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ABSTRACT

The design of this study closely follows one by Broverman in order to test the applicability of results to graduate students in counseling and counselor education programs. Subjects were administered the Sex-Role Questionnaire; masculinity, femininity, and adult agreement and health scores were computed and compared by t-tests. Results indicated that there was high consensus only in regard to the characteristics of the healthy adult, sex unspecified. It was concluded that graduate counseling students had a triple standard of health--one for adults (sex unspecified), one for adult men, and one for adult women. It was found that these different standards of health did not clearly parallel sex-role stereotypes. The results were compared and contrasted with those of Broverman and implications for counselor education programs, counselor educators, and counseling graduate students were discussed. (Author/PC)

SEX-ROLE STEREOTYPES AND CONCEPTIONS OF MENTAL HEALTH OF GRADUATE STUDENTS IN COUNSELING

BY

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THESIS

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CHAPTER I

INTRODUCTION

Statement of the Problem

This study was intended to replicate, except with a different subject population, a study in which actively functioning clinicians were found to have a double standard of mental health for men and women. Broverman et al. (1970a) hypothesized "that clinical judgements about the characteristics of healthy individuals would differ as a function of sex of person judged and furthermore, that these differences in clinical judgements would parallel stereotypic sex-role differences." Broverman et al. also hypothesized "that behavioral attributes which are regarded as healthy for an adult, sex unspecified, and thus presumably viewed from an ideal, absolute standpoint, will more often be considered by clinicians as healthy or appropriate for men than for women." Both hypotheses were confirmed. In other words, by adult standards, the adult woman was perceived as significantly less healthy than the adult man.

One implication of this discrepancy between the standard of health for adults (sex unspecified) and the standard of health for women is that this discrepancy puts the woman in a double bind. Should she develop and exhibit the characteristics of an adult, and thereby be less feminine or deviant? Or should she behave in a feminine manner, and hence be considered less healthy by adult standards? Another implication of this double standard of health is the existence of sex-typed symptoms, socially acceptable female weaknesses and socially acceptable male weaknesses. Chesler (1972, p. 40) points out that, "most women display 'female' psychiatric symptoms such as depression, frigidity, paranoia, and anxiety.

Men display 'male' diseases such as alcoholism, drug addition, personality disorders, and brain diseases." These differences then lead to different kinds of treatment for "deviant" men and women. For example (Chesler, 1972, p. 57),

> Men who act out the male role - but are too young, too poor, or too black - are usually incarcerated as 'criminals' or as 'sociopaths', rather than as 'schizophrenics' or 'neurotics'. In order to be 'men', less powerful men in our society have to 'steal' what more powerful men can 'buy'. (And they are punished for doing so.) The kinds of behaviors that are considered 'criminal' and 'mentally ill' are sex-typed, and each sex is conditioned accordingly. Psychiatric categories themselves are sex-typed. Many more women than men manifest, seek help, and are hospitalized for what we categorize as a 'psychiatric disease'. It is important to know what type of clinical treatment these psychiatric patients receive; how many clinicians there are, and the theories on which the clinicians draw, and how these psychiatrists and psychologists view their patients.[1]

One reason for this double standard of mental health suggested by Broverman et al. is that clinicians accept an adjustment notion of mental health. From this viewpoint healthy persons adjust to their environment. Therefore, in our society, in which different behavioral norms and expectations are held for men and women, a double standard of mental health is inevitable if one subscribes to an adjustment notion of health. As Broverman et al. comments (1970a, p. 6):

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[1]This sex-typing of offenses and double standard of normality has its counterpart in the juvenile court system (Chesney-Lind, 1974, p. 43), "This interest in morality and obedience to parental authority clearly poses a greater threat to the rights of girls than boys. The traditional American family exerts close control over its daughters to protect their virginity. A 'good' girl is never sexual, although she must be sexually appealing, while a healthy boy must prove his masculinity by experimenting sexually. The courts, therefore, often operate under two sets of juvenile-delinquency laws, one for boys and one for girls. They reserve their harshest and most paternalistic treatment for girls. Many statutes which apply to boys allow incarceration only for offenses that are also adult crimes. Girls, however, are often committed for offenses that have no adult counterpart."

> . . . for a woman to be healthy from an adjustment viewpoint she must adjust to and accept the behavioral norms for her sex, even though these behaviors are generally less socially desirable and considered to be less healthy for the generalized competent, mature adult.

Other implications mentioned by Broverman et al. are that by accepting these differential standards and sex-role stereotypes, clinicians are helping to perpetuate them. In doing so, clinicians are reinforcing social conflict and intrapsychic conflict. The authors also note the influence that mental health clinicians have on society and the general public because of their role of "expert." Therefore, Broverman et al. conclude (1970a, p. 7):

> It may be worthwhile for clinicians to critically examine their attitudes concerning sex-role stereotypes, as well as their position with respect to the adjustment notion of health. The cause of mental health may be better served if both men and women are encouraged toward maximum realization of individual potential rather than to an adjustment to existing restrictive sex roles.

Purpose of Study and Hypotheses

It was an assumption in this study that one of the purposes and activities of counselor education programs is to help form and influence the professional attitudes and ideas of future counselors and psychotherapists. This includes fostering students' acquisition of knowledge and understanding of human behavior, theories of personality, theories of counseling and psychotherapy, the counselor's role, the counselor's professional ethics and values, and definitions of mental health (See Patterson, 1971, pp. 90-101). It was also assumed that a critical examination of the above topics on the personal and professional level is a vital function of counselor training programs. Therefore, the purpose

of this study was to test the relevance and applicability of Broverman's et al. results to counselor training programs, counselor educators, and counselors in training. This was done by repeating that investigation with a population of counseling graduate students at the master's and doctoral levels. A further purpose of this study was to examine the relationship between the amount and degree of education and graduate training in counseling and subjects' conceptions of the characteristics of healthy men and women. How are sex-role stereotypes related to conceptions of mental health in beginning and advanced graduate students? Are there changes as students continue their training? If not, should there be?

The hypotheses of this study are: First, that counseling graduate students' concepts of the characteristics of the healthy individual will differ as a function of the sex of the person considered; Second, that these differing concepts will parallel stereotypic sex-role differences. Finally, this study tested the hypothesis that these different conceptions of mental health of men and women will not differ between counseling students at the master's level and counseling students at the doctoral level.

Before describing the methodology of this study, a review of the literature in pertinent areas will put this study more clearly into context.

CHAPTER II

REVIEW OF THE LITERATURE

Sex-role stereotypes may be defined as "consensual beliefs about the differing characteristics of men and women" (Broverman et al., 1972, p. 64). This is consistent with Sherriffs' and McKee's (1957, p. 455) more general definition of a stereotype as, "the general tendency to believe that some things are more characteristic of one group than of the other." The existence of sex-role stereotypes has been repeatedly documented in the research literature (Sherriffs and Jarrett, 1953; Seward, 1946; Rabban, 1950; Wylie, 1961). In "Sex-role stereotypes: A current appraisal," Broverman et al. (1972, p. 64) concluded that "sex-role stereotypes cut across the sex, socioeconomic class, and religion of the respondents, at least in individuals who seek education beyond the high school level." Hartley (1959) noted the existence of sex-role stereotypes among elementary school aged girls. In addition, Sherriffs and McKee (1957) attested to the strength of the stereotypes in college students in introductory psychology classes. Fernberger (1948) documented the persistence of sex-role stereotypes, despite students' exposure to a lecture which emphasized the lack of experimental evidence for the supposed differences for either race or sex.

In addition, a relationship between social desirability and sex-roles or sex-role stereotypes has been acknowledged. This relationship is demonstrated by the recognition that this culture offers the male more prestige than the female (Lynn, 1959; Rabban, 1950; Broverman et al., 1970; Kitay, 1940). More specifically, college students of both sexes thought more highly of males than of females (McKee and Sherriffs, 1957);

and boys and girls, aged 8 to 15, were more likely to assign favorable traits to boys than to girls (Smith, 1939). Rosenkrantz et al. (1968) concluded that positive characteristics were more often applied to men than to women. Reviewing the literature on sex differences and self concept, Wylie (1961, p. 145) concluded: "The findings seem more definitely to confirm the occurrence of a commonly accepted stereotype of 'women in general' which is less favorable than that for 'men in general'."

There also seems to be a relationship between social desirability and judgements of mental health or normality-abnormality. Gowen (1961) obtained a product-moment correlation coefficient of .917 between students' ratings of social desirability and clinicians' abnormality scalings. The correlation coefficients between Q sorts for social desirability and Q sorts of clinicians asked to describe the characteristics that an adjusted person would report were .88 (Wiener et al., 1959). Finally, after partialling out two factors, health-sickness and social desirability, in clinical assessments by Q array, Kogan (1957) stated that health-sickness and social desirability appear to be essentially the same variable.

In summary, the existence of sex-role stereotypes is well documented. Relationships have also been noted between sex-role stereotypes and social desirability and between social desirability and judgements of mental health. These interrelationships were the basis for Broverman's et al. hypotheses (1972, p. 1):

> Given the relationships existing between masculine versus feminine characteristics and social desirability on the one hand, and between mental health and social desirability on the other, it seems reasonable to expect that clinicians will maintain parallel

> distinctions in their concepts of what behaviorally is healthy or pathological when considering men versus women . . . [and] that abstract notions of health will tend to be more influenced by the greater social value of masculine stereotypic characteristics than by lesser valued feminine stereotypes characteristics.

The above studies dealt primarily with sex-role stereotypes among college undergraduate students and occasionally among school aged children. Studies of conceptions of mental health used primarily clinician subject populations. However, no studies dealing with both sex-role stereotypes and conceptions of mental health in counseling graduate students were found.

CHAPTER III

METHODS

Subject

The subjects were 69 graduate students in the Division of Personnel Services in the Department of Educational Psychology, College of Education, University of Illinois at Urbana. In a program of approximately 80 to 90 students, no further selection was performed. The sample size depended on the number of students who could be given and who returned the questionnaire (described below). Of these 69 students, 45 per cent were in the master's program and 54 per cent were in the doctoral program. Of the total sample, 48 per cent were females and 52 per cent were males. Ages ranged from between 20-24 years to over 40 years. Table 1 describes the sample population in more detail.

The Instrument

Historical Development

In order to make the results of this study as comparable as possible to Broverman's et al. study, the Sex Role Questionnaire was obtained from the authors. The short form of the questionnaire which consists of 82 items was used for this study, instead of the original form consisting of 122 items (Rosenkrantz et al., 1968). Of the 82 items in the short form, six were new items and 76 were items taken from the original form "selected as indicating items on which there was high consensuality among members of six different samples" (Broverman, 1970b). High consensuality for an item was defined as "agreement among Ss that a pole reflects masculine rather than feminine behavior or vice versa differed from chance

Table 1

Percentage of the Total Sample (N=69) by Questionnaire Form, Sex, Education, Age, and Marital Status

Form	Adult (sex unspecified) 38% (N=26)	Adult male 32% (N=22)	Adult female 30% (N=22)	
Sex	Female 48%	Male 52%		
Education Completed	B.A. - B.S. 45%	Master's in Counseling 32%	Master's in field other than Counseling 22%	Post-Doctoral 1%
Age	20-24 years 45%	25-29 years 38%	30-40 years 13%	Over 40 years 4%
Marital Status	Single 52%	Married 41%	Widowed or Divorced 7%	

at the .02 level of confidence in at least four of the six groups." These six groups were 366 men and 151 women, ages 17-24, the majority unmarried college students; 78 men and 86 women, 24-44 years, both married and unmarried, and with education at the college level or better; and 155 men and 146 women, 45-54 years, mostly married parents of college students, education from seven grades completed to the doctoral level with a median of 12.5 grades completed.

The questionnaire consists of 82 polar items with short phrases or adjectives describing a characteristic or behavior. For example:

Very emotional	1	2	3	4	5	Not at all emotional
Not at all easily influenced	1	2	3	4	5	Very easily influenced

The questionnaire was not validated because it was intended "to provide indices of current attitudes or perceptions, rather than as a test" (Broverman, 1970b). The original questionnaire items were generated by men and women college students asked "to list behaviors, attitudes, and personality characteristics which they considered to differentiate men and women" (Rosenkrantz et al., 1968, p. 287). The stereotype questionnaire was given to 154 college students asked to mark each item according to the extent to which it characterized the adult male, and a second time through the questionnaire to mark the extent to which it characterized the adult female. The items in which there was 75 per cent or better agreement as to which pole characterized men or women were designated as stereotypic. In addition to this data concerning the original questionnaire, information available from the authors about the short form indicated which items were classified as stereotypic by two

groups:[1] 80 female and 74 male college students, ages 17-25, unmarried; and 96 women and 102 men, ages 40-59, married. Only items designated as stereotypic by both of these groups were considered stereotypic in the present study. This criterion was met by 43 items. For these 43 items the masculine pole is the pole which was more often ascribed to men than women and the feminine pole indicates the pole which was more often ascribed to women. Odd-even reliability coefficients for the short form were .81 for the male response and .83 for the female response (Broverman, 1970b).

Based on the social desirability ratings (the average judgements) of 40 college men and 41 college women, the 43 items may be divided into male-valued and female-valued items. In the short questionnaire form used in this study, on 32 items the masculine pole is more socially desirable (male-valued), on 10 items the female pole is more socially desirable (female-valued), and on one item it was unclear whether the male or female pole was socially desirable.[2] See Table 2.

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[1]Items were classified as stereotypic "if the consensus that the 70 pole is more indicative of men than women or vice versa, exceeded the .001 level of a probability in each sex" (Broverman, 1970b).

[2]In regard to the original 122 item questionnaire (Broverman et al., 1972, pp. 66-67):

> To explore further the dimensions reflected by the stereotypic items factor analyses were performed separately on the masculinity and femininity responses in both a sample of men and a sample of women. Each analysis produced two initial factors accounting, on the average, for 61% of the total extractable communality. The two factors in all four analyses divided the stereotypic items into those on which the male pole is more socially desirable versus those on which the female pole is more socially desirable. These results indicated that the stereotypic items consist of two orthogonal domains, i.e., male-valued items and female-valued items.

The authors continue to say that the male-valued items seem to reflect a "competency" cluster while the female-valued items seem to reflect a "warmth-expressiveness" cluster.

Table 2

Male-Valued and Female-Valued Stereotypic Items
(Broverman, 1970b)

Feminine Pole	Masculine Pole
MALE-VALUED ITEMS	
Not at all aggressive	Very aggressive
Not at all independent	Very independent
Not at all consistent	Very consistent
Not at all realistic	Very realistic
Very subjective	Very objective
Never thinks before acting	Always thinks before acting
Very submissive	Very dominant
Dislikes math and science very much	Likes math and science very much
Very easily influenced	Not at all easily influenced
Very excitable in a major crisis	Not at all excitable in a major crisis
Very excitable in a minor crisis	Not at all excitable in a minor crisis
Not at all competitive	Very competitive
Very illogical	Very logical
Very home oriented	Very worldly
Not at all skilled in business	Very skilled in business
Does not know the way of the world	Knows the way of the world
Feelings easily hurt	Feelings not easily hurt
Not at all adventurous	Very adventurous
Has difficulty making decisions	Can make decisions easily
Gives up very easily	Never gives up easily
Cries very easily	Never cries
Almost never acts as a leader	Almost always acts as a leader
Always worried	Never worried
Not at all self-confident	Very self-confident
Feels very inferior	Feels very superior
Very uncomfortable about being aggressive	Not at all uncomfortable about being aggressive
Very strong need for security	Very little need for security
Not at all ambitious	Very ambitious
Unable to separate feelings from ideas	Able to separate feelings from ideas
Very dependent	Not at all dependent
Avoids new experience	Seeks out new experience
Not at all assertive	Very assertive

Table 2 (continued)

Feminine Pole	Masculine Pole
FEMALE-VALUED ITEMS	
Very emotional	Not at all emotional
Does not hide emotions at all	Almost always hides emotions
Very talkative	Not at all talkative
Able to devote self completely to others	Not at all able to devote self completely to others
Very tactful	Very blunt
Very helpful to others	Not at all helpful to others
Very religious	Not at all religious
Very interested in own appearance	Not at all interested in own appearance
Easily expresses tender feelings	Does not express tender feelings easily

In this study the items in the short form of the Sex-Role Questionnaire were revised from a 7-point scale to a 5-point scale. This revision was made so the questionnaire responses could be scored by computer. In addition, five demographic and informational items prefaced the main body of the questionnaire. The five items asked the subjects to designate which form of the questionnaire he or she completed, and their sex, education completed, age, and marital status.

Summary

The instrument used in this study, the short form of the Sex-Role Questionnaire, is based on a longer form used extensively in previous research (Rosenkrantz et al., 1968; Broverman et al., 1972). The short form consists of 82 unipolar and bipolar items, divided into five scale points. Each item consists of adjectives or short phrases describing characteristics or behavior traits. Of the 82 items, 43 have been designated as stereotypic in which one pole more often characterizes the male and the other pole more often characterizes the female. On the basis of social desirability ratings, 32 items were classified as male-valued and ten items were classified as female-valued.

Data Collection

The counseling graduate students were given the questionnaire with one of three sets of instructions: "adult person" (sex unspecified), "adult man," or "adult woman." Questionnaires with adult instructions were completed by 26 subjects, 12 females and 14 males; 11 master's students, 14 doctoral students and one postdoctoral student. The adult instructions read, "Think of normal adults and then indicate for each item the pole to which a mature, healthy, socially competent adult

person would be closer." Responses to the "adult person" form were considered as judgements of the ideal health status, irrespective of sex. The "adult man" forms were completed by 22 subjects in which they were asked to, "Think of normal, adult men and then indicate on each item the pole to which a mature, healthy, socially competent, adult man would be closer." Of the 22 subjects who completed this form, nine were females and 13 were males, and nine were master's students and 13 were doctoral students. Finally, 21 subjects were given the "adult woman" form in which they were asked similarly to describe "a mature, healthy, socially competent, adult woman." The "adult woman" form was completed by 12 females and nine males, and 11 master's students and ten doctoral students. All of the subjects were asked to "Consider the opposing poles (columns one and five) of each item as opposing directions of a characteristic or a behavior, rather than as extremes of behavior."

Questionnaires were administered primarily in classes and seminars, and occasionally individually. No verbal instructions were given other than a request that students participate in the study and that they refrain from discussing the questionnaire with other students. Students who were not in residence at the Champaign-Urbana campus were not included in the study. The three questionnaire forms were passed out randomly. See Table 3 for a description of the resulting distributions of the subsample for each form.

Analysis of Data

Only the 43 stereotypic items were analyzed. Two types of scores were developed: agreement scores and health scores. These scores were designed to reflect the differences between three groups, the respondents

Table 3

Sex and Education Completed of Questionnaire Form Subsamples (by percent), Total N=69

"Adult, Sex Unspecified" Form (38% of total sample, N=26)	Sex	Male	Female		
		54%	46%		
	Education Completed	B.A.-B.S.	Master's in Coun.	Master's in other than Counseling	Post-Doctoral
		42%	54%		1%
"Adult Man" Form (32% of total sample, N=22)	Sex	Male	Female		
		59%	41%		
	Education Completed	B.A.-B.S.	Master's		
		41%	59%		
"Adult Woman" Form (30% of total sample, N=21)	Sex	Male	Female		
		43%	57%		
	Education Completed	B.A.-B.S.	Master's		
		52%	48%		

to the three questionnaire forms. Thus, no individual total scores were computed or analyzed.

The first step in obtaining the agreement scores and health scores was ascertaining the modal value for each stereotypic item. Hence the pole (1, 2, 3, 4, or 5) to which the most subjects responded was designated as the "correct" value for that item and form of the questionnaire. Second, separately for each form (adult, man, and woman), each subject's response to each item was corrected against this modal value. If their response agreed with the modal value, the score for that item was one; if their response did not match the modal value, the score for the item was zero. Then 43 means were computed across subjects for each stereotypic item. The mean of these 43 items was determined and called the agreement score. This procedure was conducted separately for each of the three subsamples and hence yielded three agreement scores: adult agreement, masculinity agreement, and femininity agreement. The following diagram represents this process.

Adult Form

Subject	Stereotypic Item						
	1	2	3	4	5	6	. . .
1	1	0	1				
2	1	1	etc.				
3	1	0					
4	0	1					
5							
6							
7							
etc.							
	M_1	M_2	M_3	M_4	M_5	M_6	. . . A_A

Thus, M_1, M_2 . . . refers to the mean number of subjects who agreed with the modal value for item one, two, and so forth. A_A refers to the mean number of subjects with "adult person" instructions who agreed across 43 items. Similarly, a femininity agreement score (F_A) and a masculinity agreement score (M_A) were computed. The agreement score was intended to reflect the degree of consensuality within each of the three subsamples on the characteristics of the healthy adult person, adult man, or adult woman.

Wherever possible the methods of scoring and statistical analyses followed Broverman's et al. examples. As mentioned before, this was done to insure the comparability of the results of actively functioning clinicians and counseling of graduate students. In the previous study (Broverman et al., 1972, p. 2), "the pole which the majority of the clinicians consider to be healthy for an adult, independent of sex, reflects an ideal standard of health." Therefore, in this study it was assumed that the pole which the majority of the counseling students considered to be healthy for an adult, independent of sex, constituted an ideal standard of health. Two health scores were computed: a masculinity health score and a femininity health score. This was done by using the adult agreement scores as a key, and then correcting the responses to the "adult man" form and "adult woman" form in a manner similar to the way the agreement scores were derived. Thus, the masculinity health score represents the proportion of respondents to the "adult man" form who marked the pole of each item most often designated as healthy for an adult person. And the femininity health score represents the proportion of respondents to the "adult woman" form who marked the pole of each item most frequently designated as healthy for an adult person. Similar to the agreement

scores, the health scores represent the mean number of subjects ("adult man" and "adult woman" forms) who agreed across 43 items with the ideal or adult standard of health.

The data for this study will be presented in terms of t-tests between the adult agreement scores and the masculinity and femininity health scores. In addition, t-tests were conducted to determine if subjects responded differently as a function of their sex or educational level. Also, a separate analysis will be presented of the male-valued and female-valued items, specifically t-tests of the mean femininity health score on the female-valued items as compared to the mean masculinity health score on the female-valued items; and of the mean femininity health score on the male-valued items as compared to the mean masculinity health score on the male-valued items.

CHAPTER IV

RESULTS

Sex and Education Differences in Subject Responses

The adult, masculinity, and femininity health and agreement scores were compared, item by item, between male counseling graduate students and female counseling graduate students by t-tests. Out of 215 possible significant differences, males and females responded differently to six items, significant at the .05 level of probability, and to one item significant at the .001 level of probability. Since one would expect to obtain by chance seven significant different responses out of 215 possibilities, the male and female samples were not separated for further analysis, on the basis that male and female subjects were not responding differently from each other as a function of their sex.

The adult, masculinity, and femininity health and agreement scores were also compared, item by item, by t-tests between master's students and doctoral students. Out of 215 possible differences, responses to four items were significantly different at the .05 level and three items at the .01 level of probability. Again, it was concluded that by chance one would expect to obtain seven significant differences out of 215 possibilities. Hence, the master's and doctoral student samples were combined for further analysis, based on the determination that master's and doctoral students did not differ significantly in their responses.

Agreement Scores

The means and standard deviations for the masculinity, femininity, and adult agreement scores are shown in Table 4. Only the adult agreement

Table 4

Means and Standard Deviation for Adult, Masculinity, and Femininity Agreement Scores on 43 Stereotypic Items

Agreement Score	M	SD	t-score
Adult (sex unspecified)	.562	.106	3.834**
Masculinity	.522	.116	1.257
Femininity	.535	.114	2.011*

* $p < .1$

** $p < .001$

score was significantly greater (at the .001 level) than the .50 agreement score one would expect to obtain by chance. Thus, there was a high consensus among counseling graduate students on the attributes which characterize the adult person, or on what characteristics constitute an ideal standard of health. However, there was not high agreement among counseling graduate students on the behaviors and characteristics of the adult man or the adult woman.

Masculinity Health Scores and Femininity Health Scores

The masculinity, femininity, and adult health scores (expressed in means) were compared by t-tests as shown in Table 5. The masculinity health score differed from the adult health score, significant at the .05 level of probability, and the femininity health score differed from the adult health score, significant at the .001 level of probability. However, the masculinity and femininity health scores were not significantly different from each other ($t=1.823$, $p < .10$). The difference between the femininity health score and the adult agreement score and the difference between the masculinity health score and the adult agreement score was also compared by a t-test. These two values were not significantly different ($t=1.934$, $p < .10$). Thus, both the concepts of the healthy adult man and the healthy adult woman were different from the concept of the healthy adult, sex unspecified. However, there was a significantly greater difference between the concepts of the healthy adult woman and the healthy adult person, sex unspecified, than there was between the concepts of the healthy adult man and the healthy adult, sex unspecified. Nevertheless, it could not be determined whether these differences paralleled stereotypic sex-role differences, because of the subjects'

Table 5

Health Scores and T-Scores on 43 Stereotypic Items

	df	M	SD	t
Health Score				
Masculinity (M_h)		.512	.122	
Adult (A_A)		.562	.106	
Femininity (F_h)		.457	.153	
Difference between F_h and A_a (D_1)		-.104	.134	
Difference between M_h and A_a (D_2)		-.501	.126	
T-Test				
A_a and M_h	84	.537		2.041**
A_a and F_h	84	.510		3.685***
M_h and F_h	84	.484		1.823*
D_1 and D_2	84	-.772		1.934*

* $p < .1$

** $p < .05$

*** $p < .001$

low agreement on the characteristics of the healthy adult woman and the healthy adult man. Thus, counseling graduate students' concepts of the healthy individual differed as a function of the sex of the person judged, however, not necessarily in a manner parallel to stereotypic sex-role differences.

Male-Valued and Female-Valued Items

Masculinity, femininity, and adult health scores for the male-valued and female-valued items were computed in order to study the relationship between social desirability, sex-role stereotypes, and judgements of mental health. These scores are presented and compared by t-tests in Table 6. The masculinity, femininity, and adult health scores were not significantly different on the female-valued items. In contrast, on the male-valued items, the femininity health score was significantly lower than the adult agreement score. While the adult health score and the femininity health score on the male-valued items differed from each other at the .001 level of significance, the masculinity and adult health scores on the male-valued differed only at the .10 level of significance.

Table 6

Health Scores and T-Tests on 32 Male-Valued Items and on 10 Female-Valued Items

	df	M	SD	t
Health Score				
Adult				
male-valued		.575	.109	
female-valued		.515	.873	
Masculinity				
male-valued		.530	.102	
female-valued		.482	.147	
Femininity				
male-valued		.449	.149	
female-valued		.471	.175	
T-Test				
Female-valued: masculinity and femininity health scores	18	.477		.144
Female-valued: femininity and adult health scores	18	.493		.712
Female-valued: adult and masculinity health scores	18	.499		.620
Male-valued: masculinity and femininity health scores	62	.490		2.516**
Male-valued: masculinity and adult health scores	62	.522		1.689*
Male-valued: adult and femininity health scores	62	.512		3.830***

* $p < .10$
** $p < .05$
*** $p < .001$

CHAPTER V

DISCUSSION, CONCLUSIONS, AND IMPLICATIONS

Discussion

The results of this study indicate that there was high agreement among counseling graduate students only in regard to the characteristics attributed to the healthy adult, sex unspecified. This contrasts with the results obtained in a previous study with practicing clinicians in which there was high agreement on the characteristics describing the healthy adult, sex unspecified ($M = .866$, $t = 3.73$, $p < .001$), the healthy adult man ($M = .831$, $t = 3.15$, $p < .001$), and the healthy adult woman ($M = .763$, $t = .164$, $p < .005$) (Broverman et al., 1970a). As expected, there were not significant differences in the responses of male and female subjects in the present study. This finding is consistent with the results of Broverman et al. (1970a). Examination of the responses of master's level students as compared to doctoral level students indicated that the responses of counseling students at different levels in their professional studies did not differ appreciably. Therefore, the factors which might account for the different degrees of agreement between counseling graduate students and practicing clinicians on the characteristics of healthy adults, healthy adult men, and healthy adult women appear to have been constant among students at different levels in their studies. For example, higher agreement among doctoral students than among master's students might have been obtained, possibly indicating that more defined concepts of normality or health developed with increased study. Nevertheless, the results of this study did not suggest that this development occurred. The lower agreement among counseling graduate students than

among practicing clinicians may be due to graduate students' relative lack of clinical experience. The clinician who has been exposed to a wide range of individuals functioning at various levels, and who has observed and helped many clients to progress in therapy, may have a more definite, clearly formulated picture of the healthy adult than the student with more limited experiences. Different degrees of agreement may also be related to age or generation factors. The ages of Broverman's et al. subjects ranged from 22 to 55 years while 83 per cent of the subjects in the present study were 20 to 29 years of age and only 4 per cent were over 40.

It is also possible that the results of the present study reflect changing societal attitudes about sex-role stereotypes. Counseling graduate students' masculinity agreement score of .522 and femininity agreement score of .535 indicate that as a group they did not respond clearly in agreement with the sex-role dimensions which the questionnaire was designed to tap. Whereas the questionnaire has previously elicited extreme polar responses from subjects in regard to the stereotypic characteristics of men and women (Broverman et al., 1970a; Broverman, 1970b; Rosenkrantz et al., 1968), half of the graduate students' modal responses were pole three, the midpoint on a five point scale, half of their modal responses were pole two or four, and none of their modal responses were the first or fifth poles. This could indicate a response set in counseling graduate students, such as a reluctance to respond to extreme poles; or it could indicate counseling students' tendency to be less influenced by social desirability or sex-role stereotype factors than previous subject populations. Also, counseling students may have perceived many of the items as irrelevant to their conception of the healthy adult, healthy adult man, or healthy adult woman. Counseling graduate

students' lower masculinity and femininity agreement scores may reflect a general confusion about the characteristics of real people, in contrast to their higher agreement on an ideal standard of health. On the other hand, when thinking of an adult man or woman, as opposed to the more abstract adult person, counseling students may have been more apt to consider individual differences and thereby exhibit less conclusive standards of health for adult men and adult women. Thus, counseling graduate students' relatively low agreement scores may also reflect a position that people can be healthy in many different ways or that healthy individuals exhibit varying combinations and degrees of different characteristics. It is also possible that these results are a product of a particular counseling training program. For example, different results might have been obtained in a program that emphasizes different aspects of counselor education. Or, students in a primarily psychoanalytically or behavioristically oriented program might have responded differently.

Although there was not high agreement on the characteristics attributed to adult men and adult women, there were still significant differences between the adult health, masculinity health, and femininity health scores. The results of the present study tended to indicate a tripie standard of health--one standard for the sex unspecified adult (most likely an ideal standard), another standard for the adult man, and an even more different standard for the adult woman. So where practicing clinicians had a double standard of health, one for adult persons and adult men and another for adult women, counseling students appeared to have a triple standard of health. In contrast to practicing clinicians' standards of health which paralleled sex-role stereotypes, it is not clear what was the basis of the counseling students' differentiations. It is

clear though, that in Broverman's et al. study and the present study, the healthy adult woman was conceived as consistently more different from the healthy adult, sex unspecified, than the healthy adult man was from the healthy adult, sex unspecified.

This conclusion was augmented by the analysis of female-valued and male-valued items. The femininity health score was not higher or significantly different from the masculinity or adult health scores on the female-valued items, while on the male-valued items the femininity health score was significantly lower than the masculinity health and adult health scores. This did not conflict with Broverman's et al. (1970a, pp. 4-5) analysis of the male- and female-valued items,

> This result indicates that clinicians tend to consider socially desirable masculine characteristics more often as healthy for men than for women. On the other hand, only about half of the socially desirable feminine characteristics are considered more often as healthy for women than for men.
>
> On the face of it, the finding that clinicians tend to ascribe male-valued stereotypic traits more often to healthy men than to healthy women may seem trite. However, an examination of the content of these items suggests that this trite-seeming phenomenon conceals a powerful, negative assessment of women. For instance, among these items, clinicians are more likely to suggest that healthy women differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective, and disliking math and science. This constellation seems a most unusual way of describing any mature, healthy individual.

Examination of item means and item modes revealed trends among counseling students' descriptions of healthy adult men and women which are a curious mixture of traditional stereotypic characteristics and clear contradictions of stereotypic characteristics. For instance, the trends

were to characterize the healthy adult woman as more talkative, less or more consistent, less realistic, more excitable in a major crisis, less adventurous, more apt to act as a leader, less dependent, and more easily making decisions than the adult man. The healthy adult man tended to be characterized as less gentle, more skilled in business, less easily expressing tender feelings, less self-confident, more competitive, and more apt to think of men as superior to women, than both the healthy adult woman and the healthy adult, sex unspecified. The general picture which emerges is that both practicing clinicians and counseling graduate students possessed an ideal standard of health for the adult, sex unspecified. The standard of health for the adult man fell at a slightly different position on the continuum of mental health. However, the standard of health for the adult woman occupied a significantly more different position on the mental health continuum. Although counseling students' different standards of health for men and women did not clearly reflect sex-role stereotypes, their triple standard may have been a remnant of these widely held societal attitudes and of the generally less favorable evaluation of women that these sex-role stereotypes imply (Rosenkrantz et al., 1968; Broverman et al., 1970a; Kitay, 1940; McKee & Sherriffs, 1957).

Conclusions

Counseling graduate students' clinical judgements differed as a function of the sex of the person judged; however, these different judgements did not clearly parallel traditional sex-role stereotypes. Moreover, there was not high agreement or consensus among counseling graduate students on the attributes characterizing the healthy adult man or the

healthy adult woman. There was, however, consensus, significantly different at the .001 level from what would have been obtained by chance, on the characteristics of the healthy adult, sex unspecified. Furthermore, there were no significant differences between male and female subjects, or between master's students and doctoral students, on the masculinity, femininity, and adult health and agreement scores.

The meaning of the different standards of health for adult men and adult women among counseling graduate students was not clear because of the lack of high agreement on the characteristics attributed to healthy adult men and healthy adult women. Nevertheless, it is clear that the healthy adult woman was consistently and significantly more different from the healthy adult, sex unspecified, than was the healthy adult male. In addition, these results may not be generalizable to students in other counseling programs, especially in other geographic areas. Also, experience variables were not analyzed and thus, it is not known if this variable would have affected the results.

Implications

Although there was agreement among counseling students on an ideal standard of health, there was not high agreement on the standards of health for adult men and women. This may reflect the lack of agreement in the mental health profession on the definition of normality. Each theoretical orientation has its own theoretical standards for the healthy person and its own theoretical description of the abnormally functioning individual. In addition, each counselor's goals reflect his values and effect the way he practices psychotherapy. Just as it is recognized that each psychotherapist's goals and values enter into psychotherapy,

it is acknowledged that the counselor's values and his expectations for the client are perceived by the client (Fromm-Reichman, 1950; Patterson, 1974). Consequently, an important function of counselor education programs is to promote counseling students' awareness of their own values and concepts of mental health (their goals and expectations for their clients). A significant part of this awareness is an exploration of the role of societal attitudes on one's decisions, attitudes, and goals. For example, an area which needs to be examined is the relationship between clinical assessments and social desirability ratings. Much of this learning, then, involves scrutinizing personal attitudes and opinions and reaccepting or rejecting societal norms and stereotypes. Counselor education programs may help to achieve these ends by emphasizing and rewarding experiential learning and practical experience whenever possible. Counseling programs may integrate these concerns into their program by making them a part of their curriculums.

Similarly, the role of values in counseling and psychotherapy is a necessary consideration in regard to counseling students' different standards of health for men and women. Counseling students must examine their attitudes relating to different standards of health for men and women. If they do possess different standards of health for men and women, what is the basis of this differentiation, and how will it manifest itself in their professional activities? Whether or not counseling students' different standards of health for men and women are caused by their acceptance of traditional sex-role stereotypes or by the effects of the different evaluations of men and women by society in general, counselors and psychotherapists need to become sensitive to and aware of the influences sex-role stereotypes may have on their clients. For

example, studies indicate that men and women tended to incorporate sex-role stereotypes into their self concepts (Rosenkrantz et al., 1968); that women included in their feminine stereotype a neurotic trait cluster (Sherriffs & McKee, 1967); and that in comparison to men's feelings about themselves, women felt less adequate, more weak, and less personal capacity (Bennett & Cohen, 1959). It is not surprising that some women feel as though they are in a double bind. In a study on the congruence between college students' ideal, actual, and social selves, Martire and Hornblower (1957, p. 290) found that:

> With these female subjects, the introduction of the social self scale significantly lowers the levels of agreement or congruence among these measures of the self. This obtained lack of congruence for the female subjects implies that these women see themselves as being and behaving in a manner different from what they believe society expects of them. Both their hopes about themselves and their actual characteristics seem to be at variance with their understanding of social expectations. In dynamic terms, one may infer conflict between personal strivings and either present social standards or introjected values.

Again, inspection of beliefs, attitudes, values, and how they affect counselors' professional activities should be included in counseling curriculums. These topics warrant special and planned consideration and this may be accomplished through a course designed to promote growth and exploration in these areas. Counselor educators may also benefit from this type of scrutiny. For instance, counselor educators can determine what their values and biases are, whether or not they wish to change any of these attitudes, and how open they want to be about their values and decisions. Counselor educators are models for future counselors and thus, they can choose to model an open and critical concern for their own personal values, how these values and attitudes affect their students

and clients, and how these attitudes are related to societal values. Because students in counseling practicum often are just beginning to experience their personal selves in the counseling process, counseling practicum supervisors may also play an important role in helping students to work through their value conflicts.

One possible implication of different standards of mental health for men and women is that counseling students have an adjustment notion of mental health (Broverman et al., 1970a). Thus, the healthy man or woman is well adjusted to society, including society's expectations of his or her sex-appropriate behavior. As Broverman et al. (1970a) point out, this attitude may be contrasted to self-actualization theories which do not have the by-product of reinforcing restrictive social roles. Maslow suggests that human wants are organized in a hierarchy of prepotency, including physiological needs, safety needs, belongingness and love needs, esteem needs, and self-actualization needs. Similarly, Rogers (1951, p. 35) describes man's tendency toward self-actualization:

> It is the urge which is evident in all organic and human life - to expand, extend, become autonomous, develop, mature - the tendency to express and activate all the capacities of the organism, to the extent that such activation enhances the organism or the self.

The values in self-actualization theory are also expressed in therapeutic goals (Buhler, 1959, p. 578): "The postulated goal of life and the goal of psychotherapy on this basis is then that man, having become aware of his existence as well as of his potentialities, would find himself enabled to make of himself what he wanted to be . . . ."

Whether counselors and psychotherapists choose to recognize it, to a degree they function as social engineers (Maslow, 1970, p. 256):

> Theoretically, then, psychotherapy socially amounts to running counter to the basic stresses and tendencies in a sick society. Or in a more generalized form, no matter what the degree of general health or sickness of a society, therapy amounts to fighting against the sickness-producing forces in that society on an individual scale. It tries, so to speak, to turn the tide, to bore from within, to be revolutionary or radical in an ultimate etymological sense. Every psychotherapist, then, is or would be fighting in the small rather than in the large, the psychopathic forces in his society, and if these be fundamental and primary he is actually fighting his society.

The individual psychotherapist effects society by his/her activities in therapy as well as through her role as an expert in our society. Thus, he/she must consider what kind of an impact on society he would like to have. He/she must decide if restrictive sexual roles are a healthy characteristic of our society,[4] and if different standards of health for women and men are a favorable phenomenon.

Suggestions for Further Research.

This study and Broverman's et al. study were beginning attempts to investigate the relationship between sex-role stereotypes and conceptions of mental health especially as they are related to psychotherapy. As mentioned before, it is not clear to what extent clinical experience

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[4] As Seward points out, the issue is not necessarily the content of sex-roles, but the degree to which they confine or restrict individuals. The male is just as confined as the female by the lack of flexibility in sex-roles (Seward, 1972, p. 194), "Freedom of choice, however, must always remain the prerogative of the individual regardless of social mode. In view of the overlapping between the sexes, a woman's 'nature' would be as much violated by being forced into a 'feminized' curriculum as being forced to imitate men" (Komarovsky, 1953). Sufficient flexibility must be permitted to foster the talents of individuals irrespective of sex, but insofar as there are strong biologically determined predilection, the modal activities of males and females may be expected to gravitate around them, provided open choice is available.

is related to practicing clinicians' and counseling graduate students' level of agreement on the characteristics of the healthy adult man, healthy adult woman, and the healthy adult, sex unspecified. Therefore, further research which focuses on the experience factor is needed. One method of studying the experience variable is to analyze students' and clinicians' individual questionnaire responses over a period of years. The unit of analysis would be an individual difference score.

In addition, since counseling students may be revising their attitudes toward sex-role stereotypes or changing some of the content of their sex-role stereotypes, and since sex-role stereotypes and sexual roles are receiving greater attention by both lay and professional people, it may be profitable to develop a new, current questionnaire. This revision of the questionnaire might make the results of future studies more amenable to content analysis. Whereas in the present study it was difficult to specify what factors or items accounted for the different standards of health for men, women, and adults, sex unspecified, an updated questionnaire or revised scoring procedures might allow for more meaningful interpretation of the data.

There seems to be a need for studies directed toward understanding how different standards of health for men and women are manifested in counseling and psychotherapy. Having an awareness of how standards are exhibited in practice will allow counselors and psychotherapists greater freedom to choose how they will affect their clients.

CHAPTER VI

SUMMARY

The purpose of this study was to examine the relationship between sex-role stereotypes and conceptions of mental health in counseling graduate students. The design followed as closely as possible a study by Broverman et al. (1970a) in order to test the applicability of their results to counseling graduate students and counselor education programs. However, in this study the subject population was students in counseling programs at the master's or doctoral level, instead of the previous study's sample of actively practicing clinicians. Subjects were administered one of three forms of the 82 item Sex-Role Questionnaire in which they were asked to describe a "mature, healthy, socially competent" adult man, adult woman, or adult person, sex unspecified. Masculinity, femininity, and adult agreement and health scores, based on the questionnaire's 43 stereotypic items, were computed and compared by t-tests.

There was high consensus only in regard to the characteristics of the healthy adult, sex unspecified ($p < .001$). In addition, the masculinity and adult scores were significantly different ($p < .05$) as were the femininity and adult health scores ($p < .001$). It was concluded that counseling graduate students had a triple standard of health--one for adults, sex unspecified, one for adult men, and one for adult women. These results held for men and women students and master's level and doctoral level counseling students. It was not found that these different standards of health clearly paralleled sex-role stereotypes. The results were compared and contrasted with those of Broverman et al. (1970a) and

implications for counselor education programs, counselor educators, and counseling graduate students were discussed.

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APPENDIX A

SEX-ROLE QUESTIONNAIRE

Sex-Role Questionnaire*

Form A

I. Using your separate answer sheet, fill in with pencil the appropriate column for each of the following items. Begin with number 1 under section I of your answer sheet.

1. Form: A (1) B (2) C (3)

2. Sex: Male (1) Female (2)

3. Education completed:

B.A.-B.S.	M.A. or M.Ed. in Counseling	M.A., M.S. or M.Ed. in field other than Counseling	Ph.D.	Post-Doctoral
1	2	3	4	5

4. Age: Under 20 (1) 20-24 (2) 25-29 (3) 30-40 (4) Over 40 (5)

5. Marital Status: Single (1) Married (2) Widowed or Divorced (3)

II. The remainder of the questionnaire consists of a series of bipolar items. Think of normal adults and then indicate for each item the pole to which a mature, healthy, socially competent, adult person would be closer. Consider the opposing poles (columns 1, 5) of each item as opposing directions of a characteristic or a behavior rather than as extremes of behavior.

For example:

Strong dislike for the color red	1.....2.....3.....4.....5	Strong liking for the color red

1 2 3 4 5

PLEASE BE SURE TO MARK EVERY ITEM.

*Items 6-87 (Broverman, et al., 1970b).

6.	Not at all aggressive	1.....2.....3.....4.....5	Very aggressive
7.	Very irrational	1.....2.....3.....4.....5	Very rational
8.	Very practical	1.....2.....3.....4.....5	Very impractical
9.	Not at all independent	1.....2.....3.....4.....5	Very independent
10.	Not at all consistent	1.....2.....3.....4.....5	Very consistent
11.	Very emotional	1.....2.....3.....4.....5	Not at all emotional
12.	Very realistic	1.....2.....3.....4.....5	Not at all realistic
13.	Not at all idealistic	1.....2.....3.....4.....5	Very idealistic
14.	Does not hide emotions at all	1.....2.....3.....4.....5	Almost always hides emotions
15.	Very subjective	1.....2.....3.....4.....5	Very objective
16.	Mainly interested in details	1.....2.....3.....4.....5	Mainly interested in generalities
17.	Always thinks before acting	1.....2.....3.....4.....5	Never thinks before acting
18.	Not at all easily influenced	1.....2.....3.....4.....5	Very easily influenced
19.	Not at all talkative	1.....2.....3.....4.....5	Very talkative
20.	Very grateful	1.....2.....3.....4.....5	Very ungrateful
21.	Doesn't mind at all when things are not clear	1.....2.....3.....4.....5	Minds very much when things are not clear
22.	Very dominant	1.....2.....3.....4.....5	Very submissive
23.	Dislikes math and science very much	1.....2.....3.....4.....5	Likes math and science very much
24.	Not at all reckless	1.....2.....3.....4.....5	Very reckless

25.	Not at all excitable in a major crisis	1.....2.....3.....4.....5	Very excitable in a major crisis
26.	Not at all excitable in a minor crisis	1.....2.....3.....4.....5	Very excitable in a minor crisis
27.	Not at all strict	1.....2.....3.....4.....5	Very strict
28.	Very weak personality	1.....2.....3.....4.....5	Very strong personality
29.	Very active	1.....2.....3.....4.....5	Very passive
30.	Not at all able to devote self completely to others	1.....2.....3.....4.....5	Able to devote self completely to others
31.	Very blunt	1.....2.....3.....4.....5	Very tactful
32.	Very gentle	1.....2.....3.....4.....5	Very rough
33.	Very helpful to others	1.....2.....3.....4.....5	Not at all helpful to others
34.	Not at all competitive	1.....2.....3.....4.....5	Very competitive
35.	Very logical	1.....2.....3.....4.....5	Very illogical
36.	Not at all competent	1.....2.....3.....4.....5	Very competent
37.	Very worldly	1.....2.....3.....4.....5	Very home oriented
38.	Not at all skilled in business	1.....2.....3.....4.....5	Very skilled in business
39.	Very direct	1.....2.....3.....4.....5	Very sneaky
40.	Knows the way of the world	1.....2.....3.....4.....5	Does not know the way of the world
41.	Not at all kind	1.....2.....3.....4.....5	Very kind
42.	Not at all willing to accept change	1.....2.....3.....4.....5	Very willing to accept change

43.	Feelings not easily hurt	1.....2.....3.....4.....5	Feelings easily hurt
44.	Not at all adventurous	1.....2.....3.....4.....5	Very adventurous
45.	Very aware of the feelings of others	1.....2.....3.....4.....5	Not at all aware of the feelings of others
46.	Not at all religious	1.....2.....3.....4.....5	Very religious
47.	Not at all intelligent	1.....2.....3.....4.....5	Very intelligent
48.	Not at all interested in own appearance	1.....2.....3.....4.....5	Very interested in own appearance
49.	Can make decisions easily	1.....2.....3.....4.....5	Has difficulty making decisions
50.	Gives up very easily	1.....2.....3.....4.....5	Never gives up easily
51.	Very shy	1.....2.....3.....4.....5	Very outgoing
52.	Always does things without being told	1.....2.....3.....4.....5	Never does things without being told
53.	Never cries	1.....2.....3.....4.....5	Cries very easily
54.	Almost never acts as a leader	1.....2.....3.....4.....5	Almost always acts as a leader
55.	Never worried	1.....2.....3.....4.....5	Always worried
56.	Very neat in habits	1.....2.....3.....4.....5	Very sloppy in habits
57.	Very quiet	1.....2.....3.....4.....5	Very loud
58.	Not at all intellectual	1.....2.....3.....4.....5	Very intellectual
59.	Very careful	1.....2.....3.....4.....5	Very careless
60.	Not at all self-confident	1.....2.....3.....4.....5	Very self-confident

61.	Feels very superior	1.....2.....3.....4.....5	Feels very inferior
62.	Always sees self as running the show	1.....2.....3.....4.....5	Never sees self as running the show
63.	Not at all uncomfortable about being aggressive	1.....2.....3.....4.....5	Very uncomfortable about being aggressive
64.	Very good sense of humor	1.....2.....3.....4.....5	Very poor sense of humor
65.	Not at all understanding of others	1.....2.....3.....4.....5	Very understanding of others
66.	Very warm in relations with others	1.....2.....3.....4.....5	Very cold in relations with others
67.	Doesn't care about being in a group	1.....2.....3.....4.....5	Greatly prefers being in a group
68.	Very little need for security	1.....2.....3.....4.....5	Very strong need for security
69.	Not at all ambitious	1.....2.....3.....4.....5	Very ambitious
70.	Very rarely takes extreme positions	1.....2.....3.....4.....5	Very frequently takes extreme positions
71.	Able to separate feelings from ideas	1.....2.....3.....4.....5	Unable to separate feelings from ideas
72.	Not at all dependent	1.....2.....3.....4.....5	Very dependent
73.	Does not enjoy art and literature at all	1.....2.....3.....4.....5	Enjoys art and literature very much
74.	Seeks out new experience	1.....2.....3.....4.....5	Avoids new experience
75.	Not at all restless	1.....2.....3.....4.....5	Very restless

76.	Very uncomfortable when people express emotions	1.....2.....3.....4.....5	Not at all uncomfortable when people express emotions
77.	Easily expresses tender feelings	1.....2.....3.....4.....5	Does not express tender feelings easily
78.	Very conceited about appearance	1.....2.....3.....4.....5	Never conceited about appearance
79.	Retiring	1.....2.....3.....4.....5	Forward
80.	Thinks men are superior to women	1.....2.....3.....4.....5	Does not think men are superior to women
81.	Very sociable	1.....2.....3.....4.....5	Not at all sociable
82.	Very affectionate	1.....2.....3.....4.....5	Not at all affectionate
83.	Very conventional	1.....2.....3.....4.....5	Not at all conventional
84.	Very masculine	1.....2.....3.....4.....5	Not at all masculine
85.	Very feminine	1.....2.....3.....4.....5	Not at all feminine
86.	Very assertive	1.....2.....3.....4.....5	Not at all assertive
87.	Very impulsive	1.....2.....3.....4.....5	Not at all impulsive

APPENDIX B

HEALTH SCORES, STANDARD DEVIATIONS, AND MODAL VALUES FOR 43 STEREOTYPIC ITEMS

Health Scores,[1] Standard Deviations, and Modal Values[2] for 43 Stereotypic Items

Item descriptor at pole 1	Adult health		Femininity health		Masculinity health		Item mode by form		
	Mean	sd	Mean	sd	Mean	sd	Adult man	Adult woman	Adult, sex unspecified
6. Not at all aggressive	.500	.510	.476	.512	.409	.503	4	3	3
9. Not at all independent	.385	.496	.190	.402	.273	.456	4	4	3
10. Not at all consistent	.577	.504	.286	.463	.500	.512	4	3,4,5	4
11. Very emotional	.462	.508	.524	.512	.409	.503	2	2	2
12. Very realistic	.577	.504	.333	.483	.646	.492	2	3	2
14. Does not hide emotions at all	.500	.510	.190	.402	.273	.456	2	2	3
15. Very subjective	.500	.510	.571	.507	.636	.492	3	3	3
17. Always thinks before acting	.654	.485	.571	.507	.591	.503	2	2	2
18. Not at all easily influenced	.615	.496	.333	.483	.455	.510	2,3	2	3
19. Not at all talkative	.538	.508	.381	.498	.591	.503	3	4	3
22. Very dominant	.692	.470	.571	.507	.545	.510	3	3	3

Item descriptor at pole 1	Adult health		Femininity health		Masculinity health		Item mode by form		
	Mean	sd	Mean	sd	Mean	sd	Adult man	Adult woman	Adult, sex unspecified
23. Dislikes math and science very much	.538	.508	.524	.512	.636	.492	3	3	3
25. Not at all excitable in a major crisis	.385	.496	.333	.483	.591	.503	2	3	2
26. Not at all excitable in a minor crisis	.577	.504	.429	.507	.455	.510	2	2	2
30. Not at all able to devote self completely to others	.615	.496	.762	.436	.727	.456	3	4	3,4
31. Very blunt	.461	.508	.429	.507	.364	.492	4	4	4
32. Very gentle	.500	.509	.667	.483	.409	.503	3	2	2
33. Very helpful to others	.654	.485	.429	.507	.545	.510	2	2	2
34. Not at all competitive	.846	.368	.905	.301	.727	.456	4	3	3,4
35. Very logical	.654	.485	.524	.512	.545	.510	2	2	2
37. Very worldly	.615	.496	.333	.483	.455	.510	3	3	3
38. Not at all skilled in business	.538	.508	.524	.512	.727	.456	3	3	3

Item descriptor at pole 1	Adult health		Femininity health		Masculinity health		Item mode by form		
	Mean	sd	Mean	sd	Mean	sd	Adult man	Adult woman	Adult, sex unspecified
40. Knows the way of the world	.615	.496	.476	.510	.636	.492	2	2	2
43. Feelings not easily hurt	.500	.510	.524	.512	.545	.510	3	3	3
44. Not at all adventurous	.615	.496	.381	.498	.545	.510	4	3,4	4
46. Not at all religious	.577	.504	.619	.498	.591	.503	3	3	3
48. Not at all interested in own appearance	.500	.510	.429	.507	.591	.503	4	4	4
49. Can make decisions easily	.538	.508	.286	.463	.591	.503	2	1,2	2
50. Gives up very easily	.500	.510	.429	.507	.591	.503	4	4	4
53. Never cries	.653	.485	.667	.483	.363	.492	3	3	3
54. Almost never acts as a leader	.654	.485	.286	.463	.591	.503	3	4	3
55. Never worried	.692	.470	.571	.507	.545	.510	3	3	3
60. Not at all self-confident	.730	.452	.333	.483	.545	.510	4	4,5	4

Item descriptor at pole 1	Adult health		Femininity health		Masculinity health		Item mode by form		
	Mean	sd	Mean	sd	Mean	sd	Adult man	Adult woman	Adult, sex unspecified
61. Feels very superior	.730	.452	.667	.483	.591	.503	3	3	3
63. Not at all uncomfortable about being aggressive	.577	.504	.381	.498	.500	.512	2	2	2
68. Very little need for security	.538	.508	.439	.507	.409	.503	3	3	3
69. Not at all ambitious	.462	.508	.476	.512	.545	.510	4	4	4
71. Able to separate feelings from ideas	.346	.485	.381	.498	.409	.503	2	2	2
72. Not at all dependent	.423	.504	.190	.402	.409	.503	3	2	3
74. Seeks out new experience	.577	.504	.476	.512	.545	.510	2	2	2
77. Easily expresses tender feelings	.346	.485	.285	.463	.318	.477	2	1	2
80. Thinks men are superior to women	.615	.496	.571	.507	.227	.429	3	5	5
86. Very assertive	.576	.504	.524	.512	.500	.512	2	2	2

[1]As explained in Chapter III, Methods, the masculinity and femininity health scores indicate the proportion of respondents to the "adult man" instructions or "adult woman" instructions who agreed with the adult, sex unspecified, standard of health. Thus a health score of 1.0 would indicate perfect agreement, and a health score of 0.0 would indicate a complete lack of agreement. The item health scores listed in this table indicate the proportion of respondents to the adult man instructions or to the adult woman instructions that agreed with the adult, sex unspecified, standard of health for this item. Therefore, they are not mean values for each item on the five point continuum for each descriptive adjective and cannot be compared in this manner.

[2]The modal response on the five point continuum for each item.

APPENDIX C

T-TESTS OF THE AGREEMENT AND HEALTH SCORES OF STEREOTYPIC ITEMS ON WHICH MALE AND FEMALE SUBJECTS DIFFERED

T-Tests of the Agreement and Health Scores of Stereotypic Items on Which Male and Female Subjects Differed (Total N = 69, 33 Males and 36 Females)

	Item # and descriptor at pole 1	Type of Score	df	Difference between Means	se	t
11.	Very emotional	M_A	20	.429	.197	2.171**
14.	Does not hide emotions at all	M_A	20	.436	.201	2.166**
14.	" "	M_H	20	.436	.201	2.166**
15.	Very subjective	A_A	24	.679	.143	4.740****
25.	Not at all excitable in a major crisis	F_H	19	.417	.173	2.412**
26.	Not at all excitable in a minor crisis	A_A	24	-.381	.180	2.018*
33.	Very helpful to others	A_A	24	-.333	.183	1.826*
40.	Knows the way of the world	M_A	20	-.393	.209	1.884*
40.	" "	M_H	20	-.393	.209	1.884*
46.	Not at all religious	A_A	24	-.393	.188	2.093**
48.	Not at all interested in own appearance	A_A	24	-.464	.181	2.558**
49.	Can make decisions easily	F_A	19	.389	.199	1.949*
49.	" "	F_H	19	.389	.199	1.949*

* $p < .1$
** $p < .05$
*** $p < .01$
**** $p < .001$

APPENDIX D

T-TESTS OF THE AGREEMENT AND HEALTH SCORES OF STEREOTYPIC ITEMS ON WHICH MASTER'S LEVEL AND DOCTORAL LEVEL COUNSELING GRADUATE STUDENTS DIFFERED

T-Tests of the Agreement and Health Scores of Stereotypic Items on Which Master's Level and Doctoral Level Counseling Graduate Students Differed
(Total N = 68, Master's N = 31, Doctoral N = 37)

	Item # and descriptor at pole 1	Type of Score	df	Difference between Means	se	t
22.	Very dominant	F_A	19	-.427	.207	2.060*
23.	Dislikes math and science very much	A_A	23	-.422	.186	2.269**
32.	Very gentle	A_A	23	.285	.142	2.012*
38.	Not at all skilled in business	M_A	20	.581	.185	3.134***
38.	" "	M_H	20	.581	.185	3.134***
53.	Never cries	F_A	19	.518	.194	2.674**
53.	" "	F_H	19	.518	.194	2.674**
53.	" "	A_A	23	-.312	.177	1.760*
55.	Never worried	A_A	23	-.312	.177	1.760*
60.	Not at all self-confident	A_A	23	-.584	.166	3.524***
72.	Not at all dependent	M_A	20	-.350	.197	1.781*
72.	" "	M_H	20	-.350	.197	1.781*
72.	" "	F_H	19	-.409	.185	2.210**
74.	Seeks out new experience	A_A	23	-.331	.189	1.748*

* $p < .1$
** $p \leq .05$
*** $p < .01$