
<td>1.639</td>
<td>.199</td>
</tr>
<tr>
<td><strong>Explained</strong></td>
<td>8,507.71</td>
<td>17</td>
<td>500.45</td>
<td>2.103</td>
<td>.011</td>
</tr>
<tr>
<td><strong>Residual</strong></td>
<td>28,086.26</td>
<td>118</td>
<td>238.02</td>
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<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>36,593.97</td>
<td>135</td>
<td>271.07</td>
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<td></td>
</tr>
</tbody>
</table>

*α<.001
Table 14 (cont'd.)

Multiple Classification Analysis - Grand Mean - 186.49

<table>
<thead>
<tr>
<th>Variable and Category</th>
<th>N</th>
<th>Unadjusted</th>
<th>ETA</th>
<th>Adjusted for Independent Deviation</th>
<th>BETA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>80</td>
<td>4.45</td>
<td></td>
<td>4.08</td>
<td>.32</td>
</tr>
<tr>
<td>Male</td>
<td>56</td>
<td>-6.36</td>
<td></td>
<td>-5.82</td>
<td>.30</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 and Under</td>
<td>67</td>
<td>2.86</td>
<td></td>
<td>2.42</td>
<td>.17</td>
</tr>
<tr>
<td>36 and Over</td>
<td>69</td>
<td>-2.78</td>
<td></td>
<td>-2.35</td>
<td>.15</td>
</tr>
<tr>
<td><strong>Subgroup Classification</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>7</td>
<td>-6.06</td>
<td></td>
<td>-4.91</td>
<td>.21</td>
</tr>
<tr>
<td>Psychologist</td>
<td>15</td>
<td>5.98</td>
<td></td>
<td>4.67</td>
<td>.16</td>
</tr>
<tr>
<td>Social Worker</td>
<td>8</td>
<td>5.64</td>
<td></td>
<td>6.43</td>
<td></td>
</tr>
<tr>
<td>Counselor Educator</td>
<td>30</td>
<td>-4.02</td>
<td></td>
<td>-.25</td>
<td></td>
</tr>
<tr>
<td>Counselor-in-Training</td>
<td>76</td>
<td>.37</td>
<td></td>
<td>-1.05</td>
<td></td>
</tr>
<tr>
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<td></td>
<td>.146</td>
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</tr>
<tr>
<td><strong>Multiple r</strong></td>
<td></td>
<td></td>
<td></td>
<td>.383</td>
<td></td>
</tr>
</tbody>
</table>
Table 15

Three-Way Factorial Analysis of Variance on the First Personal Attributes
Questionnaire (Attributes of the Mentally Healthy Adult Male)
x Sex x Age x Subgroup Classification

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>981.53</td>
<td>6</td>
<td>163.59</td>
<td>1.941</td>
<td>.080</td>
</tr>
<tr>
<td>Sex</td>
<td>47.44</td>
<td>1</td>
<td>47.44</td>
<td>.563</td>
<td>.455</td>
</tr>
<tr>
<td>Age</td>
<td>330.24</td>
<td>1</td>
<td>330.24</td>
<td>3.918</td>
<td>.050*</td>
</tr>
<tr>
<td>Profession</td>
<td>603.86</td>
<td>4</td>
<td>150.97</td>
<td>1.791</td>
<td>.135</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>1,248.70</td>
<td>9</td>
<td>138.75</td>
<td>1.646</td>
<td>.110</td>
</tr>
<tr>
<td>Sex-Age</td>
<td>93.38</td>
<td>1</td>
<td>93.38</td>
<td>1.108</td>
<td>.295</td>
</tr>
<tr>
<td>Sex-Subgroup Class.</td>
<td>367.91</td>
<td>4</td>
<td>91.98</td>
<td>1.091</td>
<td>.364</td>
</tr>
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<td>684.58</td>
<td>4</td>
<td>171.15</td>
<td>2.031</td>
<td>.095</td>
</tr>
<tr>
<td>3-Way Interactions</td>
<td>1,100.13</td>
<td>2</td>
<td>550.07</td>
<td>6.526</td>
<td>.002</td>
</tr>
<tr>
<td>Sex-Age-Subgroup Class.</td>
<td>1,100.13</td>
<td>2</td>
<td>550.57</td>
<td>6.526</td>
<td>.002**</td>
</tr>
<tr>
<td>Explained</td>
<td>3,330.37</td>
<td>17</td>
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<tr>
<td>Residual</td>
<td>9,945.37</td>
<td>118</td>
<td>84.28</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>13,275.74</td>
<td>135</td>
<td>98.34</td>
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</tr>
</tbody>
</table>

*α<.05          **α<.01
Table 16

Three-Way Factorial Analysis of Variance on the Second Personal Attributes Questionnaire (Attributes of the Mentally Healthy Adult Female) x Sex x Age x Subgroup Classification

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>2,637.76</td>
<td>6</td>
<td>439.63</td>
<td>2.923</td>
<td>.011</td>
</tr>
<tr>
<td>Sex</td>
<td>1,642.24</td>
<td>1</td>
<td>1,642.24</td>
<td>10.921</td>
<td>.001**</td>
</tr>
<tr>
<td>Age</td>
<td>215.20</td>
<td>1</td>
<td>215.20</td>
<td>1.430</td>
<td>.234</td>
</tr>
<tr>
<td>Profession</td>
<td>780.32</td>
<td>4</td>
<td>195.08</td>
<td>1.297</td>
<td>.275</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>947.95</td>
<td>9</td>
<td>105.33</td>
<td>.700</td>
<td>.707</td>
</tr>
<tr>
<td>Sex-Age</td>
<td>332.67</td>
<td>1</td>
<td>332.67</td>
<td>2.212</td>
<td>.140</td>
</tr>
<tr>
<td>Sex-Subgroup Class.</td>
<td>373.17</td>
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<td>93.29</td>
<td>.620</td>
<td>.649</td>
</tr>
<tr>
<td>Age-Subgroup Classification</td>
<td>400.61</td>
<td>4</td>
<td>100.15</td>
<td>.666</td>
<td>.617</td>
</tr>
<tr>
<td>3-Way Interactions</td>
<td>341.62</td>
<td>2</td>
<td>170.81</td>
<td>1.136</td>
<td>.325</td>
</tr>
<tr>
<td>Sex-Age-Subgroup Classification</td>
<td>341.62</td>
<td>2</td>
<td>170.81</td>
<td>1.136</td>
<td>.325</td>
</tr>
<tr>
<td>Explained</td>
<td>3,927.32</td>
<td>17</td>
<td>231.03</td>
<td>1.536</td>
<td>.094</td>
</tr>
<tr>
<td>Residual</td>
<td>17,744.79</td>
<td>118</td>
<td>150.38</td>
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<td></td>
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<td>Total</td>
<td>21,672.11</td>
<td>135</td>
<td>160.53</td>
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**α < .01
Table 16 (cont'd.)

Multiple Classification Analysis - Grand Mean = 162.12

<table>
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<th>Variable and Category</th>
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<th>Unadjusted ETA Deviation</th>
<th>ETA</th>
<th>Adjusted for Independent ETA Deviation</th>
<th>BETA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>80</td>
<td>2.91</td>
<td>2.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>56</td>
<td>-4.15</td>
<td>-4.14</td>
<td></td>
<td>0.28</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 &amp; Under</td>
<td>67</td>
<td>1.75</td>
<td>1.78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36 &amp; Over</td>
<td>69</td>
<td>-1.70</td>
<td>-1.73</td>
<td></td>
<td>0.14</td>
</tr>
<tr>
<td>Professional Title:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>7</td>
<td>-0.69</td>
<td>0.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>15</td>
<td>-6.22</td>
<td>5.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>8</td>
<td>1.13</td>
<td>1.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor Educator</td>
<td>30</td>
<td>-0.95</td>
<td>1.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor-in-Training</td>
<td>76</td>
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<td>-1.93</td>
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<td>0.18</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>0.122</td>
</tr>
<tr>
<td>Multiple r</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.349</td>
</tr>
</tbody>
</table>
subject's perceptions of the attributes of the mentally healthy adult male. How a subject perceives the mentally healthy adult male is influenced by the interaction of the sex-age-subgroup classification variables, as indicated in Table 15. These results imply that the subjects are different in their viewpoints of the mentally healthy adult male along gender, age, and subgroup classification lines.

The third implication of the results suggests that the subjects perceive the attributes of the mentally healthy adult female differently when classified according to gender. The Multiple Classification Analysis portion of Table 16 reveals that the male subjects attribute the mentally healthy adult female with less of the stereotypic masculine attributes which are characteristically reserved for males, than do the female subjects. These data suggest that women are viewing themselves and attributing themselves with the traditional prized behavioral attributes and characteristics which are usually attributed to men.

A clear trend emerging from these data is that on all three measures, significant differences were found between women and men along gender lines regardless of the age or subgroup classification of the subjects. The results demonstrate that the male subjects are more supportive of the traditional stereotypic view of females, whereas the female subjects have demonstrated they appear to be moving away from their previous stereotypic images.
Hypothesis 3

There will be no significant differences in the level of assessed sex bias between Mental Health Professionals when the subjects are classified by sex, age, and professional title.

Results

The three-way factorial ANOVAS which were performed on the subject's scores on the ATW, the PAQ-1, and the PAQ-2 are presented in tables 17, 18, and 19. For the ATW, the main effect sex (F-ratio, 15.129, $\alpha<.01$) was found to be significant. For the first PAQ, the main effect professional title (F-ratio, 5.64, $\alpha<.05$) was found to be significant. A double interaction effect, sex x age, was found for the subjects on the second PAQ (F-ratio, 4.956, $\alpha<.05$), which is significant. Based on the data, for the ATW, the null hypothesis is accepted for the variables age and professional title, and the null hypothesis is rejected for the variable sex. For the first PAQ, the null hypothesis is rejected for the variable professional title, and accepted for the variables sex and age. For the second PAQ, the null hypothesis is accepted for the variables professional title and rejected for the variables sex and age.

Discussion

These results point to different implications in regard to the Mental Health Professional's view of the
Table 17

Three-Way Factorial Analysis of Variance: Attitudes Toward Women Scale
x Sex x Age x Professional Title for Mental Health Professionals

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>3,951.55</td>
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<td>987.886</td>
<td>4.742</td>
<td>.007</td>
</tr>
<tr>
<td>Sex</td>
<td>3,360.02</td>
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<td>3,360.017</td>
<td>15.129</td>
<td>.001**</td>
</tr>
<tr>
<td>Age</td>
<td>122.65</td>
<td>1</td>
<td>122.646</td>
<td>.589</td>
<td>.452</td>
</tr>
<tr>
<td>Title</td>
<td>468.88</td>
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<td>234.441</td>
<td>1.125</td>
<td>.344</td>
</tr>
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<td>2-Way Interactions</td>
<td>1,263.39</td>
<td>5</td>
<td>252.679</td>
<td>1.213</td>
<td>.339</td>
</tr>
<tr>
<td>Sex-Age</td>
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<td>21.841</td>
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<tr>
<td>Sex-Title</td>
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<td>41.498</td>
<td>2.119</td>
<td>.146</td>
</tr>
<tr>
<td>Age-Title</td>
<td>410.27</td>
<td>2</td>
<td>205.135</td>
<td>.985</td>
<td>.391</td>
</tr>
<tr>
<td>Explained</td>
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<td>.027</td>
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**a<.01
Table 17 (cont'd.)

Multiple Classification Analysis - Grand Mean = 189.57

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<th>BETA</th>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>7.48</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>-14.97</td>
<td></td>
<td>-13.32</td>
<td>.53</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 &amp; Under</td>
<td>11</td>
<td>7.89</td>
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<td>2.87</td>
<td>.34</td>
</tr>
<tr>
<td>36 &amp; Over</td>
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<td>-1.66</td>
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</tr>
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<td></td>
<td>-6.87</td>
<td>.29</td>
</tr>
<tr>
<td>Psychologist</td>
<td>15</td>
<td>2.90</td>
<td></td>
<td>1.11</td>
<td>.22</td>
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<td>Social Worker</td>
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<td>2.56</td>
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<td>3.92</td>
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Multiple Regression Squared  

Multiple $r$
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<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
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<td>164.75</td>
<td>3.31</td>
<td>.031</td>
</tr>
<tr>
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<td>1</td>
<td>10.42</td>
<td>.209</td>
<td>.652</td>
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<td>86.57</td>
<td>1.74</td>
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<td>281.00</td>
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<td>5.11</td>
<td>.103</td>
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<td>.013</td>
<td>.987</td>
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<td>8.88</td>
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<td>58.41</td>
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*α < .05
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<th>Unadjusted ETA</th>
<th>BETA</th>
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<tbody>
<tr>
<td><strong>Sex:</strong></td>
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<td></td>
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</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>.42</td>
<td>.15</td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>-0.83</td>
<td>-0.30</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 &amp; Under</td>
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<td>2.50</td>
</tr>
<tr>
<td>36 &amp; Over</td>
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<td>-1.44</td>
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<td><strong>Title:</strong></td>
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<td>7.27</td>
<td>7.63</td>
</tr>
<tr>
<td>Psychologist</td>
<td>15</td>
<td>-1.00</td>
<td>-1.42</td>
</tr>
<tr>
<td>Social Worker</td>
<td>8</td>
<td>-4.48</td>
<td>-4.00</td>
</tr>
<tr>
<td><strong>Multiple Regression Squared</strong></td>
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<td></td>
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<tr>
<td>Multiple r</td>
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<td>.624</td>
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</table>
Table 19

Three-Way Factorial Analysis of Variance on the Second Personal Attributes Questionnaire x Sex x Age x Professional Title for Mental Health Professionals

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>504.59</td>
<td>4</td>
<td>126.15</td>
<td>1.273</td>
<td>.314</td>
</tr>
<tr>
<td>Sex</td>
<td>299.27</td>
<td>1</td>
<td>299.27</td>
<td>3.020</td>
<td>.098</td>
</tr>
<tr>
<td>Age</td>
<td>14.04</td>
<td>1</td>
<td>14.04</td>
<td>.142</td>
<td>.711</td>
</tr>
<tr>
<td>Professional Title</td>
<td>191.29</td>
<td>2</td>
<td>95.64</td>
<td>.065</td>
<td>.398</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>890.60</td>
<td>5</td>
<td>178.12</td>
<td>1.798</td>
<td>.159</td>
</tr>
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<td>491.11</td>
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<td>491.11</td>
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<td>22.67</td>
<td>.229</td>
<td>.798</td>
</tr>
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<td>Age-Professional Title</td>
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<td>204.37</td>
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<td>.153</td>
</tr>
<tr>
<td>Explained</td>
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<td>9</td>
<td>155.02</td>
<td>1.564</td>
<td>.193</td>
</tr>
<tr>
<td>Residual</td>
<td>1,981.77</td>
<td>20</td>
<td>99.09</td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>13,376.97</td>
<td>29</td>
<td>116.45</td>
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<td></td>
</tr>
</tbody>
</table>

*α<.05
status and role of women in society, the attributes they assign to the mentally healthy adult male, and the attributes they assign to the mentally healthy adult female.

An inspection of the Multiple Classification Analysis section of Table 17 reveals that it is the younger women among the mental health professionals who have scored the most liberal, or pro-feminist, followed by the older female mental health professionals, the younger male mental health professionals, and the older male mental health professionals. An analysis of these data has allowed the implication to be made that the male subjects, particularly the older male mental health professionals, are the most traditional or sex-stereotypic in their attitudes about the status and role of women in society, as demonstrated by their summated scores on the ATW scale.

The attributes of the mentally healthy adult male were perceived as being significantly different on the PAQ-1, by the mental health professionals when they were classified by professional title. Upon inspection of the Multiple Classification Analysis of Table 18, it is revealed that it is the subject's classification of psychiatrist who is found to describe the mentally healthy adult male in the most traditional, stereotypic manner, whereas, the subjects who were classified by the professional title, social worker, were found to comprise the group of subjects who perceived the mentally healthy adult male in the most
nontraditional, stereotypic light. The implications of these findings are that the subject group, psychiatrists, being the oldest subjects of the sample, may possibly be reflecting more of the societal stereotypic and traditional view of men than are their younger colleagues.

The data from the PAQ-2 suggest that the mental health professional's perception of the mentally healthy adult female is influenced by both the sex and age of the subject. According to the scores of the subjects, the most liberal or pro-feminist are the younger female psychologists who ascribe to women the traditional, stereotypic, highly valued characteristics usually reserved for males. Just as the psychiatrists were found to appear to be the most traditional in their perceptions of the mentally healthy adult male, they also have exhibited that they are the most traditional in their view of the mentally healthy adult female.

Hypothesis 4

There will be no significant differences in the level of assessed sex bias between Counselor Educators when the subjects are classified by sex and age.

Results

The analysis of the two-way factorial ANOVAS which were performed on each of the three measuring instruments, produced mixed results. There were no significant effects
determined on the ATW; however, a two-way interaction effect, sex x age, was found for the subject's perception of the mentally healthy adult male (F-ratio, 9.912, α < .01), on the PAQ-1. There were no significant effects determined on the PAQ-2. Based on the data, for the ATW, the null hypothesis is accepted. For the first PAQ, the null hypothesis is rejected. For the second PAQ, the null hypothesis is accepted. The results of the two-way ANOVAS for the ATW, the PAQ-1, and the PAQ-2 are presented in tables 20, 21, and 22.

**Discussion**

These results indicate that counselor educators do not differ in their perception of the status and role of women in society. Both female and male educators, regardless of age share the same view of the place of women in society.

A second implication of the data is that counselor educators differ in their perception of the mentally healthy adult male. These differences appear to be influenced by the interaction of both the sex and the age of the educator. When inspecting the mean scores of the subjects, the data indicate that the female educators appear to be less stereotypically traditional in their views of the mentally healthy adult male, whereas the male subjects are adhering to the traditional stereotypic characteristics of the mentally
## Table 20

Two-Way Factorial Analysis of Variance on the Attitudes Toward Women Scale x Sex x Age for Counselor Educators

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>366.11</td>
<td>2</td>
<td>183.06</td>
<td>.533</td>
<td>.593</td>
</tr>
<tr>
<td>Sex</td>
<td>290.77</td>
<td>1</td>
<td>290.77</td>
<td>.846</td>
<td>.366</td>
</tr>
<tr>
<td>Age</td>
<td>75.34</td>
<td>1</td>
<td>75.34</td>
<td>.219</td>
<td>.644</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>1,026.26</td>
<td>1</td>
<td>102.26</td>
<td>2.99</td>
<td>.096</td>
</tr>
<tr>
<td>Sex-Age</td>
<td>1,026.26</td>
<td>1</td>
<td>102.26</td>
<td>2.99</td>
<td>.096+</td>
</tr>
<tr>
<td>Explained</td>
<td>1,392.37</td>
<td>3</td>
<td>464.12</td>
<td>1.35</td>
<td>.280</td>
</tr>
<tr>
<td>Residual</td>
<td>8,937.10</td>
<td>26</td>
<td>343.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10,329.47</td>
<td>29</td>
<td>356.19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+α > .05
Table 21

Two-Way Factorial Analysis of Variance on the First Personal Attributes Questionnaire x Sex x Age for Counselor Educators

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>1,235.71</td>
<td>2</td>
<td>617.86</td>
<td>5.415</td>
<td>.011</td>
</tr>
<tr>
<td>Sex</td>
<td>95.28</td>
<td>1</td>
<td>95.28</td>
<td>.835</td>
<td>.369</td>
</tr>
<tr>
<td>Age</td>
<td>1,140.43</td>
<td>1</td>
<td>1,140.43</td>
<td>9.995</td>
<td>.004</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>1,131.06</td>
<td>1</td>
<td>1,131.06</td>
<td>9.912</td>
<td>.004**</td>
</tr>
<tr>
<td>Sex-Age</td>
<td>1,131.06</td>
<td>1</td>
<td>1,131.06</td>
<td>9.912</td>
<td>.004**</td>
</tr>
<tr>
<td>Explained</td>
<td>2,366.77</td>
<td>3</td>
<td>788.92</td>
<td>6.914</td>
<td>.001</td>
</tr>
<tr>
<td>Residual</td>
<td>2,966.73</td>
<td>26</td>
<td>114.11</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,333.50</td>
<td>29</td>
<td>183.91</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**α<.01
Table 22

Two-Way Factorial Analysis of Variance on the Second Personal Attributes Questionnaire x Sex x Age for Counselor Educators

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>561.84</td>
<td>1</td>
<td>561.94</td>
<td>3.191</td>
<td>.086+</td>
</tr>
<tr>
<td>Age</td>
<td>11.95</td>
<td>1</td>
<td>11.95</td>
<td>.068</td>
<td>.797</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex-Age</td>
<td>12.27</td>
<td>1</td>
<td>12.27</td>
<td>.070</td>
<td>.794</td>
</tr>
<tr>
<td>Explained</td>
<td>586.17</td>
<td>3</td>
<td>195.39</td>
<td>1.110</td>
<td>.363</td>
</tr>
<tr>
<td>Residual</td>
<td>4,578.00</td>
<td>26</td>
<td>176.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,164.17</td>
<td>29</td>
<td>178.08</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+α>.05
Although the data suggest that counselor educators differ in their view of the mentally healthy adult male along gender lines, the data do not suggest that the educators differ in their perception of the mentally healthy adult female. The main effect, sex, was not quite significant, however, the trend which has been established that the subjects do differ in their view of the mentally healthy adult female when classified by sex, is suggested in the results.

Hypothesis 5

There will be no significant differences in the level of assessed sex bias between Counselors-in-Training when the subjects are classified by sex, age, and school program.

Results

A three-way factorial ANOVA was performed on the ATW, the PAQ-1, and the PAQ-2 to test for differences among counselors-in-training. For the ATW, the main effect sex (F-ratio, 4.096, α<.05) was found to be significant. For the PAQ-1, a three-way interaction, sex x age x school program (F-ratio, 5.901, α<.05) was determined. The main effect, sex (F-ratio, 3.337, α<.05) was found to be significant for the PAQ-2. Based on these results, for the ATW, the null hypothesis is accepted for the variables age and
school program, but rejected for the variable sex. The null hypothesis is rejected for the PAQ-1 across all variables. For the PAQ-2, the null hypothesis is rejected for the variable sex, and accepted for the variables age and school program. The three-way factorial analysis of variance for the ATW, PAQ-1, and PAQ-2, are presented in tables 23, 24, and 25.

Discussion

The data indicate that counselors-in-training perceive the status and role of women in society differently according to the sex of the subject. Inspection of the Multiple Classification Analysis of Table 23 reveals that the female counselor trainees are the most liberal or pro-feminist in their perception of the roles of women, whereas the male counselors trainees prefer the more traditional, stereotypic view of women. This finding is consistent with previous findings of this study, where the male subjects have demonstrated an adherence to the traditional, sex-stereotypic perceptions of women, while the female subjects appear to be claiming the traditional attributes and characteristics as part of their image, that had previously been reserved for males.

A second implication of this analysis is that the subjects differ in their perceptions of the mentally healthy adult male. The data suggest that among the counselor-
Table 23

Three-Way Factorial Analysis of Variance for Counselors-in-Training on the Attitude Toward Women Scale x Sex x Age x School Program

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>1,504.7</td>
<td>3</td>
<td>501.49</td>
<td>2.418</td>
<td>.174</td>
</tr>
<tr>
<td>Sex</td>
<td>849.53</td>
<td>1</td>
<td>849.53</td>
<td>4.096</td>
<td>.047*</td>
</tr>
<tr>
<td>Age</td>
<td>270.69</td>
<td>1</td>
<td>270.69</td>
<td>1.305</td>
<td>.257</td>
</tr>
<tr>
<td>School Program</td>
<td>384.25</td>
<td>1</td>
<td>384.25</td>
<td>1.853</td>
<td>.178</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>443.17</td>
<td>3</td>
<td>147.72</td>
<td>.712</td>
<td>.548</td>
</tr>
<tr>
<td>Sex-Age</td>
<td>.024</td>
<td>1</td>
<td>.124</td>
<td>.000</td>
<td>.991</td>
</tr>
<tr>
<td>Sex-School Programs</td>
<td>120.84</td>
<td>1</td>
<td>120.84</td>
<td>.583</td>
<td>.448</td>
</tr>
<tr>
<td>Age-School Programs</td>
<td>294.51</td>
<td>1</td>
<td>294.51</td>
<td>1.420</td>
<td>.238</td>
</tr>
<tr>
<td>3-Way Interactions</td>
<td>51.29</td>
<td>1</td>
<td>51.29</td>
<td>.247</td>
<td>.621</td>
</tr>
<tr>
<td>Sex-Age-School Program</td>
<td>51.29</td>
<td>1</td>
<td>51.29</td>
<td>.247</td>
<td>.621</td>
</tr>
<tr>
<td>Explained</td>
<td>1,998.92</td>
<td>7</td>
<td>285.56</td>
<td>1.377</td>
<td>.229</td>
</tr>
<tr>
<td>Residual</td>
<td>14,104.49</td>
<td>68</td>
<td>207.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16,103.41</td>
<td>75</td>
<td>214.71</td>
<td></td>
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</tr>
</tbody>
</table>

*α < .05
Table 23 (cont'd.)

Multiple Classification Analysis - Grand Mean = 186.86

<table>
<thead>
<tr>
<th>Variable and Category</th>
<th>N</th>
<th>Unadjusted Deviation</th>
<th>ETA</th>
<th>Adjusted for Independent Deviation</th>
<th>BETA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>51</td>
<td>2.34</td>
<td></td>
<td>2.74</td>
<td>.23</td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>-4.78</td>
<td></td>
<td>-5.59</td>
<td>.27</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 &amp; Under</td>
<td>47</td>
<td>1.40</td>
<td></td>
<td>1.54</td>
<td>.12</td>
</tr>
<tr>
<td>36 &amp; Over</td>
<td>29</td>
<td>-2.27</td>
<td></td>
<td>-2.50</td>
<td>.13</td>
</tr>
<tr>
<td><strong>School Program:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master's</td>
<td>30</td>
<td>-1.72</td>
<td></td>
<td>-2.86</td>
<td>.10</td>
</tr>
<tr>
<td>Doctoral</td>
<td>46</td>
<td>1.12</td>
<td></td>
<td>1.86</td>
<td>.16</td>
</tr>
<tr>
<td><strong>Multiple Regression Squared</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.093</td>
</tr>
<tr>
<td><strong>Multiple r</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.306</td>
</tr>
</tbody>
</table>
Table 24

Three-Way Factorial Analysis of Variance for Counselors-in-Training on the First Personal Attributes Questionnaire x Sex x Age x School Program

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>187.83</td>
<td>3</td>
<td>62.61</td>
<td>.787</td>
<td>.505</td>
</tr>
<tr>
<td>Age</td>
<td>.272</td>
<td>1</td>
<td>.272</td>
<td>.003</td>
<td>.954</td>
</tr>
<tr>
<td>School Program</td>
<td>.011</td>
<td>1</td>
<td>.011</td>
<td>.000</td>
<td>.991</td>
</tr>
<tr>
<td>Sex-Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex-School Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age-School Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-Way Interactions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex-Age-School Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explained</td>
<td>817.53</td>
<td>7</td>
<td>116.79</td>
<td>1.468</td>
<td>.193</td>
</tr>
<tr>
<td>Residual</td>
<td>5,409.67</td>
<td>68</td>
<td>79.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,227.20</td>
<td>75</td>
<td>83.03</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*α<.05
<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>S.S.</th>
<th>d.f.</th>
<th>M.S.</th>
<th>F-Ratio</th>
<th>F-Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>1,455.60</td>
<td>3</td>
<td>485.20</td>
<td>3.106</td>
<td>.032</td>
</tr>
<tr>
<td>Sex</td>
<td>833.69</td>
<td>1</td>
<td>833.69</td>
<td>3.337</td>
<td>.024*</td>
</tr>
<tr>
<td>Age</td>
<td>535.03</td>
<td>1</td>
<td>535.03</td>
<td>3.425</td>
<td>.069</td>
</tr>
<tr>
<td>School Program</td>
<td>86.88</td>
<td>1</td>
<td>86.88</td>
<td>.556</td>
<td>.458</td>
</tr>
<tr>
<td>2-Way Interactions</td>
<td>618.18</td>
<td>3</td>
<td>206.06</td>
<td>1.319</td>
<td>.275</td>
</tr>
<tr>
<td>Sex-Age</td>
<td>155.10</td>
<td>1</td>
<td>155.10</td>
<td>.933</td>
<td>.323</td>
</tr>
<tr>
<td>Sex-School Program</td>
<td>288.01</td>
<td>1</td>
<td>288.01</td>
<td>1.844</td>
<td>.179</td>
</tr>
<tr>
<td>Age-School Program</td>
<td>158.28</td>
<td>1</td>
<td>158.28</td>
<td>1.013</td>
<td>.318</td>
</tr>
<tr>
<td>3-Way Interactions</td>
<td>28.60</td>
<td>1</td>
<td>28.60</td>
<td>.183</td>
<td>.670</td>
</tr>
<tr>
<td>Sex-Age-School Program</td>
<td>28.60</td>
<td>1</td>
<td>28.60</td>
<td>.183</td>
<td>.670</td>
</tr>
<tr>
<td>Explained</td>
<td>2,102.37</td>
<td>7</td>
<td>300.34</td>
<td>1.923</td>
<td>.079</td>
</tr>
<tr>
<td>Residual</td>
<td>10,622.26</td>
<td>68</td>
<td>156.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12,724.63</td>
<td>75</td>
<td>169.66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05
<table>
<thead>
<tr>
<th>Variable and Category</th>
<th>N</th>
<th>Unadjusted Deviation</th>
<th>ETA</th>
<th>Adjusted for Independent Deviation</th>
<th>BETA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>51</td>
<td>2.32</td>
<td>2.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>-4.73</td>
<td>-5.20</td>
<td></td>
<td>.28</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 &amp; Under</td>
<td>47</td>
<td>2.00</td>
<td>2.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36 &amp; Over</td>
<td>29</td>
<td>-3.325</td>
<td>-3.42</td>
<td></td>
<td>.21</td>
</tr>
<tr>
<td><strong>School Program:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master's</td>
<td>30</td>
<td>-0.28</td>
<td>-1.36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctoral</td>
<td>46</td>
<td>.18</td>
<td>.89</td>
<td></td>
<td>.08</td>
</tr>
</tbody>
</table>

Multiple Regression Squared

Multiple $r$

114

.338
in-training sample, how they perceive the mentally healthy adult male is influenced by the interaction of the subject's sex, age, and school program (master's or doctoral). As evidenced before, the younger female subjects do not maintain the perception of the traditional view of the male, while the male subjects, particularly the older males, do hold to the more traditional view of the mentally healthy adult male.

It appears that the triple interaction of sex, age, and school program may be understood more clearly by the re-examination of the makeup of the population sample. The subjects who are in master degree school programs, are, in general, the younger members of the counselor-in-training sample, while the subjects who are in doctoral degree school programs, are in general older. The major influence of the program interaction effect, is the age effect of the younger subjects in the sample.

The third implication of the data is that the female and male counselors-in-training sample perceive the attributes of the mentally healthy adult female significantly different when the subjects are classified by sex. The Multiple Classification Analysis section of Table 25 reveals that the male counselor trainees have perceived the attributes of the mentally healthy adult female in a traditionally stereotypic view. These findings continue to confirm the results of gender differences as accountable for
differences in the perceptions of the female and male subjects, as demonstrated throughout the previous analyses.

Hypothesis 6

There will be no significant differences in the level of assessed sex bias within Mental Health Professionals, Counselor Educators, and Counselors-in-Training, when the subjects are classified by theoretical orientation.

Results

A chi-square test for independence was performed for the subject's scores on the ATW, the PAQ-1, and the PAQ-2. The results of this analysis are presented in tables 26, 27, and 28. There were no significant levels of association determined on any of the three analyses which would indicate a relationship between a subject's theoretical orientation and her/his level of assessed sex bias. Based on these results, the null hypothesis for no significant differences in sex bias is accepted.

Discussion

The results of the data indicate that a subject's perception of the role and status of women, the subject's view of the mentally healthy adult female, and the mentally healthy adult male is not a function of the subject's theoretical orientation. The implications of these results is that the subject's level of sex bias, in all likelihood,
Table 26

Chi Square Analysis: The Attitude Toward Women Scale on the First Personal Attributes Questionnaire, and the Second Personal Attributes Questionnaire x Theoretical Orientation of Mental Health Professionals

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of Subjects</th>
<th>Raw x²</th>
<th>d.f.</th>
<th>x² Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATW</td>
<td>30</td>
<td>43.882</td>
<td>35</td>
<td>.1443+</td>
</tr>
<tr>
<td>PAQ-1</td>
<td>30</td>
<td>12.757</td>
<td>15</td>
<td>.6210+</td>
</tr>
<tr>
<td>PAQ-2</td>
<td>30</td>
<td>25.344</td>
<td>20</td>
<td>.1886+</td>
</tr>
</tbody>
</table>

+α > .05
Table 27

Chi Square Analysis: The Attitude Toward Women Scale on the First Personal Attributes Questionnaire, and the Second Personal Attributes Questionnaire x Theoretical Orientation for Counselor Educators

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of Subjects</th>
<th>Raw $x^2$</th>
<th>d.f.</th>
<th>$x^2$ Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATW</td>
<td>30</td>
<td>37.986</td>
<td>30</td>
<td>.1501+</td>
</tr>
<tr>
<td>PAQ-1</td>
<td>30</td>
<td>14.017</td>
<td>25</td>
<td>.9614+</td>
</tr>
<tr>
<td>PAQ-2</td>
<td>30</td>
<td>27.224</td>
<td>20</td>
<td>.1291+</td>
</tr>
</tbody>
</table>

+α>.05
Table 28

Chi Square Analysis: The Attitude Toward Women Scale on the First Personal Attributes Questionnaire, and the Second Personal Attributes Questionnaire x Theoretical Orientation for Counselors-in-Training

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of Subjects</th>
<th>Raw $\chi^2$</th>
<th>d.f.</th>
<th>$\chi^2$ Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATW</td>
<td>76</td>
<td>27.607</td>
<td>30</td>
<td>.5912+</td>
</tr>
<tr>
<td>PAQ-1</td>
<td>76</td>
<td>18.969</td>
<td>30</td>
<td>.9406+</td>
</tr>
<tr>
<td>PAQ-2</td>
<td>76</td>
<td>30.203</td>
<td>24</td>
<td>.1781+</td>
</tr>
</tbody>
</table>

+$\alpha>.05$
has been fostered by variables other than the theoretical orientation the subject may have adopted.

**Hypothesis 7**

The data will suggest no level of association between the subject's scores on the Attitude Toward Women Scale and the second Personal Attributes Questionnaire.

**Results**

A Pearson Product Moment Correlation Coefficient \(r = .36835, \alpha < .00001\) provides conclusive evidence that the null hypothesis of no level of association should be rejected. The results of the Pearson \(r\) are presented in Table 29.

**Discussion**

The Pearson \(r\) indicates the strength of a relationship between interval level variables, but is not indicative of any causal relationship. The actual interpretation of the correlation is the amount of variance in one variable that can be accounted for by the variance in the second variable. This highly significant correlation suggests that how a subject perceives the status and role of women in society is positively related to the attributes that the subject would assign as being characteristic of the mentally healthy adult female. In other words, if the subject possesses a traditional, sex-role stereotypic viewpoint
<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correlation</td>
<td>.36835</td>
</tr>
<tr>
<td>( r ) Squared</td>
<td>.13568</td>
</tr>
<tr>
<td>Significance of ( r )</td>
<td>.00001*</td>
</tr>
<tr>
<td>Standard Error of Estimate</td>
<td>15.36348</td>
</tr>
<tr>
<td>Intercept (A)</td>
<td>108.88861</td>
</tr>
<tr>
<td>Standard Error of A</td>
<td>16.97000</td>
</tr>
<tr>
<td>Significance of A</td>
<td>.00001</td>
</tr>
<tr>
<td>Significance of B</td>
<td>.00001</td>
</tr>
<tr>
<td>Slope (B)</td>
<td>.47864</td>
</tr>
<tr>
<td>Standard Error of B</td>
<td>.10436</td>
</tr>
<tr>
<td>Plotted Values</td>
<td>136</td>
</tr>
</tbody>
</table>

\(*_{a<.001}\)
of the status and role of women, the data suggest that the subject would also reflect this stereotypic view of the mentally healthy adult female in descriptions of attributes the subject would assign to women.

Hypothesis 8

There will be no significant differences in the perceptions of Mental Health Professionals in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

Results

A t test for paired (correlated) samples produced a t value of 1.12, $\alpha<.05$. Based on the determination of the results of this analysis, the null hypothesis of no significant differences is accepted. The results of the t test are presented in Table 30.

Discussion

The data suggest that mental health professionals do not perceive the characteristics of the mentally healthy adult female and the mentally healthy adult male differently. These results were not expected, the expectations, in accordance with previous studies, were that significant differences would be determined between the mental health professional sample as to their ratings of the mentally healthy adult female and male. A re-examination of the
Table 30

Results of t Test Comparing the First Personal Attributes Questionnaire and the Second Personal Attributes Questionnaire for Mental Health Professionals

<table>
<thead>
<tr>
<th></th>
<th>PAQ-1</th>
<th>PAQ-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Mean Score</td>
<td>167.7333</td>
<td>165.3667</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>7.643</td>
<td>10.791</td>
</tr>
<tr>
<td>Standard Error</td>
<td>1.395</td>
<td>1.970</td>
</tr>
</tbody>
</table>

Difference, Mean        2.3667
Standard Deviation  11.625
Standard Error  2.122
Correlation          .241
2-Tail Probability  .200+
t-Value              1.12
Difference           29
2-Tail Probability  .274+

+α>.05
the subjects who comprise the sample provided some indications as to these unexpected results.

The group comprising the mental health professionals sample contained a high proportion of females. It appears that that influence may have produced misleading results in this analysis, as the actual interpretation of the data revealed that the attributes of the mentally healthy adult female, as rated by this subject group, were designated as possessing more traditional stereotypic masculine traits as compared with the attributes assigned to the mentally healthy adult male.

Hypothesis 9

There will be no significant differences in the perceptions of Counselor Educators in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

Results

A t test for paired (correlated) samples was performed to analyze the differences in responses of counselor educators on the PAQ-1 and the PAQ-2. A significant difference was determined between the two measures producing the following results: \( t \text{ test } = 2.05, \alpha < .05 \). Based on this, the null hypothesis of no significant differences is rejected. The results of the t test are presented in Table 31.
Table 31
Results of t Test Comparing the First Personal Attributes Questionnaire and the Second Personal Attributes Questionnaire for Counselor Educators

<table>
<thead>
<tr>
<th></th>
<th>PAQ-1</th>
<th>PAQ-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Mean Score</td>
<td>161.1667</td>
<td>168.5000</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>13.344</td>
<td>13.561</td>
</tr>
<tr>
<td>Standard Error</td>
<td>2.436</td>
<td>2.476</td>
</tr>
<tr>
<td>Difference, Mean</td>
<td></td>
<td>7.3333</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td></td>
<td>19.579</td>
</tr>
<tr>
<td>Standard Error</td>
<td>3.575</td>
<td></td>
</tr>
<tr>
<td>Correlation</td>
<td>-0.059</td>
<td></td>
</tr>
<tr>
<td>2-Tail Probability</td>
<td></td>
<td>.757+</td>
</tr>
<tr>
<td>t-Value</td>
<td>2.05</td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>2-Tail Probability</td>
<td></td>
<td>.049*</td>
</tr>
</tbody>
</table>

+α>.05  
*α<.05
Discussion

The data suggest that counselor educators as a subject group, view the attributes of the mentally healthy adult female as being different from the attributes possessed by the mentally healthy adult male. The male Counselor Educator sample held the more traditional stereotypic view of attributes possessed by the mentally healthy adult female, while the female Counselor Educators' scores suggested a more liberal or pro-feminist view of the attributes of the mentally healthy adult female. The mean scores of the Counselor Educators as measured by the second Personal Attributes Questionnaire (the attributes of the mentally healthy adult female) are presented in Table 35.

Hypothesis 10

There will be no significant differences in the perceptions of Counselors-in-Training in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

Results

The t test for paired (correlated) samples, which was performed to analyze the difference in responses of counselors-in-training on the PAQ-1 and the PAQ-2, resulted in highly significant differences. The results of the t test are: \( t\text{-value} = 4.31, \alpha < .0001 \). Based on these findings, the null hypothesis of no significant differences
is rejected. The results of the t test are presented in Table 32.

**Discussion**

This highly significant result suggests that counselors-in-training have quite divergent perspectives as to the attributes of the mentally healthy adult female and the mentally healthy adult male. An inspection of Table 35 indicates that the female counselor-in-training subject group have demonstrated they are the most pro-feminist in their assignment of behavioral characteristics to the mentally healthy adult female that are usually reserved for the adult male, while the male counselor-in-training sample has viewed the attributes of the mentally healthy adult female along more traditional stereotypic perspectives.

**Hierarchy of Subjects and Subgroups**

There has been no attempt made in this research to indicate that any group or subgroup classification of subjects is biased toward either women or men, but rather, a subject's level of assessed bias is considered relative to the level of assessed bias of the other subjects who comprise the population sample.

It has not been the focus, nor the objective of this investigation to address the question of who should be considered possessing sex-role stereotypic biases or
### Table 32
Results of t Test Comparing the First Personal Attributes Questionnaire and the Second Personal Attributes Questionnaire for Counselors-in-Training

<table>
<thead>
<tr>
<th></th>
<th>PAQ-1</th>
<th>PAQ-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects</td>
<td>76</td>
<td>76</td>
</tr>
<tr>
<td>Mean Score</td>
<td>161.2105</td>
<td>168.7237</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>13.025</td>
<td>9.112</td>
</tr>
<tr>
<td>Standard Error</td>
<td>1.494</td>
<td>1.045</td>
</tr>
<tr>
<td>Difference, Mean</td>
<td>7.5132</td>
<td></td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>15.201</td>
<td></td>
</tr>
<tr>
<td>Standard Error</td>
<td>1.744</td>
<td></td>
</tr>
<tr>
<td>Correlation</td>
<td>.091</td>
<td></td>
</tr>
<tr>
<td>2-Tail Probability</td>
<td>.434+</td>
<td></td>
</tr>
<tr>
<td>t-Value</td>
<td>4.31</td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>2-Tail Probability</td>
<td>.0001*</td>
<td></td>
</tr>
</tbody>
</table>

+α > .05
*α < .001
to determine some criteria for scoring on each of the measuring instruments whereby a subject is designated more sex biased than another subject.

What has been developed is a hierarchal table in which the subjects have been ranked according to sex, age, and subgroup classification. A hierarchal table has been developed for each of the measuring instruments the ATW, the first PAQ, and the second PAQ.

The hierarchal order of the subject's scores on the Attitude Toward Women Scale is presented in Table 33. The inspection of this table reveals a trend which demonstrates that the male subjects in the sample were the most traditional in their perception of the status and role of women in society. This trend has been confirmed by previous data analysis.

The hierarchy of the subgroup's scores on the first Personal Attributes Questionnaire (the attributes of the mentally healthy adult male) is presented in Table 34. There have been no clear patterns of responses between the subgroups as evidenced by inspection of this table. What has been demonstrated is the female subjects intermixed with male subjects in the sample, supporting the traditional stereotypic perceptions of attributes assigned to men. A close inspection allows the conclusion to be drawn that the subgroup of female subjects have the most traditional stereotypic perception of males.
Table 33

Hierarchal Order of Twenty Subgroups as Measured by the Attitudes Toward Women Scale: From Most Pro-Feminist to Most Traditional

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Title</th>
<th>Mean ATW Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Psychologists</td>
<td>199.78</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Social Workers</td>
<td>199.44</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Counselors-in-Training</td>
<td>194.17</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Psychologists</td>
<td>194.14</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Social Workers</td>
<td>193.8</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Counselor Educators</td>
<td>189.78</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Psychologists</td>
<td>188.97</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Social Workers</td>
<td>188.63</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Counselors-in-Training</td>
<td>188.53</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Psychiatrists</td>
<td>187.74</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Counselor Educators</td>
<td>184.14</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Counselors-in-Training</td>
<td>183.36</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Psychologists</td>
<td>183.33</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Social Workers</td>
<td>182.99</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Psychiatrists</td>
<td>182.1</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Counselor Educators</td>
<td>178.97</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Counselors-in-Training</td>
<td>177.72</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Psychiatrists</td>
<td>176.93</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Counselor Educators</td>
<td>173.33</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Psychiatrists</td>
<td>171.29</td>
</tr>
</tbody>
</table>
**Table 34**

Hierarchal Order of Twenty Subgroups as Measured by the First Personal Attributes Questionnaire (the Attributes of the Mentally Healthy Adult Male)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Title</th>
<th>Mean Score PAQ-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Psychiatrists</td>
<td>177.14</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Psychiatrists</td>
<td>175.94</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Psychiatrists</td>
<td>173.89</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Psychiatrists</td>
<td>172.64</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Counselors-in-Training</td>
<td>170.87</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Counselor Educators</td>
<td>170.64</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Counselors-in-Training</td>
<td>169.67</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Counselor Educators</td>
<td>169.44</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Psychologists</td>
<td>168.88</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Psychologists</td>
<td>167.68</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Counselors-in-Training</td>
<td>167.62</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Counselor Educators</td>
<td>167.39</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Counselors-in-Training</td>
<td>166.42</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Counselor Educators</td>
<td>166.19</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Psychologists</td>
<td>165.68</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Social Workers</td>
<td>165.39</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Psychologists</td>
<td>164.43</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Social Workers</td>
<td>164.19</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Social Workers</td>
<td>162.74</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Social Workers</td>
<td>160.94</td>
</tr>
</tbody>
</table>
The scores of the subjects on the second Personal Attributes Questionnaire (the attributes of the mentally healthy adult female) comprise the third hierarchy, which is presented in Table 35. A clear trend is evident, where the female subjects have supported a more pro-feminist perspective of the mentally healthy adult female, and the male subjects in the study demonstrate the support of a more traditional stereotypic view of women.
<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Title</th>
<th>Mean Score PAQ-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Psychologists</td>
<td>173.00</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Psychiatrists</td>
<td>169.55</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Social Workers</td>
<td>167.91</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Psychiatrists</td>
<td>166.09</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Psychologists</td>
<td>165.94</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Counselors-in-Training</td>
<td>165.87</td>
</tr>
<tr>
<td>Females</td>
<td>Under 35</td>
<td>Counselor Educators</td>
<td>165.83</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Social Workers</td>
<td>164.46</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Psychiatrists</td>
<td>162.64</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Psychologists</td>
<td>162.49</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Counselors-in-Training</td>
<td>162.42</td>
</tr>
<tr>
<td>Females</td>
<td>Over 36</td>
<td>Counselor Educators</td>
<td>162.38</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Social Workers</td>
<td>161.05</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Psychiatrists</td>
<td>159.03</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Counselors-in-Training</td>
<td>158.81</td>
</tr>
<tr>
<td>Males</td>
<td>Under 35</td>
<td>Counselor Educators</td>
<td>158.77</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Social Workers</td>
<td>157.40</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Psychiatrists</td>
<td>155.58</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Counselors-in-Training</td>
<td>155.36</td>
</tr>
<tr>
<td>Males</td>
<td>Over 36</td>
<td>Counselor Educators</td>
<td>155.32</td>
</tr>
</tbody>
</table>
CHAPTER V

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Introduction and Summary

This investigation was designed to examine the differences in sex-role stereotypic attitudes toward women among mental health professionals, counselor educators, and counselors-in-training. An additional focus of this study was to test the contention that a double standard of mental health exists for women and men.

To explore these two major areas three measures of stereotypic attitudes were obtained for the subjects. The first measure concerns the subject's perception of the status and role of women in society. The second is a measure of the subject's perception of the attributes of the mentally healthy adult male, and the third is a measure of the subject's perception of the attributes of the mentally healthy adult female. Using the data from these measures differences in stereotypic attitudes toward women may be examined between the subjects. By examining the differences between the subject's responses on the first and second personal attributes questionnaires the concept of a double standard of mental health may be explored.
It was expected that (a) mental health professionals would reflect the highest level of stereotypic attitudes toward women relative to counselor educators and counselors-in-training; (b) women would perceive themselves less traditionally stereotypic than men perceived them; and (c) counselors-in-training would be the least stereotypically traditional in their attitudes toward women; (d) a subject's theoretical orientation would influence her/his assessed level of stereotypic attitudes; and (e) the subjects would differ significantly in their perceptions of the attributes of the mentally healthy adult female and male, supporting the contention of a double standard of mental health.

The sample for this investigation was drawn from several sources. The mental health professionals were a random selection of therapists in private practice from the Chicago metropolitan area. Of the thirty mental health professionals whose returned questionnaires were utilized for this study, 7 were psychiatrists, 15 were psychologists, and 8 were social workers. The counselor educators were randomly selected from the faculty lists of universities with graduate school programs in counseling in the state of Illinois. A total of thirty counselor educators who had completed the research instruments were included in the study. The last group of subjects, the counselors-in-training, were randomly selected for solicitation from the listings of students who were engaged in a graduate
program in counseling within two major universities in the Chicago area. Of the counselors-in-training, 30 master's students and 46 doctoral students were utilized for the sample. The sample produced a total subject pool of 136 persons. All selections for solicitation were made using the table of random numbers.

The sample is predominantly white, with 80 females and 56 males participating. The socioeconomic backgrounds ranged from middle to upper class for this sample. All generalizations made from this study should be made in view of the narrow focus of this sample.

The procedures to gather the data were simple and straightforward. A packet containing a socio-demographic questionnaire, the three measuring instruments and instructions for completion were mailed to each of the persons drawn for solicitation. The instruments used to gather the data for this research were the Attitudes Toward Women Scale developed by Spence and Helmreich179 and the Personal Attributes Questionnaire developed by Spence, Helmreich and Stapp.180 Of the 359 packets mailed, 136 were returned producing a return rate of 37.9%.

There were several statistical paradigms used to


analyze the data. The statistic chosen was determined by the nature of the research question being asked as articulated by the various hypotheses tested in this research.

Analysis of variance allows for the inspection of differences between measures taken on two or more groups. ANOVA provides the most meaningful results when the research design is orthogonal, that is, there are equal cell observations or number of subjects in each of the groups. ANOVA is considered a robust statistic which still produces meaningful results with unequal cell observations, as is the case in this study. However, the results should be viewed more cautiously than if this work were a balanced design.

The t test is one of the most fundamental measures of differences used in behavioral science research to test two groups for difference across a single criterion variable. Three of the hypotheses were tested using this parametric statistic.

Pearson r was also used for one of the hypotheses. Although the correlation coefficient is a measure of the strength of a relationship between two interval level variables, the research must avoid the common error of inferring causal linkages between the variables, since Pearson r in no way implies or signifies a causal relationship.

The final statistical paradigm utilized in this work is the chi-square ($x^2$) test for independence. This simple statistic determines if two variables are related
Hypotheses

The hypotheses tested in this research using one of the previously mentioned statistical paradigms were:

$H_1$: There will be no significant differences in the level of assessed sex bias between the three subject groups.

$H_2$: There will be no significant differences among the three subject groups in levels of assessed sex bias when the subjects are classified by sex, age, and subgroup classification.

$H_3$: There will be no significant differences in the level of assessed sex bias between mental health professionals when the subjects are classified by sex, age, and professional title.

$H_4$: There will be no significant differences in the level of assessed sex bias between counselor educators when the subjects are classified by sex and age.

$H_5$: There will be no significant differences in the level of assessed sex bias between counselors-in-training when the subjects are classified by sex, age, and school program.

$H_6$: There will be no significant differences in the level of assessed sex bias within mental health professionals, counselor educators, and counselors-in-training.
when the subjects are classified by theoretical orientation.

$H_7$: The data will suggest no level of association between the subject's scores on the Attitude Toward Women Scale and the second Personal Attributes Questionnaire.

$H_8$: There will be no significant differences in the perceptions of mental health professionals in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

$H_9$: There will be no significant differences in the perceptions of counselor educators in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

$H_{10}$: There will be no significant differences in the perceptions of counselors-in-training in the attributes possessed by the mentally healthy adult female and the mentally healthy adult male.

The data suggest several significant findings. It was determined that the subjects differed significantly in their perception of the role and status of women in society along gender lines as suggested by hypotheses two, three, four, and five. The data also suggested that the subjects differed significantly in their perception of the mentally healthy adult female and male. In this sample women perceived themselves less stereotypically traditional than men perceived women.

It was found in hypothesis seven that there is a
high correlation between the subject's perception of the roles and status of women and the attributes they ascribed to the mentally healthy adult female. Those subjects that perceived the status and role of women less stereotypically perceived the mentally healthy adult female less stereotypically. Conversely, those subjects who perceived the status and role of women in a stereotypic view, perceived the attributes of the mentally healthy adult female more stereotypically.

Hypotheses nine and ten concerned the differences in perceptions of counselor educators and counselors-in-training in the attributes of the mentally healthy adult female and male. In both cases it was found that women and men were perceived as possessing different attributes thereby adding supportive data for the contention of a double standard of mental health.

Several of the hypotheses tested revealed no significant differences between the subjects or the subject groups. Specifically, the three subject groups did not differ significantly in their assessed level of sex bias across the three measures. These results allowed for the acceptance of hypothesis one. The sixth hypothesis was accepted since it was found that a subject's theoretical orientation did not appear to be a factor in influencing a person's attitude toward the role and status of women, the attributes of the mentally healthy female, or the
attributes of the mentally healthy adult male. The data also suggested that mental health professionals do not perceive the attributes of the mentally healthy adult female and male differently; therefore, supportive evidence was not obtained to substantiate the contention of a double standard of mental health. These results allow for the acceptance of hypothesis eight.

Conclusions

Considerable emphasis has been placed on the effects of sex-role stereotyping in the literature. Research studies by Thomas and Stewart,181 Broverman,182 Rosenkrantz,183 Spence, Helmreich, and Stapp,184 and Maslin and Davis185 have emphasized the existence of the double standard of mental health as well as the manifestation of sex-role stereotypic attitudes toward women. These findings have been most appropriately summarized by Boslooper and Hayes186

181 Thomas and Stewart, "Counselor responses to females with conforming and deviate career goals," pp. 352-357.
186 Boslooper and Hayes, The Femininity Game, pp. 178-186.
who found that women who sought to break out of their stereotypically assigned roles were rated as more deviant than clients who were viewed as accepting of, and conforming to their traditional sex-roles by the mental health professionals who comprised the sample in their research.

This research has resulted in supportive evidence of the double standard of mental health previously demonstrated in the literature, among the three subject groups in this study.

Previous research on sex-role stereotypic attitudes have found that one of the most insidious effects of sex-role stereotyping is that it has resulted in a double standard of mental health which exists in this society. Pietrofesa and Schlossberg\textsuperscript{187} and Gilbert and Waldroop\textsuperscript{188} obtained results in their studies which emphasized the double standard of mental health. The evidence from their investigations suggested that this double standard has placed a positive valuation on the ascribed masculine traits, while considering the stereotypic feminine traits as negative.

The data suggest that a subject's level of sex-stereotypic attitudes is not a function of their membership

\textsuperscript{187}Pietrofesa and Schlossberg, "Counselor Bias," ERIC Documents, CG 006056.

\textsuperscript{188}Gilbert and Waldroop, "Sex-Fair Counseling," pp. 410-419.
in a certain group, rather that stereotypic attitudes are
developed by a broader variable or set of variables which
all of the subjects share in common. Foxley,\textsuperscript{189} Gardner,\textsuperscript{190}
and Wells,\textsuperscript{191} suggest that this common set of variables
is our socialization process. Foxley asserts further that
no group of persons is immune to this socialization and
that mental health professionals as well, reflect the ster­
eotypic attitudes of the broader society. The results
suggested by this investigation add additional support to
this premise.

The most consistent findings of this work is that
women and men differ significantly in their perception of
the status and role of women in society as well as the
attributes they ascribe to the mentally healthy adult
female. These results are not consistent with the find­
ings of the research of Rosenkrantz\textsuperscript{192} and Broverman.\textsuperscript{193}
They found no differences among the subjects concerning
the attributes of the mentally healthy female, but found
that both females and males possessed stereotypic attitudes

\begin{itemize}
\item \textsuperscript{189} Foxley, "Non-Sexist Counseling," pp. 21-38.
\item \textsuperscript{190} Gardner, "Sexist Counseling," pp. 705-714.
\item \textsuperscript{191} Wells, "Up the Management Ladder," p. 223.
\item \textsuperscript{192} Rosenkrantz et al., "Sex-Role Stereotypes,"
pp. 287-295.
\item \textsuperscript{193} Broverman et al., Sex-Role Stereotypes: A
Current Appraisal.
\end{itemize}
toward women. The work of Rosenkrantz and Broverman was conducted primarily between the years 1968-1972. The results of this research is consistent with the findings of Fabrikant\(^{194}\) and Gilbert and Waldroop\(^{195}\) who have found sex differences among their subjects in their perception of the mentally healthy adult female. Their research had been conducted during the period 1974-1978. This suggests that there may be some historical effects that are influencing this change. The most obvious major societal change is the emergence of the women's movement which has actively pursued the issue of equal rights and has forced the concerns of women into public consciousness. As suggested by this research it is the younger women who were the most pro-feminist in their perspective of the status and role of women. This finding adds credence to the belief that historical effects are influencing women's perception of their own status and roles in society. Conversely, the data suggest that the men have not been as effected by the emergence of the women's movement, as they appear to be supporting the more traditional view of women.

The concept of the double standard of mental health,


a phrase coined by Broverman\textsuperscript{196} found support from the evidence suggested by this research. The mentally healthy adult female and the mentally healthy adult male are seen as possessing different attributes, and as the work of Broverman,\textsuperscript{197} Fabrikant,\textsuperscript{198} Bem and Bem,\textsuperscript{199} and the APA Task Force of Sex Bias\textsuperscript{200} suggests the male stereotypic attributes are considered more desirable, thus contributing to the negative viewpoint that women are not the equals of men. The APA Task Force on Sex Bias\textsuperscript{201} has articulated the ways in which these negative viewpoints are operationalized into a double standard of mental health in the therapeutic encounter: (a) traditional sex-roles are fostered; (b) bias expectations and devaluation of women; (c) sexist use of psychoanalytic concepts, and (d) viewing women as sex objects. When sex-stereotypic attitudes are operationalized by either mental health professionals, counselor educators and eventually counselors-in-training, the

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{196}Broverman et al., "Sex-Role Stereotypes and Clinical Judgments of Mental Health," p. 8.
\item \textsuperscript{197}Ibid.
\item \textsuperscript{198}Fabrikant, "The Psychotherapist and the Female Patient," p. 83.
\item \textsuperscript{199}Bem and Bem, "Training the Woman to Know Her Place," p. 9.
\item \textsuperscript{200}The APA Task Force on Sex Bias, \textit{American Psychologist}, p. 1169.
\item \textsuperscript{201}Ibid., p. 1174.
\end{itemize}
\end{footnotesize}
potential exists that the therapeutic encounter or the teaching experience could have some detrimental effect on female clients or students.

The evidence suggests that women are still being perceived in traditional sex-role perspectives by mental health professionals, counselor educators, and counselors-in-training alike. Therefore the potential exists that women are subjected to disparate treatment relative to their male colleagues in both the therapeutic encounter as well as in the academic environment.

Recommendations

In view of the above conclusions of this study, a number of recommendations are being suggested. These recommendations are divided into three categories; recommendations for the mental health professions, education, and further research, respectively.

The Mental Health Professions

The mental health professional is in the single most unique position to either exacerbate, foster or alleviate the insidious effects of sex-role stereotyping. It has been demonstrated in the literature that many women who seek counseling or therapy are struggling over conflicts of identity, self fulfillment, and dissatisfaction with prescribed roles within this society. Those who profess dedication to the helping professions need to be aware of
the beneficial effect of the helping relationship as well as the detrimental effect that this relationship may produce. As the APA Task Force on Sex Bias\textsuperscript{202} has pointed out, there is strong evidence that the mental health professionals are interacting with clients, particularly female clients in ways that may not be in the best interest of the client.

At minimum, the mental health professional should be aware of her/his own biases in order that these biases do not interfere with the therapeutic relationship. Sexist attitudes are contrary to the counselor's dedication to helping all persons grow to their fullest potential and self-actualization as individuals. Sex-role stereotypic attitudes are limitors, boundaries whose reinforcement does not promote healthy growth for clients. It is also recommended that mental health professionals become somewhat familiar with the feminist research in order that they at least have another perspective of the deleterious effects on both women and men due to sex-role stereotyping.

It is not being suggested that mental health professionals consciously and/or actively promote sexism, rather it is suggested that sex-role stereotypic behaviors emerge in many covert ways through sexist use of language, non-verbal communication, lack of personal awareness, as well

\textsuperscript{202}The APA Task Force on Sex Bias, \textit{American Psychologist}, pp. 1169-1175.
as reinforced sexist belief and value systems. It is also suggested that each mental health professional can influence her/his own attitude and belief systems, and by minimizing one's own stereotypic attitudes in the therapeutic encounter, as well as in the societal context, one can only produce beneficial effects for the client population.

Counselor Educators

Counselor educators are charged with the responsibility of training succeeding generations of professional counselors and educators who eventually will be serving a client system which includes women. It is recommended that graduate programs include the opportunity for the student to study women's issues in order to obtain alternate points of view as to the psychology of women, the personality development of women, and recommended therapeutic techniques that non-sexist and feminist therapists and researchers suggest as being beneficial for female clients. It is acknowledged and accepted that traditional forms of therapy have their place and value with women clients, but the alternatives to these traditional modalities also have their place and value. Exposed to alternatives, the student is in the position of making an informed choice of a therapeutic or counseling modality that is most appropriate not only for their own style of counseling, but what may be
more beneficial to their client system. This additional knowledge may influence the development of new professionals who are better equipped to enter the world of counseling and education.

Counselors-in-Training

The counselor-in-training has the opportunity to study alternative viewpoints as to the nature of the therapeutic relationship, her/his role in that relationship, and the positive or negative effects that the quality of that relationship may foster. Traditionally, students are exposed to traditional counseling theories that have been promoted for years. They are also exposed to traditional theories of personality. The contribution of these traditional theories to the understanding of the human psychological condition is undeniable, but they are not static, and other theories offer understanding and explication of human psychology. The models which owe their origin to psychodynamic theory have all portrayed women in less positive perspectives than men, as has been amply discussed in the survey of literature.

There are alternatives to traditional theories as to the nature of the female psyche. It is suggested that the student become aware of these alternatives in order that she/he may make an informed choice as to the most appropriate mode of intervention with female clients. It
is also suggested that the student become familiar with the non-sexist and feminist literature which amply highlights how traditional modes of therapy may be used to benefit women clients rather than used to their detriment. Many feminist therapists are psychodynamic in their orientation and have found this therapeutic structure to be the most productive for their clients. They have, however, been able to adapt these traditional modalities to feminist therapy without adopting the stereotypic behavioral constructs of the nature of the female which has been articulated by these theories.

It is also recommended that counselor-trainees spend time exploring their own sex-role stereotypic attitudes. The student is in the enviable position to engage in self-awareness before interacting with a female client system. This awareness may aid the counselor-in-training in preparing her/himself for the day when she/he join their established colleagues as mental health professionals and/or educators.

**Implications for Further Research**

This study highlights the need for further research. This study was conducted using unequal cell observations. Although convention allows for the use of ANOVA with unequal cells, research which conforms to this basic assumption of analysis of variance is considered more powerful than
research which violates it. Secondly, more controls need to be implemented in the selection of subjects. It is evident that the population which is represented by the sample of mental health professionals used in this study is not proportionately the same in terms of its gender characteristics. The sample contains a ratio of females that far exceeds the ratio of females to males in the general population of mental health professionals. It is suspected that this disproportionate sample may have influenced some of the findings of this study concerning the mental health professional.

Additional research is needed to support or counter the contention that sexist attitudes are transmitted through the therapeutic process. Although there are studies in the literature which state that biases are transmitted, the data are not conclusive enough to allow for a rigid adoption of this position. They are conclusive enough, however, to suggest that this is indeed the case. Additional research would contribute to our understanding of this problem and its potential effects on both female and male clients.

It has been a premise of this work that evidence of a double standard of mental health exists if women and men ascribe different attributes to males and females and the male attributes are more desirable and positively valued. As in other studies, the subjects in this research had been
asked to rate how they view the mentally healthy adult female and the mentally healthy adult male. The evidence of this study has supported the results and findings of previous research, in that females and males do support a double standard of mental health and prescribe particular feminine role-ideals and masculine role-ideals to women.

Another area needing further research concerns the instrumentation utilized to gather data on sex-stereotypic attitudes. With the available instruments the researcher cannot be sure if a subject is reporting a personal attitude or belief about the status and role of women or is reflecting a realistic perception of the actual status and roles women do occupy in society. The former may be described as a stereotypic attitude while the latter is a statement of actual conditions. Today's instruments do not possess the sensitivity to clearly delineate the difference, either would be reported as sex-role stereotyping. This problem speaks to the validity or lack of it that these instruments possess. If an instrument lacks validity, then any conclusions drawn from the data gathered with these instruments must be considered suspect.
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APPENDIX A
ATTITUDES TOWARD WOMEN

The following statements describe attitudes toward the role of women in society which different people have. These are opinions; there are no right or wrong answers.

You are asked to express your feelings about each statement by indicating whether you:

(A) Agree strongly
(B) Agree mildly
(C) Disagree mildly
(D) Disagree strongly

Please indicate your opinion by marking the letter next to the statement which best describes your personal attitude.

Please respond to every item.

_____ 1. Women have an obligation to be faithful to their husbands.

_____ 2. Swearing and obscenity are more repulsive in the speech of a woman than a man.

_____ 3. The satisfaction of her husband's sexual desires is a fundamental obligation of every woman.

_____ 4. Divorced men should help support their children, but should not be required to pay alimony if their wives are capable of working.

_____ 5. Under ordinary circumstances, men should be expected to pay all the expenses while out on a date.

_____ 6. Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.
7. It is all right for wives to have an occasional, extramarital affair.

8. Special attentions like standing up for a woman who comes into a room, or giving her a seat on a crowded bus, are outmoded and should be discontinued.

9. Vocational and professional schools should admit the best qualified students, independent of sex.

10. Both husband and wife should be allowed the same grounds for divorce.

11. Telling dirty jokes should be mostly a masculine prerogative.

12. Husbands and wives should be equal partners in planning the family budget.

13. Men should continue to show courtesies to women such as holding open the door or helping them on with their coats.

14. Women should claim alimony not as persons incapable of self-support, but only when there are children to provide for, or when the burden of starting life anew after the divorce is obviously heavier for the wife.

15. Intoxication among women is worse than among men.

16. The initiative in dating should come from the man.

17. Under modern economic conditions with women being active outside the home, men should share in household tasks such as washing dishes and doing the laundry.

18. It is insulting to women to have the "obey" clause remain in the marriage ceremony.

19. There should be a strict merit system in job appointment and promotion without regard to sex.

20. A woman should be free as a man to propose marriage.
21. Parental authority and responsibility for discipline of the children should be equally divided between husband and wife.

22. Women should worry less about their rights and more about becoming good wives and mothers.

23. Women earning as much as their dates should bear equally the expense when they go out together.

24. Women should assume their rightful place in business and all the professions along with men.

25. A woman should not expect to go to exactly the same places or to have quite the same freedom of action as a man.

26. Sons in a family should be given more encouragement to go to college than daughters.

27. It is ridiculous for a woman to run a locomotive and for a man to darn socks.

28. It is childish for a woman to assert herself by retaining her maiden name after marriage.

29. Society should regard the services rendered by the woman worker as valuable as those of men.

30. It is only fair that male workers should receive more pay than women ever for identical work.

31. In general, the father should have greater authority than the mother in the bringing up of children.

32. Women should be encouraged not to become sexually intimate with anyone before marriage, even their fiancés.

33. Women should demand money for household and personal expenses as a right rather than a gift.

34. The husband should not be favored by law over the wife in the disposal of family property or income.
35. Wifely submission in an outworn virtue.

36. There are some professions and types of businesses that are more suitable for men than women.

37. Women should be concerned with the duties of childrearing and housetending, rather than with desires for professional and business careers.

38. The intellectual leadership of a community should be largely in the hands of men.

39. A wife should make every effort to minimize irritation and inconvenience to the male head of the family.

40. There should be no greater barrier to an unmarried woman having sex with a casual acquaintance than having dinner with him.

41. Economic and social freedom is worth far more to women than acceptance of the ideal of femininity which has been set up by men.

42. Women should take the passive role in courtship.

43. On the average, women should be regarded as less capable of contribution to economic production than are men.

44. The intellectual equality of woman with man is perfectly obvious.

45. Women should have full control of their persons and give or withhold sexual intimacy as they choose.

46. The husband has in general no obligation to inform his wife of financial plans.

47. There are many jobs in which men should be given preference over women in being hired or being promoted.

48. Women with children should not work outside the home if they don't have to financially.
49. Women should be given equal opportunity with men for apprenticeship in the various trades.

50. The relative amounts of time and energy to be devoted to household duties on the one hand, and to a career on the other, should be determined by personal desires and interests rather than by sex.

51. As head of the household, the husband should have more responsibility for the family's financial plans than the wife.

52. If both husband and wife agree that sexual fidelity isn't important, there's no reason why both shouldn't have extramarital affairs if they want.

53. The husband should be regarded as the legal representative of the family group in all matters of the law.

54. The modern girl is entitled to the same freedom from regulation and control that is given to the modern boy.

55. Most women need and want the kind of protection and support that men have traditionally given them.
APPENDIX B
On the following pages there is a series of 5-point scales which describe a variety of psychological characteristics. For each one, you are asked to rate how you view the mentally healthy adult male.

For example: How artistic is the mentally healthy adult male?

On the scale below, very artistic is indicated at the far right, while on the far left, not at all artistic is indicated.

Not at all artistic  A...B...C...D...E... Very artistic

If you view the mentally healthy adult male as moderately artistic, your answer might be D; if you view him as very unartistic, you would choose A, etc.

For each scale, select the letter that best describes the mentally healthy adult male, and indicate it on the space next to the letter.

Please be sure to answer every item.
PERSONAL ATTRIBUTES SCALE

1. Not at all aggressive A...B...C...D...E... Very aggressive
2. Not at all independent A...B...C...D...E... Very independent
3. Not at all emotional A...B...C...D...E... Very emotional
4. Does not hide emotions at all A...B...C...D...E... Almost always hides emotions
5. Nonconforming to social expectations A...B...C...D...E... Conforming to social expectations
6. Not at all considerate A...B...C...D...E... Very considerate
7. Not at all easily influenced A...B...C...D...E... Very easily influenced
8. Very ungrateful A...B...C...D...E... Very grateful
9. Very submissive A...B...C...D...E... Very dominant
10. Dislikes math and science very much A...B...C...D...E... Likes math and science very much
11. Poor at sports A...B...C...D...E... Good at sports
12. Not at all excitable in a major crisis A...B...C...D...E... Very excitable in a major crisis
13. Not at all excitable a minor crisis A...B...C...D...E... Very excitable in a minor crisis
14. Very passive
15. Not at all able to devote self completely to others
16. Very blunt
17. Weak conscience
18. Very rough
19. Not at all helpful to others
20. Not at all competitive
21. Very home oriented
22. Not at all skilled in business
23. Knows the way of the world
24. Not at all kind
25. Low mechanical aptitude
26. Indifferent to other's approval
27. Feelings not easily hurt

A....B....C....D....E....

Very active
Able to devote self completely to others
Very tactful
Very strong conscience
Very gentle
Very helpful to others
Very competitive
Very worldly
Very kind
High mechanical aptitude
Highly needful of other's approval
Feelings easily hurt
<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Example</th>
<th>Opposite Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.</td>
<td>Not at all adventurous</td>
<td>A...B...C...D...E...</td>
<td>Very adventurous</td>
</tr>
<tr>
<td>29.</td>
<td>Not at all aware of feelings of others</td>
<td>A...B...C...D...E...</td>
<td>Very aware of feelings of others</td>
</tr>
<tr>
<td>30.</td>
<td>Not at all religious</td>
<td>A...B...C...D...E...</td>
<td>Very religious</td>
</tr>
<tr>
<td>31.</td>
<td>Not at all outspoken</td>
<td>A...B...C...D...E...</td>
<td>Very outspoken</td>
</tr>
<tr>
<td>32.</td>
<td>Not at all interested in sex</td>
<td>A...B...C...D...E...</td>
<td>Very interested in sex</td>
</tr>
<tr>
<td>33.</td>
<td>Can make decisions easily</td>
<td>A...B...C...D...E...</td>
<td>Has difficulty making decisions</td>
</tr>
<tr>
<td>34.</td>
<td>Gives up very easily</td>
<td>A...B...C...D...E...</td>
<td>Never gives up easily</td>
</tr>
<tr>
<td>35.</td>
<td>Very shy</td>
<td>A...B...C...D...E...</td>
<td>Very outgoing</td>
</tr>
<tr>
<td>36.</td>
<td>Never cries</td>
<td>A...B...C...D...E...</td>
<td>Cries very easily</td>
</tr>
<tr>
<td>37.</td>
<td>Almost never acts as a leader</td>
<td>A...B...C...D...E...</td>
<td>Almost always acts as a leader</td>
</tr>
<tr>
<td>38.</td>
<td>Very neat in habits</td>
<td>A...B...C...D...E...</td>
<td>Very sloppy in habits</td>
</tr>
<tr>
<td>39.</td>
<td>Very quiet</td>
<td>A...B...C...D...E...</td>
<td>Very loud</td>
</tr>
<tr>
<td>40.</td>
<td>Not at all intellectual</td>
<td>A...B...C...D...E...</td>
<td>Very intellectual</td>
</tr>
<tr>
<td>41.</td>
<td>Not at all self-confident</td>
<td>A...B...C...D...E...</td>
<td>Very self-confident</td>
</tr>
<tr>
<td>42.</td>
<td>Feels very inferior</td>
<td>A...B...C...D...E...</td>
<td>Feels very superior</td>
</tr>
</tbody>
</table>
43. Not at all creative
44. Always sees self as running the show
45. Always takes a stand
46. Not at all understanding of others
47. Very cold in relations with others
48. Very little need for security
49. Not at all ambitious
50. Dislikes children
51. Does not enjoy art and music at all
52. Easily expresses tender feelings
53. Goes to pieces under pressure
54. Retiring
55. Not at all timid

A....B....C....D....E....
Never sees self as running the show
Never takes a stand
Very understanding of others
Very warm in relations with others
Very strong need for security
Very ambitious
Likes children
Enjoys art and music very much
Does not express tender feelings at all
Stand up well under pressure
Forward
Very timid
The second questionnaire is the same, except that you are now asked to rate how you view the mentally healthy adult female.

For each scale, select the letter on the scale that best describes the mentally healthy adult female, and indicate it on the space next to the letter.

Please be sure to answer every item.
<table>
<thead>
<tr>
<th>PERSONAL ATTRIBUTES SCALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Not at all aggressive</td>
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<tr>
<td>2. Not at all independent</td>
</tr>
<tr>
<td>3. Not at all emotional</td>
</tr>
<tr>
<td>4. Does not hide emotions at all</td>
</tr>
<tr>
<td>5. Nonconforming to social expectations</td>
</tr>
<tr>
<td>6. Not at all considerate</td>
</tr>
<tr>
<td>7. Not at all easily influenced</td>
</tr>
<tr>
<td>8. Very ungrateful</td>
</tr>
<tr>
<td>9. Very submissive</td>
</tr>
<tr>
<td>10. Dislikes math and science very much</td>
</tr>
<tr>
<td>11. Poor at sports</td>
</tr>
<tr>
<td>12. Not at all excitable in a major crisis</td>
</tr>
<tr>
<td>13. Not at all excitable in a minor crisis</td>
</tr>
</tbody>
</table>
14. Very passive

15. Not at all able to devote self completely to others

16. Very blunt

17. Weak conscience

18. Very rough

19. Not at all helpful to others

20. Not at all competitive

21. Very home oriented

22. Not at all skilled in business

23. Knows the way of the world

24. Not at all kind

25. Low mechanical aptitude

26. Indifferent to other's approval

27. Feelings not easily hurt

A....B....C....D....E....

Very active

A....B....C....D....E....

Able to devote self completely to others

Very tactful

Very strong conscience

Very gentle

Very helpful to others

Very competitive

Very worldly

Very skilled in business

Does not know the way of the world

Very kind

High mechanical aptitude

Highly needful of other's approval

Feelings easily hurt
28. Not at all adventurous A...B...C...D...E... Very adventurous
29. Not at all aware of feelings of others A...B...C...D...E... Very aware of feelings of others
30. Not at all religious A...B...C...D...E... Very religious
31. Not at all outspoken A...B...C...D...E... Very outspoken
32. Not at all interested in sex A...B...C...D...E... Very interested in sex
33. Can make decisions easily A...B...C...D...E... Has difficulty making decisions
34. Gives up very easily A...B...C...D...E... Never gives up easily
35. Very shy A...B...C...D...E... Very outgoing
36. Never cries A...B...C...D...E... Cries very easily
37. Almost never acts as a leader A...B...C...D...E... Almost always acts as a leader
38. Very neat in habits A...B...C...D...E... Very sloppy in habits
39. Very quiet A...B...C...D...E... Very loud
40. Not at all intellectual A...B...C...D...E... Very intellectual
41. Not at all self-confident A...B...C...D...E... Very self-confident
42. Feels very inferior A...B...C...D...E... Feels very superior
APPENDIX C
PERSONAL DATA QUESTIONNAIRE

Professional Title: ____________________________________________

(Psychiatrist, Psychologist, Social Worker, etc.)

Age: _______ Sex: _______

Personal Background

Ethnic Background: ____________________________________________

Religious Affiliation: __________________________________________

Generation: 1st___ 2nd ___ 3rd ___ Other _____

Type of Childhood Environment:

Urban: _______ Rural: _______ Suburban: _______

Socioeconomic Background During Childhood:

Upper Class _______ Upper Middle Class _______

Middle Class _______ Lower Middle Class _______

Middle Class _______

Lower Class _______

Marital Status:

Married _____ Single _____ Divorced _____

Widow/Widower ______ Separated ____ Cohabitation ____

Professional Background

Highest Academic Degree: _______ Year Awarded: _______

Area of Specialization: ________________________________________

Do you maintain a private practice?

Yes _____ No _____

If yes, number of years: _______
Percentage of work week devoted to private practice: ____

Percentage of work week devoted to:

- College or University ____
- Private Hospital ____
- Public Hospital ______
- CMHC ______
- Other (Please Specify): ________

Estimated percentage of clientele:

- Adult Male ______
- Adult Female ________
- Adolescent Male ______
- Adolescent Female ________
- Male Children ________
- Female Children ________

Please state your theoretical orientation:

________________________________________

Please specify how you prefer to be addressed:

- Dr. ____
- Miss ____
- Mr. ____
- Ms. ____
- Other ____

The following question is of a highly personal and sensitive nature. Your response would be greatly appreciated and helpful; however, please take the option of not responding if you prefer.

The preferred method of temporary birth control, in your opinion is:

- Rhythm _____
- IUD _____
- Diaphragm _____
- Foam _____
- Birth Control Pill ________
- Prophylactic ________
- Other ________

The preferred method of permanent birth control, in your opinion, is:
Tubal Ligation ____ Vasectomy _______
Hysterectomy _______ Other ________
PERSONAL DATA QUESTIONNAIRE

Age: _______  Sex: _______

Marital Status:
   Married ____  Single ____  Divorced ____
   Widow/Widower ____  Separated ____  Cohabitation ____

Ethnic Background: ________________________________

Religious Affiliation: ________________________________

Generation: 1st ____  2nd ____  3rd ____  Other ____

Type of Childhood Environment:
   Urban ____  Rural ____  Suburban ____

Socioeconomic Background During Childhood:
   Upper Class ____  Upper Middle Class ____
   Middle Class ____  Lower Middle Class ____
   Lower Class ______

Presently Enrolled:
   Master's Program _______  Doctoral Program _______
   Year: 1st ____  2nd ____  3rd ____  4th ____  5th ____

If you have developed a theoretical orientation, please specify: ________________________________

Present Employment:  Full time ____  Part-time ____
   None_______

If Employed:
   Length of time ___________________________
   Type of work ___________________________
Will you pursue this work after completion of your degree? Yes ______  No ______

Please specify how you prefer to be addressed:

Miss ______  Mr. ________  Mrs. ________  Ms. ________

Other ________

The following question is of a highly personal and sensitive nature. Your response would be greatly appreciated and helpful; however, please take the option of not responding if you prefer.

The preferred method of temporary birth control, in your opinion, is:

Rhythm ________  IUD ________  Diaphragm ________

Foam ________  Birth Control Pill ________

Prophylactic ________  Other ________

The preferred method of permanent birth control, in your opinion is:

Tubal Ligation ________  Vasectomy ________

Hysterectomy ________  Other ________
APPENDIX D
During the past several years, there has been a substantial increase in interest among the mental health profession concerning the nature and equality of the therapeutic relationship. The research literature overwhelmingly endorses the position that the nature and quality of the client-counselor and/or therapist relationship is one of the primary factors influencing the potential benefit of the intervention for the client. Accepting this tenet, then conversely, the therapeutic relationship has the potential of producing deleterious consequences for the client.

Attitudes toward women among mental health professionals, which are part of the counselor/therapist value system, invariably will be revealed in the therapeutic relationship.

This research, as part of a dissertation, is designed to explore attitudes toward women held by mental health professionals, counselor educators, and counselors-in-training.

As a mental health professional, your cooperation is being solicited for this research.

Enclosed are questionnaires which you are being asked to complete and return, using the enclosed self addressed, stamped envelope. Your cooperation and
assistance is greatly appreciated.

I assure you that your answers will remain confidential and that all results will be reported in the dissertation in collective form only. I look forward to receiving your completed questionnaires at your earliest convenience.

In appreciation for your cooperation and your participation in this research, I would like to acknowledge your name in the dissertation. However, I will need your signed release if you wish your name to be mentioned in the acknowledgments. Again, there would be no connection of your name to any answers in this research. If I may acknowledge your participation, please sign the following release and return it with the completed questionnaires.

I, __________________________________________ authorize Judith Housos to use my name in the acknowledgment section of her dissertation. I understand that no connection will be made between my name and these questionnaires.

Date: __________________________
Thank you again for your time and cooperation.

Sincerely,

Judith Y. Housos
Ph.D. Candidate
Loyola University

170 N. Ridgeland Avenue
Oak Park, Illinois 60302
During the past several years, there has been a substantial increase in interest among the mental health profession concerning the nature and quality of the therapeutic relationship. The research literature overwhelmingly endorses the position that the nature and quality of the client-counselor/therapist relationship is one of the primary factors influencing the potential benefit of the intervention for the client. Accepting this tenet, then conversely, the therapeutic relationship has the potential of producing deleterious consequences for the client.

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This research, as part of a dissertation, is designed to explore attitudes toward women held by mental health professionals, counselor educators, and counselors-in-training.

As a counselor educator, and professional, your cooperation is being solicited for this research.

Enclosed are questionnaires which you are being asked to complete and return, using the enclosed self addressed, stamped envelope. Your cooperation and
assistance is greatly appreciated.

I assure you that your answers will remain confidential and that all results will be reported in the dissertation in collective form only. I look forward to receiving your completed questionnaires at your earliest convenience.

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Thank you again for your time and cooperation.

Sincerely,

Judith Y. Housos
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This research, as part of a dissertation, is designed to explore attitudes toward women held by mental health professionals, counselor educators, and counselors-in-training.

As a counselor-in-training, and future professional, your cooperation is being solicited for this research.

Enclosed are questionnaires which you are being asked to complete and return, using the enclosed self addressed, stamped envelope. Your cooperation and
assistance is greatly appreciated.

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Date: __________________________
Thank you again for your time and cooperation.

Sincerely,

Judith Y. Housos
Ph.D. Candidate
Loyola University

170 N. Ridgeland Avenue
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The dissertation submitted by Judith Y. Housos has been read and approved by the following committee:

Dr. John A. Wellington, Director
Professor, Guidance and Counseling, Education
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Dr. Ernest I. Proulx
Professor, Guidance and Counseling, Curriculum and Instruction, Education
Loyola University

Dr. Judy Mayo
Assistant Professor, Guidance and Counseling, Education
Loyola University

Dr. Robert A. Patrick
Statistical Consultant
Northwestern University

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

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

December 12, 1979
Date

John A. Wellington, Ph.D.
Director's Signature