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PHENOMENA REVISITED: PSYCHOANALYTIC PSYCHOLOGISTS'
PERCEPTIONS OF SEX-ROLE PREFERENCE FOR SELF AND OTHER

City University of New York

Ph.D. 1987

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PSYCHOANALYTIC PSYCHOLOGISTS' PERCEPTIONS
OF SEX-ROLE PREFERENCE
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by

Louisa Katz

A dissertation submitted to the Graduate Faculty
in Psychology in partial fulfillment of the
requirements for the degree of
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1987

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

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Abstract

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Louisa Katz

Adviser: Professor Florence L. Denmark

This study investigated the sex-role preference of psychoanalytic psychologists for themselves and for a "healthy man, woman or adult" (sex unspecified). It was a variation on the theme of the 1970 study by Broverman, et al, in which they found that a healthy man and a healthy woman differed from one another but that a healthy adult was seen as similar to a healthy man. Psychologists from Division 39 were given two counterbalanced copies of the Bem Sex Role Inventory for self and other. In 1986, male and female psychoanalysts perceived a healthy man and a healthy woman as different from one another, but now a healthy adult was seen as similar to a healthy woman. Other differences were found in the comparisons of female and male subjects and target categories.

Acknowledgements

One day, what seems a long time ago, I asked myself, "What are you going to do for the rest of your life?" That question required serious thought and considerable planning because what I wanted was going to entail many years of schooling and great perserverance. I was not sure I had the courage to persue my goals, no less reach them. But I took the risk and I've done it. The actual "doing it" was completed alone but this whole experience never could have been endured nor finished without the help, support and nuturance of my family, friends, faculty and colleagues.

First and foremost, my thanks goes to Jerry, my husband of twenty-nine years. He encouraged me to return to Hunter College and then to continue on with graduate school. Little did we realize how long it would take me to complete the process! However, most of the time Jerry has been a good sport and I think it is a toss-up as to who is more delighted that it is completed. Now I can do what we both want--get a job! I would also like to thank our children, Buddy and Marjorie, who had the good sense to grow-up (because of and it spite of us), move out on their own and turn over their room to me and my computer.

To the members of my dissertation committee, I extend a special thanks for their creativity, enthusiasm, interest and flexibility. This process would have been more difficult without the gracious help of Dr. Herbert Krauss, Dr. Bernard Seidenberg, Dr. Vita Rabinowitz and Dr. Michele Paludi. As Chairperson of my committee, mentor throughout my undergraduate and graduate academic career and friend 'extraordinaire,' Dr. Florence L. Denmark has been my touchstone. Of this I am sure, it has been far better to have had this experience with her than without her. The whole nature of my graduate education would have been different without Florence's consistent accessibility, gentle prodding and good humor.

My last expression of gratitude is saved for the one person without whom I know I would not be at this crossroad in my life. My thanks to Dr. Rachelle Dattner with whom I learned that choice was possible and it was mine to make. We did it! I did it!

Being a woman, wife, mother, daughter, sister, student and occasional employee has been an enlightening experience that on a warm day in August I would recommend to anyone but in the hard glare of winter, I have had second thoughts. Now that "this seemingly endless task" is over, I anticipate that this next new chapter in my life will be exciting and will continue to provide the opportunity for me to grow.

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I INTRODUCTION

From the earliest recorded history until this day, man and woman have been perceived and described differently. In Genesis, God created man in his own image and while the man was in a deep sleep, God removed a rib from the man and created woman and brought her to the man. When the woman ate the apple from the tree, because it was good for food and was desired to make one wise, God punished them both. Man would labor for the rest of his days and to the woman, God said: "I will greatly multiply thy pain and thy travail; in pain thou shalt bring forth children; and thy desire shall be to thy husband, and he shall rule over thee." (Old Testament, Genesis 1-16). This is the general form of the origin myth that is ascribed to Jews, Christians and Moslems. The implications of this myth are pervasive: man is like God, woman is subordinate and subserviant to man, woman is morally weak and leads man into sin, and man engages in productive labor while woman experiences her contribution (childbirth) in pain (Hunter College Women's Studies Collective, 1983). Thus, were created sex role stereotypes!

It is amazing how little the perception of man and woman has changed in thousands of years. Modern day social

scientists have made similar statements. Parson and Bales (1955) described masculinity as an instrumental orientation; a cognitive process in getting the job done. Femininity was an expressive orientation; a concern for the welfare of others. Similarly Bakan (1966) defined masculinity as an agentic orientation: a concern for oneself as an individual and femininity as a communal orientation; a concern for the relationship between oneself and others. Thus, God's words were operationalized!

Today sex-role stereotypes are a pervasive concept that continue to influence our intrapsychic and interpersonal lives. The qualities of the stereotypic sex-role categories have changed with time but the overall nature of a stereotype as an organizing factor remains part of our psychological make-up. Without cognitive organizing strategies we would be constantly overloaded by new information; with them we have a tendency to view the world in a more or less inflexible manner.

The way in which sex-role stereotypes have been used as a definition of mental health has also changed over time. For example, Douvan & Adelson (1966) have endorsed a sex-typed model of mental health. This would be a positive relationship between one's biological sex and one's sex-role preference. Jones, Chernovetz & Hansson (1978) have supported a masculinity model wherein there is a

positive relationship between masculinity and adjustment. Since 1974, when Sandra Bem introduced her conceptualization of psychological androgyny as a viable sex-role preference, there has been extensive research which has shown that there is a positive relationship between androgyny and adjustment (Bem & colleagues 1974, 1975, 1976, 1977, 1978, 1979; Heilbrun, 1976; Ickes & Barnes, 1978; Kelly & Worrell, 1977; LaFrance & Carman, 1980; O'Conner, Mann & Bardwick, 1978; Orlofsky, 1977; Orlofsky & Windle, 1978; Schiff & Koopman, 1978).

In 1970, Broverman, Broverman, Clarkson, Rosenkrantz & Vogel published their landmark study which indicated that the mental health practitioner community held a double standard of mental health for men and women. A "healthy male" and a "healthy female" were seen in a sex-typed manner which was significantly different from one another. Moreover, a "healthy male" and a "healthy adult" were seen in the same way; a "healthy female" (by the very nature of her 'healthy' description) was deviant from the adult model. This functional paradox of the needs and limitations of sex-role stereotypes as seen by the mental health practitioners is one component that prompted this investigation.

Since 1970, there has been change within psychology and in our cultural environment that may very

well influence the way we approach the perception of mental health and sex-role stereotyping today. The psychological instruments for measuring sex-role preference have changed dramatically in that they are now orthogonal and not bipolar continuum scales. The American Psychological Association Task Force on Sex Bias and Stereotyping of Women in Psychotherapeutic Practice (1975) also addressed these issues after surveying female APA members. The report found the following: 1) perpetuation of traditional sex-roles; 2) bias in the devaluation of women; 3) sexist use of psychoanalytic concepts; 4) response to women clients as sex objects. Society has also experienced fifteen years of influence of the Women's Movement which has had its effect in the restructuring of many facets of private and public life for both women and men. Thus now, in the mid-1980s, the availability of multi-dimensional instruments, the possibility of new sex-role definitions for women and men and greater awareness of and sensitivity to bias within the therapeutic community may have influenced mental health practitioners' perceptions of women and men and may have helped create new perceptions of mental health for males and females.

Review of the Literature

Early investigations of sex-roles were concerned with stereotypic differences of masculinity and femininity. The investigations were based on two major assumptions: 1) women's domestic role was biologically determined and 2) her cultural contributions to society were of lesser importance than men's contributions (Williams, 1977). The researchers' task was to find the functional mechanisms to account for the differentially displayed behavior. In 1974, Maccoby & Jacklin published The Psychology of Sex Differences; an extensive review of the literature of sex differences in which they stated that generally the existence of these differences was not supported (except for some evidence in the area of aggression and spatial ability). The stereotyped differences did not exist; however some researchers and the general public still persisted in perceiving masculinity and femininity as being mutually exclusive. The underlying belief in this idea of opposites was based on biological differences; that 'biology is destiny.' For example, classical Freudian psychoanalysis holds that the physiological and anatomical differences between the sexes predispose each sex to have different intrapsychic conflicts and anxieties and thus, different personality

characteristics. Certainly Freudian theory has had a powerful influence in the origination and maintenance of sex-roles and sex-role stereotyping. However, subsequent researchers have found that biological differences do not necessarily mean that the sexes will exhibit opposite personality attributes and behavior (Bem, 1974; Bernard, 1974; Spence & Helmreich, 1978; Weitz, 1977; Yorburg, 1974).

SEX-ROLES: MASCULINITY/FEMININITY/ANDROGyny

Sex-role orientation is a multifaceted concept and is global in nature. The components of this concept are gender identity, sex-role identity, sex-role preference and sex-role adoption. These terms are not synonymous nor interchangeable. Because they have been used indiscriminately, there is confusion as to their meaning. Gender identity refers to one's biological sex (e.g., I am female). Sex-role identity refers to one's sense of oneself (e.g., I am feminine). Sex-role preference refers to one's choice of role (e.g., I choose to be feminine). Finally, sex-role adoption refers to the overt manifestations of behavior (e.g., I act feminine). These elements were initially defined by Biller & Borstelmann (1967) as being separate and basic to one's sex-role orientation. However, this view does not imply an implicit or explicit direction of one's orientation. It is possible

for the categories to not be congruent (i.e., to not be all female or feminine or not be all male or masculine). One's orientation is composed of degree and kind of one's choices and in no way is determined by one's selection of sexual partners of the same or other sex. Although it is more prevalent for persons to choose sexual partners of the other biological sex, this is not solely determined by one's orientation as sex-typed or cross sex-typed.

Part of the current controversy regarding gender identity, sex-role identity, sex-role preference and sex-role adoption is actually a confusion between traditional sex differences and sex stereotypes and current, new definitions of these same categories. The traditional definitions are determined by our socio-cultural history and attitudes as to what composed the appropriate (stereotyped) role of masculinity or femininity. Our current description of these roles is in a state of flux because of the great changes in our society (especially in the last fifteen years) due to the ramifications of the Women's Movement, socialization practices, the economy and rapid technological advancements.

Within the field of psychology, the traditional, bipolar concept of a masculinity/femininity continuum was challenged by Constantinople (1973). She questioned three

basic assumptions on which the early psychological measurement scales of masculinity/femininity were based. These were: 1) were masculinity and femininity bipolar opposites; 2) was the concept itself unidimensional; and 3) is the concept best defined in terms of sex differences? Constantinople suggested that people can (and maybe, should) exhibit characteristics of either sex; that masculinity and femininity were not opposite poles of a continuum but independent dimensions that could be characteristic of a person in varying degrees. Because of the unsubstantiated assumptions of the traditional conceptualization, it was suggested that the measurement of masculinity and femininity required the development of new instruments that would assess these attributes as independent dimensions. These thoughts prompted a whole new line of research in the understanding of sex-role orientation.

Two new instruments to measure masculinity and femininity were published in the middle 1970s. Bem (1974) created the Bem Sex Role Inventory (BSRI) and Spence, Helmreich & Stapp (1975) created the Personality Attributes Questionnaire (PAQ). Both researchers validated that masculinity and femininity were independent dimensions and that it was possible for a person to subscribe to characteristics of both. The domain of overlap was called

psychological androgyny and implied the possibility for an individual to be both masculine and feminine; both instrumental and expressive; both agentic and communal depending on the appropriateness of the situation. It further implied a blending of the characteristics in a single act. Bem (1974) suggested that "...strongly sex-typed individuals might be seriously limited in the range of behaviors available to them as they move from situation to situation" (pg. 155).

SEX-ROLES AND MENTAL HEALTH

The relationship of the stereotyped descriptors of masculinity and femininity and mental health has undergone a reformulation since Constantinople's earlier challenge. Prior to the acceptance of psychological androgyny as a viable sex-role preference, sex-role congruity (i.e. males possessed masculine characteristics and females possessed feminine characteristics) was considered normative as one aspect of mental health (Douvan & Adelson, 1976; Garai, 1970). This would be the position of classical psychoanalytic theory. Jones, Chernovetz & Hansson (1978) continue to endorse a masculinity model: a positive relationship between masculinity and adjustment. However, many researchers began to demonstrate the flexibility and adaptability of psychological androgyny. Bem and her

colleagues (1974, 1975, 1976, 1977, 1978, 1979) showed androgynous persons to exhibit more behavioral flexibility than sex-typed, cross sex-typed or undifferentiated persons and were also less likely to experience psychological discomfort in doing a cross sex-typed task. Orlofsky & Windle (1978) found androgynous persons to be assertive and expressive in the telling of TAT stories. Ickes & Barnes (1978) found greater interactional ease and personal attraction in androgynous mixed-sex dyads. Kelly & Worrell (1977) found in a variety of social skills that androgynous persons were most effective and competent. LaFrance & Carmen (1980) found androgynous persons to exhibit both of what is traditionally thought of as masculine and feminine non-verbal behavior (interrupting and filled pauses; smiling and gazing). Most importantly, androgynous persons have consistently been shown to exhibit high self-esteem and ego development and well differentiated personalities with strong identity resolution (Bem, 1977; Heilbrun, 1976; O'Conner, Mann & Bardwick, 1978; Orlofsky, 1977; Schiff & Koopman, 1978; Spence, Helmreich & Stapp, 1975). Since the validity and reliability of androgyny have been demonstrated, it no longer seems reasonable to adhere to a rigid sex-typed or masculine definition of mental health. Psychological androgyny permits a broad range of behavior and potential effectiveness and has become a current, alternative model of mental health.

Androgyny has been demonstrated as a viable sex-role preference and has been advanced as an adaptive model of mental health. This choice permits people a wide range of behaviors in many situations and therefore, is likely to enhance effectiveness and self-esteem (Ben, 1974). Androgyny has also been supported by some clinicians as an ideal goal for psychotherapy. For example, White (1979) has stated that people with competence in the agentic and communal domains were at an advantage compared to others who were competent in only one area (i.e. those who are androgynous have an advantage over those who are sex-typed). Maracek (1979) has suggested that in an increasingly changing world, the androgynous person is at an advantage because of his/her greater behavioral flexibility in diverse situations. Various techniques and procedures have been suggested to endorse androgyny as a goal for clients and therapists (Kaplan, 1979; Gulanick, Howard & Moreland, 1979; Lenny, 1979). Kenworthy (1979) and Lenny (1979) both endorsed androgyny as the model of choice; however, they both caution that an androgynous sex-role may become as restrictive as the sex-typed roles of the past. This concern is one that must be taken seriously as it would be 'catch-22' for an emancipating concept of today to become the restrictive trap of tomorrow.

Historically, the congruence model of mental health (males were to be masculine and females were to be feminine) was vividly shown in a classic study in 1970 by Broverman, Broverman, Clarkson, Rosenkrantz & Vogel. They gave the Sex Role Questionnaire Inventory (Rosenkrantz, Vogel, Bee, Broverman & Broverman, 1968) to male and female clinicians who were asked to rate a "healthy male, female or adult" (sex unspecified). Whereas male and female clinicians did not differ from one another in their ratings of each category, there was a significant difference in their ratings of a "healthy male" and a "healthy female." However, a "healthy adult" was rated similarly to a "healthy man" and therefore, a "healthy woman" was seen as deviant from the adult model of mental health. Broverman, et al, concluded that there existed a double standard of health for females: they must accept and adjust to the stereotype of their biological sex and gain social approval or they can assume the cross sex characteristics and behavior of mature adults and have their femininity in question. The researchers concluded: "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." (pg. 174).

Another 1970 study by Neulinger, Stein, Schillinger and Welkowitz found similar results to the Broverman, et al work. One hundred and fourteen therapists ranked Murray's needs for the optimally intergrated man and woman. The needs of dominance and acheivement were higher for men; the needs of nuturance and succorance were higher for women.

There have been numerous replications of the Broverman et al. (1970) conceptualization. These studies have found various results: that practicing mental health workers continued to view a "healthy man" and a "healthy woman" in sex-role stereotyped ways; there were different models of mental health for women and men based upon their biological sex; clinicians hold differential descriptions of their clients as a function of either their or their clients' biological sex. Fabrikant (1974) found that male and female therapists gave a negative rating to 68-70% of the words assigned to the female role; they gave a positive rating to 67-71% of the words assigned to the male role. Cowan (1976) stated that therapists in their study did not view the difficulties of their male clients in sex stereotyped ways but that they saw their female client as 'too feminine.' Billingsley (1977) in an analog study

reported that clinicians did not assign female treatment goals for their female clients because of the negative connotation connected with these aims. Tanney and Birk (1976) found that even though there were no personality differences between male and female clients, the counselors interviewed described similar characteristics between a typical woman and neurotic symptoms. Brown and Hellinger (1975) found that 50% of their therapist sample subscribed to a traditional description for female clients and that male therapists were significantly more biased than female therapists. This male bias against women by male therapists was also reported by Anderson (1975), Aslin (1977), and Kahn (1977). Goldberg (1974) and Maxfield (1976) in their dissertations did not find any prejudicial sex-role bias towards mental health standards in their clinical sample. Dremen (1978) found the reverse results among her Israeli practitioners; women clinicians endorsed stereotypes and male clinicians were more egalitarian.

Similar studies were conducted with social workers by Harris and Lucas (1976), with counselors-in-training by Maslin and Davis (1975), and graduate students by Hayes and Wolleat (1978). These studies found that male social workers and future practitioners were more likely to see their male and female clients in sex stereotyped ways. However, for female social workers and future practitioners

there was essentially no difference between a healthy male, a healthy female and a healthy adult.

In addition to studies of professional therapists and those in training, there has been similar evidence gained from studies of undergraduate college students. Nowacki and Poe (1973) found that subjects held different descriptions of mental health for males and females. Mezydlo and Betz (1980) found that feminist students held similar ideas of a "healthy man" and a "healthy woman." The students who did not see themselves in a feminist manner did hold stereotyped views of mental health for both sexes. Gilbert, Deutsch and Strahan (1978) found that there was a more balanced view of male and female characteristics as a description of mental health but female subjects endorsed a masculine model of health for women whereas male subjects did not.

It is also of interest to recognize that sex-role stereotyping is not the exclusive domain of the mental health practitioners. Greenberg and Zeldow (1980) had male and female subjects rate their ideal therapist. They found that females consistently indicated a preference for a therapist that would fit the male stereotyped sex-role. Male subjects chose the opposite; a consistent preference for a therapist that would fit the female stereotyped sex-role. These results taken with those mentioned above

seemed to indicate that the common proclivity to stereotype is a cultural phenomenon.

In 1977, Striker reviewed the field of psychotherapy and women. In his critique of the studies, he made a strong objection to the methodological aspects of the original Broverman, et al, work (1970) and subsequent research. According to Striker, of great importance was the fact that there was no item analysis to the SRQI (Rosenkrantz, et al., 1968) so that it is impossible to know if the actual differences were statistically significant. The SRQI questionnaire contains more masculine than feminine items and the higher male health scores could have been a methodological artifact. He felt that a double standard of mental health and negative evaluations of women were premature. Whitley (1979) also felt that there were methodological shortcomings to the Broverman, et al, (1970) study. He felt that frequently the stereotyped conceptualizations of mental health were based on the sex-role instrument that was utilized. He suggested that the outcome of future studies might be very different if the measure used was one of the more recently developed instruments such as the Bem Sex Role Inventory (Bem, 1974). Bassoff (1982) conducted a meta-analytic study of 26 studies (from 1961-1980) that related mental health with masculinity, femininity and androgyny. She concluded that

there was a strong, positive relationship between masculinity and mental health; in fact, it is the masculine component not the blending of masculinity and femininity (i.e., androgyny) that accounted for higher levels of mental health.

There have been a few studies that have asked 'the Broverman, et al, questions' in conjunction with the BSRI scale for the description of the healthy target person. Shapiro (1977) asked graduate students in counseling to describe a "healthy man or woman." Both "healthy men and women" were described as androgynous. Brooks-Gunn and Fisch (1980) found that male college students were more likely to describe a "healthy adult" in a traditionally sex-stereotyped manner than were female college students. Thus, male students' results were similar to the original Broverman, et al, (1970), findings but female students saw both a "healthy male" and a "healthy female" as similar to a "healthy adult." This suggests that female college students are less likely to rely on stereotypes in their definitions of mental health. Kravitz and Jones (1981) asked 183 mental health practitioners to rate a "healthy man, woman or adult" on the BSRI. Fifty nine percent of the subjects defined a "healthy man, woman or adult" as androgynous. An additional 40% rated the "healthy man, woman or adult" as significantly more masculine than

feminine. Only one percent chose a feminine sex-role preference for any of the target categories and they were eliminated from the rest of their analyses. Masculinity was endorsed by both male and female subjects and femininity was not valued by either group. Feminine endorsement only occurred in conjunction with masculinity (i.e., androgyny) and was conspicuous by its absence as a sex-role preference in its own right. There was no significant difference for the androgyny rating of a "healthy man" and a "healthy woman" nor for the rating of a "healthy woman" and a "healthy adult;" but there was a significant difference for the androgyny rating of a "healthy man" and a "healthy adult" in that a "healthy adult" was seen as more androgynous than a "healthy man." However, Kravitz and Jones (1981) did not assess the personal sex-role preference of their subjects; they used biological gender to classify their clinicians. Swenson and Ragucci (1984) also used the BSRI and asked mental health practitioners to rate a "healthy man, woman or adult." They got different results from Kravitz and Jones (1981) in that their sample of mental health practitioners found a "healthy adult" as masculine, a "healthy man" as androgynous and a "healthy woman" as undifferentiated (below the median on the masculine and feminine scales). Masculine personality characteristics were still the

primary valued descriptors and it appears that these studies have shown that sex-role stereotyping still exists. It is only the attribution to the target person that has changed. However, in both the Kravitz and Jones (1981) and Swenson and Ragucci (1984) studies, the subjects' personal sex-role preferences were not investigated. In addition, there was no item analysis of the differences found for each sex-role category and the subjects in both studies were a cross-section of the spectrum of mental health providers; they were not psychoanalysts.

No conclusive results have emanated from the above studies. As frequently experienced in psychology, the literature raises more questions than it answers. However, questions of stereotyping and bias are as relevant today as in our past. A concern with rigid stereotyped sex-roles, a negative bias towards women and the sexist use of psychoanalytic concepts in clinical practice was expressed in 1975 by the creation of a Task Force on Sex Bias and Stereotyping of Women in Psychotherapeutic Practice by the American Psychological Association. The purpose of their survey was to investigate the impact of restrictive practices upon women as students, therapists and consumers of services. In 1978, the Task Force recommended that the therapist/client (particularly psychoanalyst/patient)

relationship should be free of bias and sex-role stereotyping. They also stated the need for psychologists to be aware of bias and stereotyping in themselves. Therefore, since the same questions still exist in the professional literature, it was relevant to re-examine the issues from a newer perspective. This study differed from Kravitz and Jones (1981) and Swenson and Regucci (1984) in that although once again practicing clinicians were given the BSRI to ascertain their perception of sex-role preference for a "healthy man, woman or adult", they were additionally asked to describe themselves on another BSRI to see if there was a relationship between their perception of themselves and how they saw the "healthy other." This was one way to investigate stereotyping and bias in the mental health practitioner population; did the clinicians see the "healthy other" as they saw themselves? Because one of the major findings of the 1978 Task Force of APA was the sexist use of psychoanalytic concepts, it was decided to use psychoanalytic psychologists as the clinician sample. It was felt that this was an appropriate group to investigate if bias and sexism were displayed by these mental health practitioners, since psychoanalytic concepts would be the basis of their psychotherapeutic technique. Earlier studies did not specifically investigate psychoanalysts.

THE PURPOSE OF THIS STUDY

The four important issues that were mentioned previously became the rationale for this study: 1) the double standard of mental health for men and women (eg. the findings of Broverman, et al, 1970), 2) the Striker (1977) and Whitley (1979) critiques of methodological shortcomings in the study by Broverman, et al, (1970), 3) the changing conceptualization of sex-roles (i.e., the inclusion of androgyny as a viable sex-role preference) and the new instruments which were developed for their assessment (eg., the BSRI), and 4) the findings of the 1975 report of the APA Task Force of the perpetuation of stereotyping of women, bias in the devaluation of women, the response to women clients as sex objects and the sexist use of psychoanalytic concepts by practitioners.

1. Based on the findings of Broverman, et al (1970), it could be hypothesized that in 1986, male and female clinicians would rate a "healthy man, woman or adult" in a sex-typed manner as the clinicians did in the prior study. Or conversely, it could be hypothesized that in 1986, clinicians using the BSRI would rate a "healthy man, woman or adult" as androynous, masculine or undifferentiated in the same way as the clinicians did in

the Kravitz and Jones (1981) or Swenson and Regucci (1984) studies. Therefore, we are left with the question of how would male and female psychoanalytic psychologists rate a "healthy man", a "healthy woman" or a "healthy adult" (sex unspecified) on the BSRI? Would these clinicians endorse a stereotyped gender based model, a masculine model or an androgynous model of mental health for the target categories? Would male and female clinicians differ from one another in how they saw a "healthy man", a "healthy woman" or a "healthy adult as the subjects did in the Brooks-Gunn and Fisch (1980) study?" Or would male and female clinicians concur in their description of a "healthy man", a "healthy woman" or a "healthy adult" as the subjects did in the Broverman, et al, (1970), Kravitz and Jones (1981), Shapiro (1977) and Swenson and Ragucci (1984) studies?

2. Freud, in his 1925 paper, Some Psychological Consequences of the Anatomical Distinction Between the Sexes, suggested that because of different intrapsychic conflicts that were based on biological differences, males and females would resolve the Oedipal conflict by exhibiting a differential sexual orientation. Thus, males would become masculine and females would become feminine. Later, in Analysis Terminable and Interminable (1937), he

suggested that even though it was extremely difficult and susceptible to the greatest resistances, the healthy person would be in touch with both the masculine and feminine side of her/himself and that personality characteristics would be based on the "bisexual" nature of the person. Over the years, Freud would change his theories without refuting his prior comments. Based on the 1925 paper with its emphasis on the importance of the resolution of the Oedipal conflict for sexual identification, it could be hypothesized that the personal sex-role preference of the psychoanalysts in this study would be sex-typed (i.e., masculine for males and feminine for females). Based on the 1937 paper and its statement that the healthy person would be in touch with the "bisexual" nature of her/himself, it could be hypothesized that the personal sex-role preference of the already analysed psychoanalysts would be a blend of masculinity and femininity (i.e., to be androgynous). Therefore, the question to be investigated was what would be the personal sex-role preference of the male and female psychoanalysts on the BSRI?

3. If the subjects perceived themselves in a sex-typed manner as would be hypothesized from Freud's 1925 paper, would they see the "healthy man" and the "healthy woman" in a sex-typed way also? How would they perceive

the "healthy adult" (sex unspecified)? If the subjects perceived themselves as androgynous as would be hypothesized from Freud's 1937 paper, would they see the "healthy other" in the same manner? Thus, we are left with question of what was the relationship between the psychoanalysts' self-perception of sex-role preference and their perception of the "healthy other?"

4. What, if any, were the demographic characteristics that may have contributed to the current findings?

5. In a general way, how did the results of this 1986 study relate to the Broverman, et al, findings of the 1970 study?

II METHOD

SUBJECTS

Survey questionnaires were mailed to 466 persons (248 males (53.2%) and 218 females (46.8%)) from the membership lists of Division 39 (Psychoanalysis), subdivision 1 (Psychologist-Psychoanalyst-Practitioners) of the American Psychological Association and various psychoanalytic training institutes in the metropolitan New York area. The mailing continued until there was a minimum response level of fifteen subjects in each category (i.e., "healthy man, healthy woman or healthy adult") for both male and female subjects. In essence, this study examined the gender of the subject in relationship to his or her sex-role preference (masculine, feminine or androgynous) for the target person (a healthy man, woman or adult) and for his or herself .

PROCEDURE

Each subject received an envelope containing a letter of introduction (see Appendix A), two copies of the Bem Sex Role Inventory (Bem, 1974) (see Appendix B1 and B2, B3 or B4), a demographic data form (see Appendix C), and a stamped return envelope addressed to this investigator. The introductory letter contained an explanation of the

purpose and procedure of the study. Consent was granted by the subjects' completion and return of the forms. Each package was coded for assignment purposes only; thus, in this way, the subjects' anonymity was protected. Each subject was asked to fill out all forms in the order presented to her/him. One BSRI form contained the following instructions: "Think of yourself and then indicate for each item the number that would most accurately describe your perception of yourself. Please answer every item. DO NOT LEAVE ANY BLANKS." The other BSRI form had the following instructions: "Think of normal, adult men (women or adults) and then indicate for each item the number that would most accurately describe a mature, healthy, socially competent adult man (woman or person). Please answer every item. DO NOT LEAVE ANY BLANKS." As Broverman, et al (1970) have stated, "responses to these 'adult' instructions may be considered indicative of 'ideal' health patterns, without respect to sex" (pg. 2). Half the subjects in each category were asked to complete the 'self' form before the 'other' form; the other half were asked to do the reverse. Thus the BSRI forms were counterbalanced within each group. The demographic form was always presented last for all subjects. The two BSRI forms and the demographic form were then placed in the stamped envelope and returned to sender.

INSTRUMENTS

DEMOGRAPHIC FORM - The demographic data form was developed by this author and was used to obtain information about the personal and professional lives of the respondents.

Bem Sex Role Inventory - Traditionally, masculinity/femininity were the endpoints of a bipolar conceptualization of sex-role identification. Masculinity and femininity were seen as mutually exclusive identifications which were based on gender; men were to be masculine and women were to be feminine.

The BSRI was developed by Sandra Bem in 1974. She stated that her measure was empirically derived and not based on a particular theory because sex-role orientation is ubiquitous. At the time, her scale was different from other instruments in that the masculine and feminine scales could vary independently and were orthogonal from each other. The instrument consists of separate masculinity, femininity and neutral scales. The masculine and feminine scales consist of attributes that were considered to be desirable; however, the neutral scale is half positive and half negative traits. The masculine scale consists of 20 items that are considered to be more desirable by American society for a typical man than a woman. The feminine scale

differs in that the 20 items are considered by American society to be more desirable for a typical woman than a man. The neutral scale is appropriate to both sexes and was designed as a filler scale and does not figure in the scoring. The 20 traits for each scale were selected by a large sample of college students from a pool of over 400 items. A person rates him/herself on a seven point scale (1 - never or almost never true; 7 - always or almost always true). Two scores are figured for the masculine and feminine scales. Originally a t-ratio was used with the androgyny score falling between +1.00 and -1.00. This was criticized by Spence, Helmreich & Stapp (1975) as not separating high masculine and high feminine subjects from those who were low on both scales. Bem (1976, 1977) accepted the rationale of the criticism and altered the scoring system to a median split procedure. In this way, sex-typed feminine would be above the median on the feminine scale and below the median on the masculine scale; sex-typed masculine would be above the median on the masculine scale and below the median on the feminine scale; androgyny would be above the median on the masculine and feminine scales. Those persons with scores below the median on both scales are classified as undifferentiated. Bem (1974) found that the BSRI masculinity and femininity scores had a correlations of close to zero and that these

dimensions were truly independent. The test-retest reliability after four weeks was .9 or above for masculinity, femininity and androgyny. Androgyny, as measured by the t-ratio procedure had a correlation of .05 with social desirability; thus, Bem concluded that she was not measuring social desirability. There is no data specifically testing the reliability of the median split procedure; however, this is the accepted scoring method for this instrument. Bem and her associates (1975, 1976) conducted studies to investigate the empirical validity of the BSRI and found what she described as the androgynous person having the best of both worlds; "...to display behavioral adaptability across situations, engaging in whatever behavior seems most appropriate at the moment, regardless of its stereotype as appropriate for one sex or another" (1975,pg.642).

III RESULTS

The BSRI forms and questionnaire were returned by 108 respondents (23.2%) of the 466 persons solicited. Of this group, 51 were male and 57 were female (48.2% and 52.8% of the sample respectively). Males had a return rate of 20.6% and the females had a return rate of 26.1%. Table 1 shows that a χ^2 of the return rate between subjects was not significant ($\chi^2=1.7311$, $df=1$, $p<.20$).

The demographic characteristics of this sample showed them to be a highly trained, very experienced group of psychologists (see Table 2). The sample included 108 clinicians; 102 persons with a Ph.D. and 6 with an Ed.D. Eighty-six persons reported attending a post-graduate psychoanalytic training institute for four to eleven years. The mean age of the sample was 52.6 years (54.1 years for males and 51.3 years for females). They had a range of years of clinical experience of 8-49 years with a mean of 22 years. 95.4% engaged in private practice with 88 stating the orientation of their clinical work as psychoanalytic and 18 stating it was psychodynamic. The subjects were primarily doing individual treatment with adults. The caseload of both male and female practitioners was predominately women with female clinicians treating a greater percentage of women patients (50% or more) than

Table 1
Sample Size

	<u>Returned</u>	<u>Not Returned</u>	<u>Total</u>
<u>Males</u>	n=51 (20.6%) (row %)	n=197 (79.4%) (row %)	n=248 (100%) (row %)
	(47.2%) (column %)	(55.0%) (column %)	(53.2%) (column %)
<u>Females</u>	n=57 (26.1%) (row %)	n=161 (73.9%) (row %)	n=218 (100%) (row %)
	(52.8%) (column %)	(45.0%) (column %)	(46.8%) (column %)
<u>Total</u>	n=108 (23.2%) (row %)	n=358 (76.8%) (row %)	n=466 (100%) (row %)
	(100%) (column %)	(100%) (column %)	(100%) (column %)

$\chi^2=1.7311$, $df=1$, $p<.20$, n.s.

Table 2

Demographic DataSex of subjects

Male n=51
Female n=57

Age of subjects

	<u>Mean</u>	<u>Median</u>	<u>Range</u>
All subjects	52.6	53.5	36-85
Male subjects	54.1	55.0	38-75
Female subjects	51.3	50.0	36-85

Marital status

married	75
single (never married)	6
single (spouse deceased)	5
single (divorced or seperated)	22

Location of professional practice

New York and metropolitan area 90

Other (San Francisco, Ca., Los Angeles, Ca.,
Stockbridge, Mass., Ann Arbor, Mich.,
Philadelphia, Penna., Washington D.C., etc.) 18

Discipline of practice

Psychology 107
Other 1

Highest degree earned

Ph.D. 102
Ed.D. 6

Degree granting institution

New York University	34
Columbia University	20
Adelphi University	5
City University of New York	4
Yeshiva University	4
Rutgers University	3
University of Chicago	3
Syracuse University	2
Fordham University	2
University of Michigan	2
University of California-Berkeley	2
University of Minnesota	2
Others	19

cont.

Table 2 cont.

<u>Post-graduate training institute</u>	
New York University	25
William Allison White	14
National Psychological Association for Psychoanalysis	8
Postgraduate Center for Mental Health	8
Adelphi Center for Psychoanalytic Training	4
New York Center for Psychoanalytic Training	3
Feudian Society	3
Washington School of Psychiatry	2
Hampstead, England	2
Privately	4
Other	13

Years of training
 Range 4-11 years

<u>Training institutes' orientation</u>	
Psychoanalytic	76
Interpersonal	18
Other	9

Number of years of clinical experience
 Range 8-49 years
 Mean 22 years
 Median 20 years

Currently engaged in clinical practice
 Yes 104
 No 4

<u>Current employment</u>	
	<u>Mean %</u>
Private practice	95.4%
Supervision	51.0%
Teaching	33.3%
Administrative	17.6%
Employed by others	5.6%

<u>Approximate task hours per week</u>	
	<u>Mean %</u>
Self-employed	32.5%
Employed by others	16.1%
Research	8.2%
Post-doctoral training	7.3%
Meetings and study groups	3.5%
Other (writing)	6.7%

cont.

Table 2 cont.

Approximate hours engaged in type of psychotherapy

	<u>Mean %</u>
Individual	27.7%
Couple, family and group	5.5%
Supervision	5.9%

Caseload

	<u>Mean %</u>
Adults	91.1%
Adolescents	16.2%
Children	16.9%

Percentage of males and female in caseload

	<u>Mean %</u>
Males	38%
Females	62%

Psychological orientation of subjects' therapeutic work

Psychoanalytic	88
Psychodynamic	18
Other	2

Membership in American Psychological Association

Yes	104
No	4
Division 35	6

Years of actively practicing psychotherapy

1-5 years	none	36-40 years	4
6-10 years	9	41-45 years	2
11-15 years	23	46-50 years	none
16-20 years	18	51-55 years	none
21-25 years	24	56-60 years	none
26-30 years	14	more!	none
31-35 years	13		

Reason for choosing current profession

Self-growth	33
Self-satisfying	33
Early interest	29
Social value: helping others	25
Intellectually interesting	24
Role models	8
Challenging	8

Having a strong religious conviction

Yes	22
No	84

cont.

Table 2 cont.

Religious denomination

Jewish	35
Christian	9
Agnostic	9
Atheist	3
Quaker	2
Ethical Culture	1

Having a strong political conviction

Yes	75
No	29

Political affiliation

Yes	65
No	37

Political party membership

Democrat	58
Republican	3
Other	1

Political self-description

Liberal	77
Middle-of-the-road	19
Conservative	3
Radical	1

Parents' occupation

<u>Mother</u>		<u>Father</u>	
Homemaker	64	Professional	32
Professional	14	Sales	26
Trade	10	Trade	26
Clerical/secretarial	6	Self-employed	17
Sales	5	Other	2
Self-employed	3		
Arts	1		

Reasons for filling out this questionnaire

Empathy for author	61.2%
Identification with author	41.6%
Advance scientific inquiry	16.7%
Curiosity	12.0%
Had available time	11.1%
To be a subject (repay a debt)	3.7%

male clinicians (98.2% of female clinicians, 78.0% of male clinicians). Female clinicians were treating more women patients than men patients (98.2% women patients, 11.3% men patients). There were 78.0% male clinicians with 50% or more women patients and 58.0% with 50% or more men patients. Eighteen of 50 (36.0%) male clinicians had a 50/50% man/woman caseload; 5 of 53 (9.4%) female clinicians had a 50/50% man/woman caseload. Of the 23 subjects with a 50/50% caseload, 78.3% were male subjects and 21.7% were female subjects. They chose their profession because it was a way of continued self-growth, it had social value by helping others, it was self-satisfying, it was an early interest, it was intellectually interesting and because of prior role models. They did not see themselves as having strong religious convictions but they did feel they had strong political beliefs. Seventy-seven people thought of themselves as liberal in their political convictions while 19 stated they were middle-of-the-road, 3 were conservative and 1 was radical. Sixty-four subjects came from households in which their mother was a homemaker; one came from a household in which the father was the homemaker. In response to being asked why they filled out the forms, most of these psychoanalysts responded that they felt empathy for me (61.2%) and felt they identified with my experience of completing the requirements for the doctoral degree (41.6%).

Of the 51 male subjects in the sample, 17 respondents returned questionnaires who were in the "healthy man" category, 18 respondents returned them in the "healthy woman" category and 16 respondents returned them in the "healthy adult" category. For the 57 female subjects in the sample, 20 respondents who returned the questionnaires were in the "healthy man" group, 18 were in the "healthy woman" group and 19 were in the "healthy adult" group. A χ^2 for gender of subject x target category was carried out and was not significant ($\chi^2=.1675$, $df=2$, $p<.95$). This is shown in Table 3.

Each subject filled out the BSRI for him or herself and a χ^2 was computed for gender of the subject (male or female) x the sex-role preference of the subject (androgynous, masculine, feminine or undifferentiated). Table 4 shows that this comparison was not significant ($\chi^2=4.3592$, $df=3$, $p<.30$). The median split procedure was used to assign each subject to a sex-role preference category (medians for self on masculinity and femininity for male, female and all subjects are 5.20 & 4.70; 4.85 & 4.85; and 5.05 & 4.80 respectively). Male and female subjects equally saw themselves as androgynous (13 and 14 respectively), sex-typed (18 and 18 respectively), and cross sex-typed (10 and 11 respectively); fewer male subjects than female subjects saw themselves as

Table 3
Subjects Within Each Target Category

<u>Subjects</u>	<u>Targets</u>		
	<u>Man</u>	<u>Woman</u>	<u>Adult</u>
<u>Males</u>	17	18	16
<u>Females</u>	20	18	19

$\chi^2 = .1675$, $df = 2$, $p < .95$, n.s.

Table 4

Clinicians' Sex-Role Preference for Self

	<u>Undifferentiated</u>	<u>Feminine</u>	<u>Masculine</u>	<u>Androgynous</u>
<u>Males</u> (n=51)	n=10 (19.6%) (row %)	n=10 (19.6%) (row %)	n=18 (35.3%) (row %)	n=13 (25.2%) (row %)
	(41.7%) (column %)	(35.7%) (column %)	(62.1%) (column %)	(48.1%) (column %)
<u>Females</u> (n=57)	n=14 (24.6%) (row %)	n=18 (31.6%) (row %)	n=11 (19.3%) (row %)	n=14 (24.6%) (row %)
	(58.3%) (column %)	(64.3%) (column %)	(37.9%) (column %)	(51.9%) (column %)
<u>Total</u> (108)	n=24	n=28	n=29	n=27
% of total	(22.2%)	(25.9%)	(26.9%)	(25.0%)

$\chi^2=4.3592$, $df=3$, $p<.30$, n.s.

undifferentiated (10 and 14 respectively). However, whereas an equal number of male clinicians (10) saw themselves as either cross sex-typed feminine or undifferentiated, more female clinicians saw themselves as undifferentiated (14) than saw themselves as cross sex-typed masculine (11).

Male and female clinicians rated a healthy man as androgynous, undifferentiated, masculine or feminine (14,10, 7, 6 respectively). This is specified in Table 5. Again, the median split procedure was used to assign the subjects' perception of the targets' sex-role preference (medians for a "healthy man" on masculinity and femininity for male, female and all subjects were 5.05 & 4.25; 5.25 & 4.25; 5.10 & 4.25 respectively; medians for a "healthy woman" were 4.73 & 4.93; 5.08 & 4.60; 4.90 & 4.85 respectively; medians for a "healthy adult" were 4.75 & 4.75; 5.15 & 4.65; 5.05 & 4.65 respectively). Female clinicians to a greater percentage than male clinicians (45.0% to 29.4%) saw a "healthy man" as androgynous. All subjects saw a "healthy woman" as either androgynous, feminine, masculine or undifferentiated (10,10,9,7 respectively). An equal percentage of male and female subjects (50% each) saw a "healthy woman" as androgynous. Seventy percent (70%) of those subjects who saw a "healthy woman" as feminine were male; whereas 77.8% of those

Table 5

Clinicians' Sex-Role Preference for Targets

	<u>Undifferentiated</u>	<u>Feminine</u>	<u>Masculine</u>	<u>Androgynous</u>
<u>A_Healthy_Man</u>				
<u>Males</u> (n=17)	n=5 (29.4%)* (50.0%)+	n=4 (23.5%)* (66.7%)+	n=3 (17.6%)* (42.9%)+	n=5 (29.4%)* (35.7%)+
<u>Females</u> (n=20)	n=5 (25.0%)* (50.0%)+	n=2 (10.0%)* (33.3%)+	n=4 (20.0%)* (57.1%)+	n=9 (45.0%)* (64.3%)+
<u>Total</u> (n=37)	n=10 (27.0%)**	n=6 (16.2%)**	n=7 (18.9%)**	n=14 (37.8%)**
<u>A_Healthy_Woman</u>				
<u>Males</u> (n=18)	n=4 (22.2%)* (57.1%)+	n=7 (38.9%)* (70.0%)+	n=2 (11.1%)* (22.2%)+	n=5 (27.8%)* (50.0%)+
<u>Females</u> (n=18)	n=3 (16.7%)* (42.9%)+	n=3 (16.7%)* (30.0%)+	n=7 (38.9%)* (77.8%)+	n=5 (27.8%)* (50.0%)+
<u>Total</u> (n=36)	n=7 (19.4%)**	n=10 (27.8%)**	n=9 (25.0%)**	n=10 (27.8%)**
<u>A_Healthy_Adult</u>				
<u>Males</u> (n=16)	n=5 (31.3%)* (55.6%)+	n=4 (25.0%)* (57.1%)+	n=1 (6.3%)* (16.7%)+	n=6 (37.5%)* (46.2%)+
<u>Females</u> (n=19)	n=4 (21.1%)* (44.4%)+	n=3 (15.8%)* (42.9%)+	n=5 (26.3%)* (83.3%)+	n=7 (36.8%)* (53.8%)+
<u>Total</u> (n=35)	n=9 (25.7%)**	n=7 (20.0%)**	n=6 (17.1%)**	n=13 (37.1%)**

- * row percentage
- + column percentage
- ** percentage of total

subjects who saw a "healthy woman" as masculine were female. For a "healthy woman," femininity was the first choice among male clinicians and the last choice for female clinicians. For female subjects, the first choice for a "healthy woman" was masculinity; this category was the last choice for male subjects. The first choice (femininity for male subjects and masculinity for female subjects) percentage (38.9%) was identical for male and female clinicians. The "healthy adult" category is of primary interest because this group is sex unspecified and therefore can be assumed to be indicative of an 'ideal' mental health description (Broverman, et al, 1970). All subjects saw a "healthy adult" as androgynous, undifferentiated, feminine or masculine (13,9,7,6 respectively). Essentially, an equal percentage of male and female clinicians (37.5% and 36.8%) saw a "healthy adult" as androgynous but a greater percentage of female than male clinicians (26.3% and 6.3%) saw a "healthy adult" as masculine. It is important to notice that in each category (i.e. a "healthy man, woman or adult") male subjects endorsed femininity to a greater percentage than did female subjects and conversely, female subjects endorsed masculinity to a greater percentage than did male subjects. Androgyny was the primary description of choice for all subjects in each target category though it was

chosen equally with femininity in the "healthy woman" category. This was because of male clinicians' preference of femininity as a sex-role category for a "healthy woman." (Percentages were used because the expected frequencies for five of the eight cells were too small for Chi Square or Fisher's Exact Test to be carried out.)

The percentage of clinicians as well as targets (a "healthy man, woman or adult") who were described as androgynous, masculine, feminine or undifferentiated was examined also. Table 6 shows there was a tendency for subjects to see the "healthy adult" as they saw themselves. This was exhibited by those who saw themselves as androgynous, undifferentiated or masculine. Those subjects who saw themselves as feminine were equally likely to see the "healthy adult" as feminine or androgynous.

For the "healthy man" category, those clinicians who saw themselves as androgynous or undifferentiated saw the "healthy man" in the same way. Those that saw themselves as masculine saw the "healthy man" as undifferentiated and those who saw themselves as feminine saw the "healthy man" as androgynous.

Again, in the "healthy woman" category, those subjects who saw themselves as undifferentiated primarily saw the "healthy woman" in the same way and those who saw themselves as feminine primarily saw the "healthy woman" as

Table 6
Clinicians' Sex-Role Preference for Self and Target

<u>All Subjects</u>	<u>Undifferentiated</u>	<u>Feminine</u>	<u>Masculine</u>	<u>Androgynous</u>
	<u>A_Healthy_Man</u>			
<u>Self</u>				
<u>Undifferentiated</u> (9; 24.3%)**	4 (44.4%)* (40.0%)+	2 (22.2%)* (33.3%)+	2 (22.2%)* (28.6%)+	1 (11.1%)* (7.1%)+
<u>Feminine</u> (7; 18.9%)**	1 (14.3%)* (10.0%)+		1 (14.3%)* (14.3%)+	5 (71.4%)* (35.7%)+
<u>Masculine</u> (11; 29.7%)**	4 (36.4%)* (40.0%)+	2 (18.2%)* (33.3%)+	3 (27.3%)* (42.9%)+	2 (18.2%)* (14.3%)+
<u>Androgynous</u> (10; 27.0%)**	1 (10.0%)* (10.0%)+	2 (20.0%)* (33.3%)+	1 (10.0%)* (14.3%)+	6 (60.0%)* (42.9%)+
<u>Total</u> (37; 100.0%)**	10 (27.0%)*	6 (16.2%)*	7 (18.9%)*	14 (37.8%)*
	<u>A_Healthy_Woman</u>			
<u>Self</u>				
<u>Undifferentiated</u> (6; 16.7%)**	4 (66.7%)* (57.1%)+	1 (16.7%)* (10.0%)+	1 (16.7%)* (11.1%)+	
<u>Feminine</u> (12; 33.3%)**	1 (8.3%)* (14.3%)+	3 (25.0%)* (30.0%)+	2 (16.7%)* (22.2%)+	6 (50.0%)* (60.0%)+
<u>Masculine</u> (10; 27.8%)**		4 (40.0%)* (40.0%)+	4 (40.0%)* (44.4%)+	2 (20.0%)* (20.0%)+
<u>Androgynous</u> (8; 22.2%)**	2 (25.0%)* (28.6%)+	2 (25.0%)* (20.0%)+	2 (25.0%)* (22.2%)+	2 (25.0%)* (20.0%)+
<u>Total</u> (36; 100.0%)**	7 (19.4%)*	10 (27.8%)*	9 (25.0%)*	10 (27.8%)*
	<u>A_Healthy_Adult</u>			
<u>Self</u>				
<u>Undifferentiated</u> (9; 25.7%)**	6 (66.7%)* (66.7%)+	1 (11.1%)* (14.3%)+		2 (22.2%)* (15.4%)+
<u>Feminine</u> (9; 25.7%)**		4 (44.4%)* (57.1%)+	1 (11.1%)* (16.7%)+	4 (44.4%)* (30.8%)+
<u>Masculine</u> (8; 22.9%)**	2 (25.0%)* (22.2%)+	1 (12.5%)* (14.3%)+	3 (37.5%)* (50.0%)+	2 (25.0%)* (15.4%)+
<u>Androgynous</u> (9) (25.7%)**	1 (11.1%)* (11.1%)+	1 (11.1%)* (14.3%)+	2 (22.2%)* (33.3%)+	5 (55.6%)* (38.5%)+
<u>Total</u> (35; 100.0%)**	9 (25.7%)*	7 (20.0%)*	6 (17.1%)*	13 (37.1%)*

* row percentage
+ column percentage

**category percentage

androgynous. Those who saw themselves as androgynous equally saw the "healthy woman" as undifferentiated, masculine, feminine or androgynous. Those subjects that saw themselves as masculine equally saw the "healthy woman" as masculine and feminine. (Again, it must be noted that the expected frequencies for each cell were too small for Chi Square or Fisher's Exact Test to be conducted.)

Table 7 shows the percentage of subjects and targets that were described as androgynous, masculine, feminine or undifferentiated within each target category was also examined separately for male and female subjects. Male subjects who saw themselves as endorsing an androgynous, feminine or undifferentiated sex-role primarily saw the "healthy adult" in the same manner. Sex-typed male subjects saw a "healthy adult" as undifferentiated or feminine. No sex-typed male subjects saw a "healthy adult" as masculine or androgynous; however, 68.8% of male subjects saw a "healthy adult" as androgynous or undifferentiated. (It is important to remember that undifferentiated differs from androgynous only in that both the masculinity and femininity scores are below the median instead of above the median as in an androgynous preference. The same characteristics may be endorsed in both categories. It is a difference of degree not of kind.) Only one of sixteen male subjects endorsed a

Table 7
Male Clinicians' Sex-Role Preference for Self and Target

	Undifferentiated	Feminine	Masculine	Androgynous
<u>A_Healthy_Man</u>				
<u>Self</u>				
<u>Undifferentiated</u>	1		1	
(2; 11.8%)**	(50.0%)* (20.0%)*		(50.0%)* (33.3%)*	
<u>Feminine</u>			1	1
(2; 11.8%)**			(50.0%)* (33.3%)*	(50.0%)* (20.0%)*
<u>Masculine</u>	3	2	1	2
(8; 47.1%)**	(37.5%)* (60.0%)*	(25.0%)* (50.0%)*	(12.5%)* (33.3%)*	(25.0%)* (40.0%)*
<u>Androgynous</u>	1	2		2
(5; 29.4%)**	(20.0%)* (20.0%)*	(40.0%)* (50.0%)*		(40.0%)* (40.0%)*
<u>Total</u>	5	4	3	5
(17; 100.0%)**	(29.4%)*	(23.5%)*	(17.6%)*	(29.4%)*
<u>A_Healthy_Woman</u>				
<u>Self</u>				
<u>Undifferentiated</u>	2	1		
(3; 16.7%)**	(66.7%)* (50.0%)*	(33.3%)* (14.3%)*		
<u>Feminine</u>		1		2
(3; 16.7%)**		(33.3%)* (14.3%)*		(66.7%)* (40.0%)*
<u>Masculine</u>		4	1	2
(7; 38.9%)**		(57.1%)* (57.1%)*	(14.3%)* (50.0%)*	(28.6%)* (40.0%)*
<u>Androgynous</u>	2	1	1	1
(5; 27.8%)**	(40.0%)* (50.0%)*	(20.0%)* (14.3%)*	(20.0%)* (50.0%)*	(20.0%)* (20.0%)*
<u>Total</u>	4	7	2	5
(18; 100.0%)**	(22.2%)*	(38.9%)*	(11.1%)*	(27.8%)*
<u>A_Healthy_Adult</u>				
<u>Self</u>				
<u>Undifferentiated</u>	3			2
(5; 31.3%)**	(60.0%)* (60.0%)*			(40.0%)* (33.3%)*
<u>Feminine</u>		3		2
(5; 31.3%)**		(60.0%)* (75.0%)*		(40.0%)* (33.3%)*
<u>Masculine</u>	2	1		
(3; 18.8%)**	(66.7%)* (40.0%)*	(33.3%)* (25.0%)*		
<u>Androgynous</u>			1	2
(3; 18.8%)**			(33.3%)* (100.0%)*	(66.7%)* (33.3%)*
<u>Total</u>	5	4	1	6
(16; 100.0%)**	(31.3%)*	(25.0%)*	(6.3%)*	(37.5%)*

* row percentage
* column percentage

** category percentage

masculine sex-role preference for a "healthy adult." Male subjects were not endorsing masculinity as an ideal model of health.

In addition, only three (17.6%) male subjects (one each who saw himself as undifferentiated, masculine and feminine) endorsed a masculine sex-role preference for a "healthy man." No man who chose an androgynous preference for himself saw a "healthy man" as masculine. In fact, those who saw themselves as sex-typed chose masculinity least as a sex-role preference for a "healthy man." Eight of seventeen (47%) subjects saw a "healthy man" as androgynous or masculine. This was the lowest percentage of androgynous and undifferentiated or androgynous and sex-typed for any of the three categories ("healthy man, woman or adult").

Seven of eighteen (38.9%) male subjects endorsed a feminine sex-role preference for a "healthy woman." Five subjects (27.8%) saw a "healthy woman" as having an androgynous sex-role preference. Sex-typed male subjects predominantly saw a "healthy woman" as sex-typed feminine. Twelve of eighteen (66.7%) subjects saw a "healthy woman" as feminine or androgynous. It is interesting to note that male subjects endorsed masculinity the least frequently in any category. They also endorsed androgyny for a "healthy man" and a "healthy adult" but see a "healthy woman" as sex-typed.

Female subjects who saw themselves as androgynous, masculine or undifferentiated primarily saw a "healthy adult" in the same way they saw themselves (see Table 8). Those who endorsed a feminine sex-role preference for themselves saw a "healthy adult" as androgynous. Female subjects endorsed a feminine sex-role preference less often than any other choice for a "healthy adult." Twelve of nineteen (63.1%) subjects saw a "healthy adult" as having an androgynous or masculine sex-role preference.

There were 4 of 20 (20%) female subjects who saw a "healthy man" as having a masculine sex-role preference, while 9 (45%) subjects saw a "healthy man" as androgynous. Those subjects who saw themselves as androgynous or feminine saw a "healthy man" as androgynous. Those who saw themselves as masculine or undifferentiated endorsed the same sex-role preference for a "healthy man." No sex-typed female subject saw a "healthy man" as sex-typed masculine. This is in direct contrast to sex-typed male subjects who saw a "healthy woman" as sex-typed feminine. Thirteen of twenty (65%) subjects saw a "healthy man" as androgynous or masculine.

Only 3 of 18 (16.7%) female subjects saw a "healthy woman" as having a feminine sex-role preference. An equal number and percentage (3, 16.7%) saw a "healthy woman" as undifferentiated. Twelve of eighteen (66.7%)

Table 8
Female Clinicians' Sex-Role Preference for Self and Target

	<u>Undifferentiated</u>	<u>Feminine</u>	<u>Masculine</u>	<u>Androgynous</u>
<u>A_Healthy_Man</u>				
<u>Self</u>				
<u>Undifferentiated</u> (7; 35.0%)**	3 (42.9%)* (60.0%)+	2 (28.6%)* (100.0%)+	1 (14.3%)* (25.0%)+	1 (14.3%)* (11.1%)+
<u>Feminine</u> (5; 25.0%)**	1 (20.0%)* (20.0%)+			4 (80.0%)* (44.4%)+
<u>Masculine</u> (3; 15.0%)**	1 (33.3%)* (20.0%)+		2 (66.7%)* (50.0%)+	
<u>Androgynous</u> (5; 25.0%)**			1 (20.0%)* (25.0%)+	4 (80.0%)* (44.4%)+
<u>Total</u> (20; 100.0%)**	5 (25.0%)*	2 (10.0%)*	4 (20.0%)*	9 (45.0%)*
<u>A_Healthy_Woman</u>				
<u>Self</u>				
<u>Undifferentiated</u> (3; 16.7%)**	2 (66.7%)* (66.7%)+		1 (33.3%)* (14.3%)+	
<u>Feminine</u> (9; 50.0%)**	1 (11.1%)* (33.3%)+	2 (22.2%)* (66.7%)+	2 (22.2%)* (28.6%)+	4 (44.4%)* (80.0%)+
<u>Masculine</u> (3; 16.7%)**			3 (100.0%)* (42.9%)+	
<u>Androgynous</u> (3; 16.7%)**		1 (33.3%)* (33.3%)+	1 (33.3%)* (14.3%)+	1 (33.3%)* (20.0%)+
<u>Total</u> (18; 100.0%)**	3 (16.7%)*	3 (16.7%)*	7 (38.9%)*	5 (27.8%)*
<u>A_Healthy_Adult</u>				
<u>Self</u>				
<u>Undifferentiated</u> (4; 21.1%)**	3 (75.0%)* (75.0%)+	1 (25.0%)* (33.3%)+		
<u>Feminine</u> (4; 21.1%)**		1 (25.0%)* (33.3%)+	1 (25.0%)* (20.0%)+	2 (50.0%)* (28.6%)+
<u>Masculine</u> (5; 26.3%)**			3 (60.0%)* (60.0%)+	2 (40.0%)* (28.6%)+
<u>Androgynous</u> (6; 31.6%)**	1 (16.7%)* (25.0%)+	1 (16.7%)* (33.3%)+	1 (16.7%)* (20.0%)+	3 (50.0%)* (42.9%)+
<u>Total</u> (19; 100.0%)**	4 (21.1%)*	3 (15.8%)*	5 (26.3%)*	7 (36.8%)*

* row percentage
+ column percentage

** category percentage

female subjects saw a "healthy woman" as masculine or androgynous. Those subjects who saw themselves as undifferentiated or masculine primarily saw a "healthy woman" as they saw themselves. Those who saw themselves as feminine saw a "healthy woman" as androgynous and those who saw themselves as androgynous equally endorsed a masculine, feminine or androgynous sex-role preference. Female subjects endorsed femininity less often than any other category. In this way, both female and male subjects endorsed their stereotyped sex-role (masculinity for males and femininity for females) least frequently in any category. The female subjects like the male subjects endorsed androgyny for a "healthy man and adult" but not for a "healthy woman." Female subjects, unlike the male subjects, endorsed masculinity as the sex-role preference for a "healthy woman."

A series of t-tests were conducted to examine if there were differences between male and female subjects in how they saw themselves on their masculinity, femininity and androgyny scores (see Table 9). (Shaw (1982) conducted a study to obtain a continuous androgyny score so that subjects could be compared within or between the four categories. He found the simplest and most efficient androgyny score was to add the mean masculinity and femininity scores; $M+F=A$.) No significant differences

Table 9

T-tests of Means and Standard Deviations
for Self, Man, Woman and Adult
Between Male and Female Subjects

	<u>Masculine</u>		<u>Feminine</u>		<u>Androgyny</u>	
	<u>Mean</u>	<u>S.D.</u>	<u>Mean</u>	<u>S.D.</u>	<u>Mean</u>	<u>S.D.</u>
	<u>Self</u>					
<u>Males</u> (n=51)	5.15	.63	4.74	.47	9.89	.69
<u>Females</u> (n=57)	4.97	.64	4.87	.33	9.84	.74
	n.s.		n.s.		n.s.	
	<u>Man</u>					
<u>Males</u> (n=17)	5.02	.73	4.19	.45	9.21	.90
<u>Females</u> (n=20)	5.13	.65	4.25	.39	9.38	.90
	n.s.		n.s.		n.s.	
	<u>Woman</u>					
<u>Males</u> (n=18)	4.73	.74	4.91	.39	9.64	.85
<u>Females</u> (n=18)	5.16	.54	4.69	.41	9.85	.81
	t=1.96 n.s. p<.06		n.s.		n.s.	
	<u>Adult</u>					
<u>Males</u> (16)	4.84	.45	4.67	.35	9.51	.68
<u>Females</u> (19)	5.22	.37	4.66	.28	9.88	.55
	t=2.62 p<.02		n.s.		n.s.	

were found for male and female subjects on how they rated themselves on masculinity, femininity and androgyny. There were also no significant differences in how male and female subjects rated a "healthy man" or a "healthy woman" on masculinity, femininity and androgyny. There was a trend ($p < .06$) for female subjects to rate a "healthy woman" as more masculine than did male subjects. There was no significant difference in how male and female subjects rated a "healthy adult" on femininity and androgyny. However, there was a significant difference ($p < .02$) in the subjects' rating of masculinity for a "healthy adult." Female subjects rated a "healthy adult" higher on masculinity than did male subjects. Because this difference was found, it was not possible to group male and female subjects in the rest of the analyses. Therefore, further examination of the data was conducted separately for male and female subjects.

One of the major questions raised in this study was how did psychoanalytic psychologists rate a "healthy man, woman and adult" and would the clinicians' descriptions of each target category be different from one another. A series of paired comparison t-tests was conducted and it was found that male and female subjects were in agreement in their perceptions of similarities and differences (see Table 10). Both male and female

Table 10

T-tests Between Targets (Man/Woman/Adult) on
Masculinity, Femininity and Androgyny
for Male and Female Subjects

	Male_Ss.	Female_Ss.
<u>Man/Woman</u>	n=17/18	n=20/18
<u>masculinity</u>	5.02/4.73 M>W t=1.96 p<.06 n.s.	5.13/5.16 n.s.
<u>femininity</u>	4.19/4.91 W>M t=5.05 p<.001	4.25/4.69 W>M t=3.38 p<.002
<u>androgyny</u>	9.21/9.64 W>M t=1.46 p<.16 n.s.	9.38/9.85 W>M t=1.91 p<.07 n.s.
 <u>Man/Adult</u>	 n=17/16	 n=20/19
<u>masculinity</u>	5.02/4.84 n.s.	5.13/5.22 n.s.
<u>femininity</u>	4.19/4.67 A>M t=3.45 p<.002	4.25/4.66 A>M t=3.77 p<.001
<u>androgyny</u>	9.21/9.51 n.s.	9.38/9.88 A>M t=2.09 p<.05
 <u>Woman/Adult</u>	 n=18/16	 18/19
<u>masculinity</u>	4.73/4.84 n.s.	5.16/5.22 n.s.
<u>femininity</u>	4.91/4.67 n.s.	4.69/4.66 n.s.
<u>androgyny</u>	9.64/9.51 n.s.	9.85/9.88 n.s.

M=Man
W=Woman
A=Adult

clinicians saw a "healthy man" and a "healthy woman" as different from each other on femininity but similar on masculinity. There was a trend for both subject groups to see a difference on androgyny: the "healthy woman" being rated higher than the "healthy man."

Male subjects saw a "healthy man" and a "healthy adult" as different from each other on femininity but similar on masculinity and androgyny. Female subjects saw a "healthy man" and a "healthy adult" as different on femininity and androgyny and similar on masculinity. In the female subjects' comparison, the score for the "healthy adult" was consistently higher than that for the "healthy man," i.e., a "healthy adult" was seen as more masculine, feminine and androgynous than a man.

In the "healthy woman" and "healthy adult" comparison, there was no difference in masculinity, femininity or androgyny for either male or female subjects. A "healthy adult" (the supposed ideal description of mental health) was seen as similar to a "healthy woman." In addition, both male and female subjects saw a "healthy adult" as more feminine and female subjects saw a "healthy adult" as more androgynous than a "healthy man." Therefore, in this study the results are considerably different than the findings of Broverman, et al (1970). In 1986, male and female psychoanalytic

clinicians saw a "healthy man" and a "healthy woman" as different from each other and saw a "healthy adult" in the same way as they saw a "healthy woman!" The pendulum has made a wide swing and now it is the "healthy man" who is in the double bind. He was seen as different from a "healthy woman" and a "healthy adult." If he subscribed to the "healthy adult" model, he was seen as deviant from the stereotypic sex-role model for a "healthy man" and if he choose the sex-role description that is typically ascribed to a "healthy man", he was seen as deviant from the "healthy adult" model.

Another question that was raised in this study was would clinicians see the healthy target person in the same way they saw themselves. A series of paired comparison t-tests were used to investigate this question and the results are shown in Table 11. Male and female subjects did find differences between themselves and the assigned target for masculinity, femininity and androgyny. In only one category did subjects see the target as they saw themselves and this was for male clinicians in the self/adult category. This was so for 16 male subjects (47.8% of the self/adult group, 31.4% of male subjects and 14.8% of the total sample). It is interesting that no clinician saw any difference on masculinity, femininity or androgyny between a "healthy woman" and a "healthy adult"

Table 11

T-tests Between Self and Target (Man, Woman, Adult)
on Masculinity, Femininity, and Androgyny
for Male and Female Subjects

	Male Subjects	Female Subjects
Self/Man	n=17	n=20
Masculinity	5.16/5.02 n.s.	4.88/5.13 M>S t=1.83 p<.08) n.s.
Femininity	4.74/4.19 S>M t=5.70 p<.001	4.65/4.25 S>M t=8.29 p<.001
androgyny	9.90/9.21 S>M t=3.94 p<.001	9.73/9.38 S>M t=2.10 p<.05
Self/Woman	n=18	n=18
Masculinity	5.26/4.73 S>W t=2.51 p<.03	4.88/5.16 W>S t=2.19 p<.05
Femininity	4.74/4.91 n.s.	4.32/4.69 S>W t=2.90 p<.01
androgyny	10.0/9.64 S>W t=2.13 p<.05	9.80/9.85 n.s.
Self/Adult	n=16	n=19
Masculinity	5.00/4.84 n.s.	5.16/5.22 n.s.
Femininity	4.76/4.67 n.s.	4.83/4.66 S>A t=2.45 p<.03
androgyny	9.76/9.51 n.s.	9.99/9.88 n.s.

S=Self
M=Man
W=Woman
A=Adult

in the previously described analysis (see Table 10). However, there was a significant difference on femininity between a "healthy man" and a "healthy adult" for male subjects (see Table 10) but in this comparison male subjects (though few in number (16)) saw a "healthy adult" in the same way as they saw themselves. Male subjects saw no difference between themselves and a "healthy adult" but did see a difference between a "healthy man" and a "healthy adult" (a "healthy adult" was seen as more feminine than a "healthy man"). Female subjects saw no difference between a "healthy woman" and a "healthy adult" but did see a difference between themselves and a "healthy adult" (themselves being seen as more feminine than a "healthy adult"). This begins to make sense because male clinicians saw themselves as more feminine and androgynous than they saw a "healthy man." They also saw no difference between themselves and a "healthy woman" on femininity, between themselves and female subjects in their preference of sex-role category (see Table 4) and on femininity for themselves, a "healthy man, woman or adult" (see Table 9). By combining these data, it appears that male clinicians may be in touch with the feminine side of themselves.

The picture is somewhat different for female subjects. Femininity is still a primary identification for female clinicians in that they saw themselves as more

feminine than a "healthy man, woman or adult" and it was the first choice sex-role preference for them (see Table 4). They saw themselves as more androgynous than a man and a trend ($p < .08$) for a man to be more masculine than they were. They saw a woman as more masculine than themselves. In addition, a significant difference was exhibited by female subjects in the masculinity score for a "healthy adult" and there was a trend in the same direction for masculinity for a "healthy woman" (see Table 9). Female clinicians appeared to be describing an 'ideal' in finding no significant differences between a woman and an adult in the previous analysis; one they don't subscribe to themselves.

One of Striker's (1977) major criticisms lodged against the original Broverman, et al, (1970) study was that there was no item analysis of the scale they used. This made it impossible to know if the actual differences were statistically significant. In this study, a series of item analyses was conducted for male and female subjects. The result of the first of these comparisons is shown in Table 12.

The first group of t-tests was between male and female clinicians for self, a "healthy man, woman and adult." In the self category, male subjects rated themselves higher on one item from the masculine

Table 12

T-Tests of 60 Items Between Male and Female Subjects for Self, Man, Woman and Adult

<u>Masculine Items</u>	<u>Feminine Items</u>	<u>Neutral Items</u>
<u>Self</u> (n=51/57)		
<u>Masculine</u>	<u>Feminine</u>	
5.37/2.88 M>F	5.37/2.88 F>M	
t=11.58 p>.001	t=12.16 p>.001	
	<u>Sympathetic</u>	
	6.02/5.71 F>M	
	t=2.08 p>.05	
	<u>Compassionate</u>	
	5.96/5.65 F>M	
	t=2.29 p>.03	
<u>Man</u> (n=17/20)		
<u>Has leadership abilities</u>	<u>Flatterable</u>	<u>Likable (+)</u>
5.30/4.29 F>M	4.35/3.35 F>M	5.30/4.53 F>M
t=3.10 p>.01	t=2.22 p>.04	t=2.46 p>.02
<u>Woman</u> (n=18/18)		
<u>Independent</u>	<u>Flatterable</u>	<u>Conventional (-)</u>
6.11/5.39 F>M	4.50/3.44 M>F	4.44/3.56 M>F
t=2.48 p>.02	t=2.69 p>.02	t=2.56 p>.02
<u>Self-sufficient</u>	<u>Soft-spoken</u>	
6.06/5.44 F>M	4.56/3.67 M>F	
t=2.04 p>.05	t=2.44 p>.02	
<u>Willing to take a stand</u>	<u>Gullible</u>	
5.94/5.06 F>M	3.28/2.44 M>F	
t=2.94 p>.01	t=2.25 p>.04	
<u>Acts as a leader</u>	<u>Loves children</u>	
5.17/4.44 F>M	5.83/5.11 M>F	
t=2.48 p>.02	t=2.56 p>.02	
	<u>Gentle</u>	
	5.39/4.83 M>F	
	t=2.53 p>.02	
<u>Adult</u> (n=16/19)		
<u>Self-reliant</u>	<u>Feminine</u>	
6.06/5.63 F>M	4.63/3.88 F>M	
t=2.18 p>.04	t=2.84 p>.01	
<u>Independent</u>		
5.79/5.13 F>M		
t=2.88 p>.01		
<u>Assertive</u>		
5.53/5.00 F>M		
t=2.17 p>.04		

M=Males
 F=Females
 (+)=Positive
 (-)=Negative

scale and female subjects rated themselves higher on three feminine characteristics. There were no significant differences between subjects on the neutral scale.

In the "healthy man" category, there were three items that were identified as being significantly different; one masculine, one feminine and one neutral characteristic. In all three cases female subjects rated a "healthy man" higher on these characteristics than did male subjects.

For the "healthy woman" grouping, male subjects rated a "healthy woman" higher on five feminine characteristics and one neutral one while female subjects rated a "healthy woman" higher on four masculine characteristics.

In the "healthy adult" category, only female subjects rated a "healthy adult" higher on one feminine and three masculine characteristics. The gender terms-masculine and feminine-were only significantly different in the self and "healthy adult" categories. Males saw themselves as higher on masculinity and females saw themselves and a "healthy adult" as higher on femininity.

On 36 of a total of 60 items (60%), female subjects rated a "healthy adult" higher than did male subjects (19 of 20 (95%) masculine items, 7 of 20 (35%)

feminine items and 10 of 20 (50%) neutral items). Female subjects were responsible for three of the four (75%) significant differences in the self category and for 11 of 17 (64.7%) significant differences in the target categories. It appears that the female clinicians consistently rated themselves or the target with a more definite response.

The second group of t-tests was on the 60 scale items for male and female subjects in the "healthy man/woman, woman/adult and man/adult" categories (see Table 13). In the "healthy man/woman" category, a significant difference was found for the means of 15 items for male subjects. The two masculine items-dominant and masculine were the only two characteristics on which male subjects endorsed a higher mean score for a "healthy man" than they gave a "healthy woman." The reverse; where male subjects gave a "healthy woman" a higher rating than a "healthy man," was indicated on 13 characteristics. This was the case on 11 feminine items and two neutral.

In the "healthy woman/adult" comparison, four of the five items on which there was a significant difference were found to have the "healthy woman" with a higher mean score than the "healthy adult." Masculine, the only masculine scale item on which there was a significant difference, was found to have the "healthy adult" rated higher than the "healthy woman."

Table 13

T-tests of 60 Items Between Man/Woman, Woman/Adult
and Man/Adult for Male Subjects

<u>Masculine Items</u>	<u>Feminine Items</u>	<u>Neutral Items</u>
<u>Man/Woman (n=17/18)</u>		
Dominant 4.35/3.50 M>W t=2.34 p<.03	Flatterable 3.35/4.50 W>M t=3.00 p<.005	Theatrical (-) 2.71/3.44 W>M t=2.23 p<.04
Masculine 5.47/2.56 M>W t=7.97 p<.001	Feminine 2.76/5.89 W>M t=9.18 p<.001	Tactful (+) 4.76/5.50 W>M t=2.30 p<.03
	Sensitive to the needs of others 4.94/5.72 W>M t=2.38 p<.03	
	Understanding 5.12/5.83 W>M t=2.46 p<.02	
	Compassionate 4.88/5.89 W>M t=3.36 p<.002	
	Soft-spoken 3.71/4.56 W>M t=3.10 p<.004	
	Warm 4.88/5.56 W>M t=2.22 p<.04	
	Tender 4.59/5.44 W>M t=2.92 p<.006	
	Does not use harsh language 3.94/5.28 W>M t=3.84 p<.001	
	Loves children 4.71/5.83 W>M t=4.31 p<.001	
	Gentle 4.47/5.39 W>M t=3.26 p<.003	
<u>Woman/Adult (n=18/16)</u>		
Masculine 2.56/4.25 A>W t=4.71 p<.001	Flatterable 4.50/3.81 W>A t=2.09 p<.05	Moody (-) 3.61/2.88 W>A t=2.12 p<.05

cont.

Table 13 (cont.)

<u>Masculine_Items</u>	<u>Feminine_Items</u>	<u>Neutral_Items</u>
<u>Woman/Adult</u>		
	Feminine	
	5.89/3.88 W>A	
	t=7.16 p<.001	
	Loves children	
	5.83/5.13 W>A	
	t=2.62 p<.02	
<u>Man/Adult (n=17/16)</u>		
Has leadership	Cheerful	Happy (+)
abilities	4.71/5.19 A>M	4.76/5.50 A>M
4.29/5.06 A>M	t=2.06 p<.05	t=2.70 p<.02
t=2.31 p<.03	Feminine	Likable (+)
Masculine	2.76/3.88 A>M	4.53/5.38 A>M
5.47/4.25 M>A	t=3.23 p<.003	t=3.22 p<.003
t=2.31 p<.002	Compassionate	Friendly (+)
	4.88/5.75 A>M	5.18/5.81 A>M
	t=2.59 p<.02	t=2.34 p<.03
	Eager to soothe	Adaptable (+)
	hurt feelings	5.06/5.81 A>M
	4.12/4.94 A>M	t=2.17 p<.04
	t=2.36 p<.03	Tactful (+)
	Soft-spoken	4.76/5.63 A>M
	3.71/4.31 A>M	t=3.21 p<.003
	t=2.96 p<.006	
	Does not use	
	harsh language	
	3.94/5.19 A>M	
	t=3.27 p<.003	
	Gentle	
	4.47/5.38 A>M	
	t=3.11 p<.004	

M=Man
W=Woman
A=Adult
(+)=Positive
(-)=Negative

In the "healthy man/adult" grouping, 14 significant differences were found with the "healthy adult" seen as higher on 13 of 14 items. The only item seen in the reverse was masculine.

Only the gender characteristics-masculine and feminine overlap in all three categories with the "healthy man" as more masculine and less feminine than the "healthy woman", the "healthy adult" as more masculine and less feminine than the "healthy woman" and the "healthy adult" as less masculine and more feminine than the "healthy man." There were additional overlaps between categories that were primarily on the feminine characteristics.

Table 14 shows that for female subjects, there was a significant difference on 19 items in the "healthy man/woman" comparison category: 7 masculine, 9 feminine and 3 neutral. Female subjects rated a "healthy man" higher on two masculine characteristics (athletic and masculine) and one neutral characteristic (conventional (-)). The other 16 items (all the feminine, 5 masculine and 2 neutral) were rated higher for a "healthy woman" than a "healthy man."

In the "healthy woman/adult" comparison, there were five items on which a significant difference was found for female subjects. Three of these were masculine items and two were feminine characteristics. Two of the means for the masculine items (athletic and masculine) were found

Table 14

T-tests of 60 Items Between Man/Woman, Woman/Adult
and Man/Adult for Female Subjects

<u>Masculine Items</u>	<u>Feminine Items</u>	<u>Neutral Items</u>
<u>Man/Woman (n=20/18)</u>		
Independent 5.40/6.11 W>M t=2.60 p<.02	Affectionate 5.20/5.72 W>M t=2.14 p<.04	Adaptable (+) 4.80/5.67 W>M t=2.53 p<.02
Athletic 4.90/4.28 M>W t=2.07 p<.05	Feminine 2.55/5.78 W>M t=9.98 p<.001	Tactful (+) 4.60/5.50 W>M t=3.84 p<.001
Makes decisions easily 4.75/5.39 W>M t=2.44 p<.02	Sympathetic 4.90/5.89 W>M t=4.12 p<.001	Conventional (-) 4.20/3.56 M>W t=2.29 p<.03
Self-sufficient 5.45/6.06 W>M t=2.31 p<.03	Sensitive to the needs of others 5.00/5.67 W>M t=2.20 p<.04	
Masculine 5.55/2.78 M>W t=7.45 p<.001	Understanding 5.10/5.83 W>M t=2.59 p<.02	
Willing to take a stand 5.20/5.94 W>M t=2.73 p<.01	Compassionate 5.30/6.11 W>M t=2.62 p<.02	
Individualistic 4.70/5.67 W>M t=3.49 p<.001	Warm 5.20/5.89 W>M t=2.67 p<.02	
	Tender 4.75/5.50 W>M t=2.30 p<.03	
	Does not use harsh language 3.80/4.78 W>M t=2.41 p<.03	
<u>Woman/Adult (n=18/19)</u>		
Athletic 4.28/4.84 A>W t=2.07 p<.05	Feminine 5.78/4.63 W>A t=4.95 p<.001	
Masculine 2.78/4.63 A>W t=5.37 p<.001	Warm 5.89/5.37 W>A t=2.19 p<.04	
Willing to take a stand 5.94/5.42 W>A t=2.03 p<.05		

cont.

Table 14 cont.

<u>Masculine_Items</u>	<u>Feminine_Items</u>	<u>Neutral_Items</u>
<u>Man/Adult (n=20/19)</u>		
Self-reliant 5.45/6.05 A>M t=2.60 p<.02	Feminine 2.55/4.63 A>M t=6.22 p<.001	Tactful (+) 4.60/5.32 A>M t=2.72 p<.01
Makes decisions easily 4.75/5.63 A>M t=3.59 p<.001	Sympathetic 4.90/5.53 A>M t=2.94 p<.006	
Masculine 5.55/4.63 M>A t=3.24 p<.003	Sensitive to the needs of others 5.00/5.68 A>M t=2.39 p<.03	
Individualistic 4.70/5.32 A>M t=2.38 p<.03	Understanding 5.10/5.68 A>M t=2.12 p<.05	
	Tender 4.75/5.47 A>M t=2.70 p<.02	
	Does not use harsh language 3.80/4.79 A>M t=2.85 p<.007	

M=Man
W=Woman
A=Adult
(+)=Positive
(-)=Negative

to be higher for a "healthy adult" than for a "healthy woman." These two characteristics were the same items that female subjects described as higher for a "healthy man" than a "healthy woman." The other masculine and the two feminine characteristic means were found to be higher for a "healthy woman" than a "healthy adult."

There were 11 significant differences found on the comparison of the means in the "healthy man/adult" category. Only one masculine item was found higher for a "healthy man" than a "healthy adult" and this was the gender description, masculine. There were three masculine, six feminine and one neutral item on which significant differences were found with the "healthy adult" higher than the "healthy man."

Female subjects found a significant difference on the gender characteristics (masculine and feminine) in all three comparisons. Even though the specific items differed, the female subjects, like the male subjects, found the "healthy man" as more masculine and less feminine than the "healthy woman", the "healthy adult" as more masculine and less feminine than the "healthy woman" and the "healthy adult" as less masculine and more feminine than the "healthy man." There were additional overlaps on characteristics between categories on both masculine and feminine items.

Including the concurrence by male and female subjects on the gender descriptions of masculine and feminine, there was agreement on nine items in the "healthy man/woman" category, two in the "healthy woman/adult" category and four in the "healthy man/adult" comparison (see Table 15). Male and female subjects had the greatest divergence of description in the "healthy man/woman" category. This was because female clinicians saw a difference on eight items and male clinicians saw a difference on only one item.

Table 16 shows the third group of paired comparison t-tests of the 60 scale items between self and target for male and female subjects. For male subjects in the self/"healthy man" comparison, a significant difference was found on 21 items (four masculine, 11 feminine and six neutral). In all cases except one masculine item (aggressive), male clinicians endorsed a higher rating for themselves than for a "healthy man."

In the self/"healthy woman" comparison, there were nine items that elicited a significant difference but only two (one feminine, feminine and one neutral, tactful (+)) in which the male subjects saw a "healthy woman" as higher than a themselves.

In the self/"healthy adult" comparison, there were significant differences on 17 items; five masculine, two

Table 15

Overlap Items of Significant Difference
for Male and Female Subjects in Man/Woman,
Woman/Adult and Man/Adult Categories

<u>Masculine Items</u>	<u>Feminine Items</u>	<u>Neutral Items</u>
------------------------	-----------------------	----------------------

Man/Woman

Masculine
M>W

Feminine
W>M
Sensitive to the
needs of others
W>M
Understanding
W>M
Compassionate
W>M
Warm
W>M
Tender
W>M
Does not use
harsh language
W>M

Tactful (+)
W>M

Woman/Adult

Masculine
A>W

Feminine
W>A

Man/Adult

Masculine
M>A

Feminine
A>M
Does not use
harsh language
A>M

Tactful (+)
A>M

M=Man
W=woman
A=Adult
(+)=Positive

Table 16

T-Tests of 60 Items Between Self/Man,
Self/Woman and Self/Adult for Male Subjects

<u>Masculine Items</u>	<u>Feminine Items</u>	<u>Neutral Items</u>
<u>Self/Man (n=17)</u>		
Analytical 6.29/4.94 S>M t=5.28 p<.001	Cheerful 5.12/4.71 S>M t=2.13 p<.05	Conscientious (+) 6.24/5.76 S>M t=2.22 p<.05
Has leadership abilities 5.12/4.29 S>M t=2.46 p<.03	Loyal 6.53/5.65 S>M t=5.22 <.001	Reliable (+) 6.53/5.65 S>M t=4.24 p<.001
Aggressive 3.88/4.53 M>S t=2.18 p<.05	Sympathetic 5.76/5.00 S>M t=2.75 p<.02	Sincere (+) 6.12/5.71 S>M t=2.13 p<.05
Individualistic 5.35/4.59 S>M t=2.75 p<.02	Sensitive to the needs of others 5.76/4.94 S>M t=2.55p<.03	Likable (+) 5.66/4.53 S>M t=4.15 p<.001
	Compassionate 5.59/4.88 S>M t=2.78 p<.02	Friendly (+) 5.82/5.18 S>M t=2.52 p<.03
	Soft-spoken 4.82/3.71 S>M t=3.50 p<.003	Tactful (+) 5.59/4.76 S>M t=3.57 p<.003
	Warm 5.59/4.88 S>M t=4.24 p<.001	
	Tender 5.41/4.59 S>M t=3.57 p<.003	
	Loves children 5.88/4.71 S>M t=5.10 p<.001	
	Gentle 5.59/4.47 S>M t=4.97 p<.001	
	Eager to soothe hurt feelings 5.24/4.14 S>M t=3.95 p<.001	

cont.

Table 16 cont.

<u>Masculine_Items</u>	<u>Feminine_Items</u>	<u>Neutral_Items</u>
<u>Self/Woman (n=18)</u>		
Strong personality 5.72/5.22 S>W t=2.15 p<.05	Loyal 6.22/5.61 S>W t=2.65 p<.02	Conscientious (+) 6.44/5.83 S>W t=3.33 p<.004
Analytical 6.28/4.89 S>W t=7.58 p<.001	Feminine 2.72/5.89 W>S t=6.79 p<.001	Reliable (+) 6.44/5.89 S>W t=2.40 p<.03
Dominant 4.28/3.50 S>W t=2.52 p<.03		Tactful (+) 4.78/5.50 W>S t=2.50 p<.03
Masculine 5.67/2.56 S>W t=9.10 p<.001		
<u>Self/Adult (n=16)</u>		
Analytical 6.06/5.06 S>A t=3.04 p<.008	Flatterable 4.50/3.81 S>A t=2.42 p<.03	Helpful (+) 5.94/5.44 S>A t=2.24 p<.05
Makes decisions easily 4.44/5.25 A>S t=3.57 p<.003	Feminine 3.00/3.88 A>S t=2.78 p<.02	Moody (-) 3.88/2.88 S>A t=2.66 p<.02
Masculine 4.81/4.25 S>A t=2.18 p<.05		Conscientious (+) 6.44/5.75 S>A t=3.91 p<.001
Acts as a leader 5.19/4.63 S>A t=2.18 p<.05		Theatrical (-) 3.94/3.25 S>A t=3.91 p<.001
Competitive 4.69/3.81 S>A t=2.91 p<.02		Happy (+) 4.38/5.50 A>S t=3.92 p<.001
		Reliable (+) 6.25/6.00 S>A t=2.24 p<.05
		Jealous (-) 3.63/2.81 S>A t=2.28 p<.04
		Secretive (-) 3.75/2.69 S>A t=2.64 p<.02
		Conceited (-) 3.88/2.69 S>A t=4.07 p<.001
		Adaptable (-) 5.19/5.81 A>S t=3.10 p<.007
	S=Self M=Man W=Woman A=Adult (+)=Positive (-)=Negative	

feminine and 10 neutral (seven negative and three positive). The "healthy adult" was rated higher on one masculine, one feminine and two neutral items (both positive); the other 13 items were rated higher for themselves.

For female subjects in the self/"healthy man" comparison, a significant difference was found on 22 items: four masculine, 12 feminine and six neutral (see Table 17). On 18 characteristics the female subjects endorse a higher rating for themselves than a "healthy man." The four items on which they found a man higher than themselves were assertive, forceful and the masculine gender item, masculine; and the neutral item, conceited (which is a negative characteristic).

In the self/"healthy woman" category, female subjects endorsed a significant difference on 12 items: five masculine, four feminine and three neutral. They found the "healthy woman" higher on four of the five masculine items, one feminine item and two neutral (negative) items. The one feminine item was the gender description-feminine.

In the self/"healthy adult" category, female subjects endorsed a significant difference on nine characteristics: five masculine, two feminine and two neutral items. They found themselves higher on all the

Table 17

T-Tests of 60 Items Between Self/Man, Self/Woman
and Self/Adult for Female Subjects

<u>Masculine Items</u>	<u>Feminine Items</u>	<u>Neutral Items</u>
<u>Self/Man (n=20)</u>		
Assertive 5.15/5.55 M>S t=2.37 p<.03	Loyal 6.25/5.55 S>M t=4.27 p<.001	Helpful (+) 5.75/5.10 S>M t=3.58 p<.002
Forceful 4.25/4.90 M>S t=2.37 p<.03	Feminine 5.25/2.55 S>M t=6.78 <.001	Conscientious (+) 6.20/5.40 S>M t=2.56 p<.02
Analytical 5.85/5.15 S>M t=2.40 p<.03	Sympathetic 6.05/4.90 S>M t=6.90 p<.001	Reliable (+) 6.25/5.70 S>M t=2.77 p<.02
Masculine 2.85/5.55 M>S t=7.15 p<.001	Sensitive to the needs of others 5.75/5.00 S>M t=3.00 p<.007	Sincere (+) 6.10/5.68 S>M t=2.36 p<.03
	Understanding 6.15/5.10 S>M t=4.70 p<.001	Conceited (-) 2.30/3.05 M>S t=2.21 p<.04
	Compassionate 5.95/5.30 S>M t=2.56 p<.02	Tactful (+) 5.35/4.60 S>M t=3.13 p<.005
	Eager to soothe hurt feelings 5.15/4.25 S>M t=3.94 p<.001	
	Warm 5.65/5.20 S>M t=3.33 p<.004	
	Gullible 3.35/2.45 S>M t=2.93 p<.009	
	Does not use harsh language 4.80/3.80 S>M t=4.36 p<.001	
	Loves children 5.60/4.95 S>M t=2.46 p<.03	
	Gentle 5.50/4.70 S>M t=3.39 p<.003	

cont.

Table 17 cont.

<u>Masculine Items</u>	<u>Feminine Items</u>	<u>Neutral Items</u>
<u>Self/Woman (n=18)</u>		
Independent 5.50/6.11 W>S t=3.05 p<.001	Feminine 5.33/5.78 W>S t=2.41 p<.03	Conscientious (+) 6.28/5.67 S>W t=2.37 p<.03
Assertive 4.94/5.50 W>S t=2.56 p<.02	Soft-spoken 4.67/3.67 S>W t=3.19 p<.005	Theatrical (-) 2.83/2.89 W>S t=2.56 p<.02
Analytical 6.11/5.22 S>W t=4.19 p<.001	Loves children 5.83/5.11 S>W t=2.50 p<.03	Conceited (-) 2.50/2.94 W>S t=2.20 p<.05
Self-sufficient 5.61/6.06 W>S t=2.20 p<.05	Gentle 5.33/4.83 S>W t=2.47 p<.03	
Acts as a leader 4.06/5.17 W>S t=3.16 p<.006		
<u>Self/Adult (n=19)</u>		
Athletic 4.00/4.84 A>S t=2.11 p<.05	Feminine 5.53/4.63 S>A t=3.39 p<.003	Conscientious (+) 6.26/5.63 S>A t=2.88 p<.01
Analytical 5.84/5.37 S>A t=2.28 p<.04	Eager to soothe hurt feelings 5.32/4.58 S>A t=3.24 p<.005	Sincere (+) 6.16/5.74 S>A t=3.02 p<.007
Makes decisions easily 5.21/5.63 A>S t=3.02 p<.007		
Masculine 3.26/4.63 A>S t=4.08 p<.001		
Ambitious 5.63/5.16 S>A t=2.28 p<.04		

S=Self
M=Man
W=Woman
A=Adult
(+)=Positive
(-)=Negative

feminine and neutral items and on two of the five masculine items.

Table 18 shows that there were 17 items in which male and female subjects concurred in the self/"healthy man", self/"healthy woman" and self/"healthy adult" comparisons. In 16 of the agreed difference, male and female subjects rated themselves higher than the target person. On only one characteristic (makes decisions easily) did male and female subjects rate the "healthy adult" higher than themselves. Two characteristics overlapped all three comparisons: analytical and conscientious; with the self rated higher than the "healthy man, woman or adult."

Additional t-tests were computed to see if particular demographic characteristics such as age, year of graduate degree, years of clinical practice, year of ending psychoanalytic training, mothers' employment, membership in APA Division 35; Psychology of Women (for female subjects only; there were no male members of Division 35), orientation of institute and self orientation had any effect on the subjects' masculinity, femininity and androgyny scores. None of the comparisons exhibited a significant difference between subjects. Therefore, further analysis within these categories did not appear to be productive (see Table 19).

Table 18

Overlap Items of Significant Difference
for Male and Female Subjects in Self/Man,
Self/Woman and Self/Adult Categories

<u>Masculine Items</u>	<u>Feminine Items</u>	<u>Neutral Items</u>
<u>Self/Man</u>		
Analytical S>M	Loyal S>M Sympathetic S>M Sensitive to the needs of others S>M Compassionate S>M Warm S>M Loves children S>M Gentle S>M	Conscientious (+) S>M Reliable (+) S>M Sincere (+) S>M Tactful (+) S>M
<u>Self/Woman</u>		
Analytical S>W	Feminine W>S	Conscientious (+) S>W
<u>Self/Adult</u>		
Analytical S>A Makes decisions easily A>S		Conscientious (+) S>A

Table 19

T-Tests of Demographic Comparisons on
Masculinity, Femininity and Androgyny

<u>Demographic Characteristic</u>	<u>Masculinity</u>	<u>Femininity</u>	<u>Androgyny</u>
<u>Age</u>			
Older than mean age 53 (n=56)	5.06	4.80	9.86
Younger than mean age 53 (n=52)	5.05	4.82	9.87
	p<.97	p<.79	p<.90
	n.s.	n.s.	n.s.
<u>Year of graduate degree</u>			
After median year 1967 (n=54)	5.02	4.81	9.83
Before median year 1967 (n=51)	5.03	4.81	9.84
	p<.94	p<.96	p<.93
	n.s.	n.s.	n.s.
<u>Years of clinical experience</u>			
More than median year 21 (n=53)	5.05	4.82	9.87
Less than median year 21 (n=55)	5.05	4.79	9.84
	p<.99	p<.68	p<.81
	n.s.	n.s.	n.s.
<u>Year of ending psychoanalytic training</u>			
After median year 1974 (n=51)	5.04	4.81	9.85
Before median year 1974 (n=46)	5.03	4.80	9.83
	p<.97	p<.91	p<.92
	n.s.	n.s.	n.s.
<u>Mothers' occupation</u>			
Mothers employed (n=39)	5.10	4.82	9.92
Mothers as homemakers (n=64)	5.02	4.82	9.84
	p<.54	p<.96	p<.59
	n.s.	n.s.	n.s.
<u>Female subjects' membership in APA Division 35</u>			
Non-members (n=51)	4.95	4.88	9.83
Members (n=6)	5.11	4.74	9.85
	p<.42	p<.33	p<.92
	n.s.	n.s.	n.s.
<u>Orientation of institute</u>			
Interpersonal (n=18)	5.07	4.76	9.83
All others (n=90)	5.05	4.82	9.87
	p<.88	p<.61	p<.85
	n.s.	n.s.	n.s.
<u>Orientation of self</u>			
Psychoanalytic (n=88)	5.07	4.81	9.88
All others (n=20)	4.97	4.79	9.76
	p<.39	p<.87	p<.38
	n.s.	n.s.	n.s.

IV DISCUSSION

The purpose of this study was to investigate the current stereotype perceptions of male and female psychoanalytic psychologists regarding a "healthy man, woman or adult." The Broverman et al. (1970) study found that male and female clinicians agreed in their definitions of what constituted a "healthy man, woman or adult." In addition, it was their finding that there was a significant difference between a "healthy man" and a "healthy woman" and that a "healthy adult" was perceived as similar to a "healthy man." Thus, a "healthy woman" was seen as deviant from the adult model and if she was seen as a "healthy adult", she was deviant from the female model. This was catch-22 for women!

The current study was a variation on the theme of the Broverman, et al, (1970) work. The stereotype information was gathered with an androgyny scale (BSRI) which makes it possible to conceptualize masculinity and femininity as orthogonal constructs; therefore, one could endorse masculinity, femininity or psychological androgyny as a sex-role preference for self or other. The subjects who were all psychoanalytic psychologists were not only asked to fill out the BSRI for their perceptions of a "healthy man, woman or adult" but they were also asked to

fill out the scale for themselves to investigate if there was a relationship between how the psychoanalysts saw themselves and how they perceived the other. Finally, an item analysis of the scale characteristics was conducted for the man/woman, man/adult and woman/adult comparisons and the self/man, self/woman and self/adult comparisons. The results found in this study were quite different from the Broverman, et al, (1970) findings; however, the current results raised questions of their own. It is now the "healthy man" who is caught in catch-22!

The concepts of sex-role preference and stereotypes are empirically derived and not based on any particular theory. The sex-role preferences for self and other by psychoanalysts could be derived from Freud's conceptualization of sexual identity in either his 1925 or 1937 papers. Therefore, where appropriate, all statistical tests were two-tailed.

The mailing went to 466 people and was returned by 108 subjects. There were no differences in the Chi Square analyses between male and female practitioners in the participation rate (Table 1) or in the number of clinicians in each target category (Table 3). Of the total persons solicited, 53.2% were male and 46.8% were female. The final sample consisted of 47.2% male and 52.8% female clinicians. It was interesting to note that the final

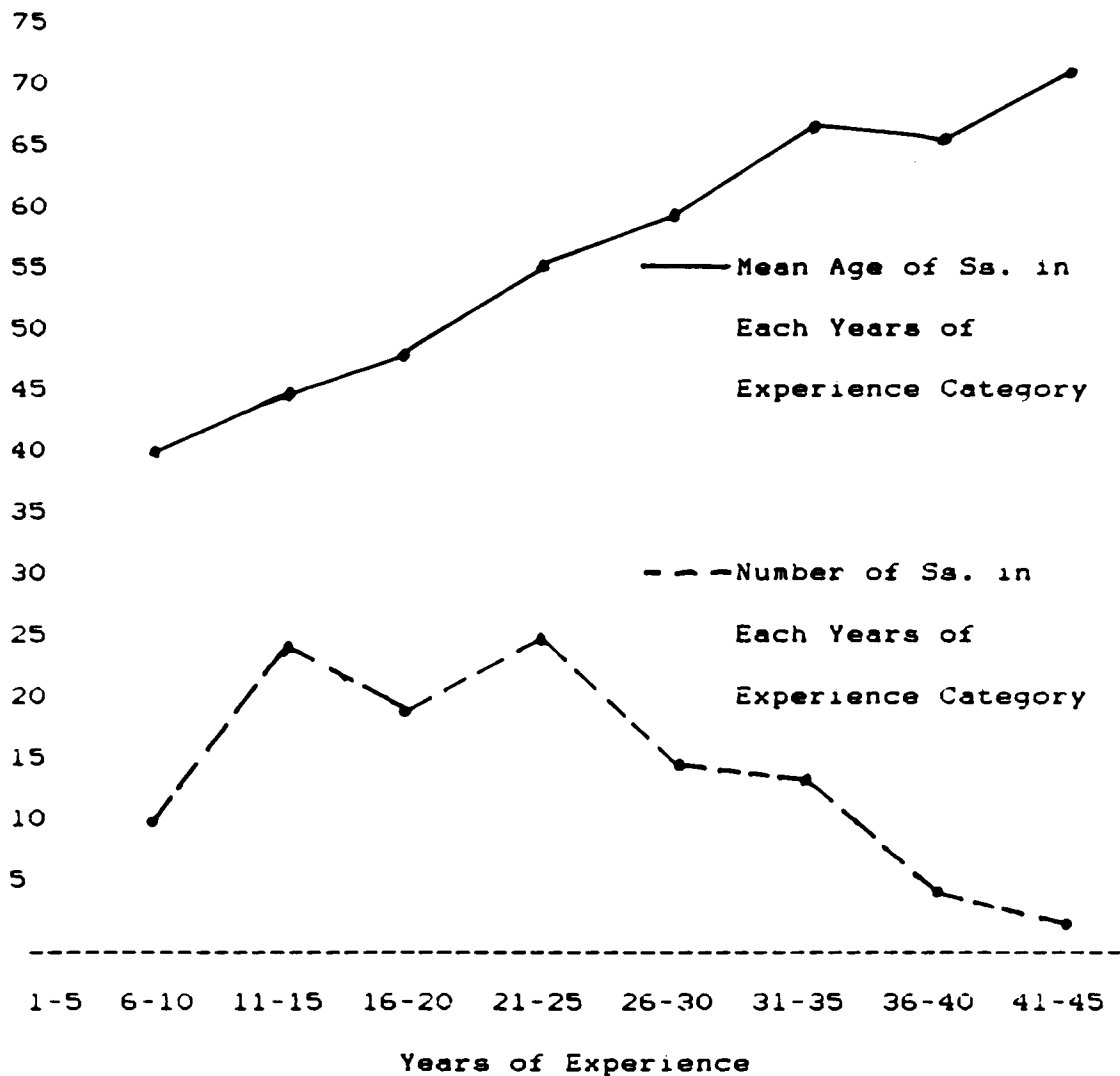
percentage of male subjects (47.2%) approximated the total percent of female subjects solicited (46.8%); the final percentage of female subjects (52.8%) approximated the total percentage of male subjects solicited (53.2%). The increased representation of female subjects and decreased representation of male subjects could possibly have indicated the increased or decreased concern the respective clinicians felt for the subject matter of the study and the materials sent to them. Judging from the subjects' comments and additionally, from their lack of comment, it did not appear that the subjects were aware (or even differentially aware) of the intent of the study. The mean age of the group was 52.6 years and the mean number of years of clinical practice was 22 years; therefore, the majority of these clinicians had received their doctoral degree and completed their psychoanalytic training before the publication of the studies of Broverman et al (1970) and Bea (1974).

The demographic data gathered from the questionnaire furnished evidence that this group of psychoanalytic psychologists was a mature, highly educated, well trained and clinically experienced group of people. Their professional practice was primarily in the New York city metropolitan area although there was a small representation from other major cities. Half of the

subjects received their doctoral degree from New York University and Columbia University while the other 50% received their degrees from 31 different graduate schools (including the Universities of Ottawa, London and Paris). The psychologists attended 24 different post-doctoral psychoanalytic training institutes (including Canadian Institute of Psychoanalysis, Tavistock and Hampstead) with the majority receiving their training in New York city. All the subjects were engaged in treatment as practitioners, supervisors and/or administrators. No subject was doing only one task: there were combinations of private practice (95.4%), supervision (51.0%), teaching (33.3%), administrative (17.6%), and employment by others (5.6%). Most people spent a major part of their time in self-employment (32.5%) while also employed by others (16.1%), engaging in research (8.2%), involved in post-doctoral training (7.3%), attending meetings and study groups (3.5%) and engaging in other activities such as writing (6.7%). The average number of hours per week that a practitioner spent doing individual therapy was 27.7% with 91.1% of their caseload being adults. Of these adult patients, 62% were females and 38% were males. The caseloads were predominantly female (i.e., 50.0% or more) with women practitioners treating more females than males to a disproportionate degree (98.2% female patients to

11.3% male patients). Male clinicians treated more females than males also, but not in the same imbalanced proportion (78.0% female patients to 58.0% male patients). This discrepancy can have important implications with regard to how male and female practitioners see male and/or female patients in relation to their perceptions of themselves. (This will be discussed in further detail in the section reviewing the self/other comparisons.) The psychoanalysts had been practicing for a range of 6-45 years with the greatest number (65 of 108, 60.2%) between 11-25 years. As expected, there was direct relationship between the mean age of the clinicians and their years of experience. This can be seen in Figure 1. As a group, these subjects did not see themselves as having strong religious beliefs but they did feel they had strong political beliefs with most persons seeing themselves as middle-of-the-road or liberal in their views. Their fathers' occupation fell within traditional lines. Of the 103 persons who answered this question, 64 (62.1%) had mothers who were homemakers while 39 (37.9%) had mothers who were employed. It is interesting that among the employed parents, 14 (35.9%) were professional women while only 32 (31.1%) of the fathers were professional men. Most often when people receive research requests in the mail, they throw them away; therefore, it was of interest to know why those who did

Figure 1



Distribution of Mean Age and Number of Subjects
for Each Years of Experience Category

respond did so. Of those persons who gave answers to this question, 61.2% felt empathy for this author's struggle to complete her doctoral degree and 41.6% identified with my current position. I believe that these are not unexpected responses from psychoanalysts, but it is with pleasure that I report that their comments gave me 'emotional refueling' and determination. So, in capsule form, these subjects are highly educated, highly trained and highly experienced. They came from traditional families, they see themselves as open-minded and concerned and their professional endeavors are reflective of the general psychotherapeutic community.

Although the Chi Square analysis of clinicians' sex-role preference for themselves did not exhibit any significant differences, it is interesting to note that the first choice of sex-role preference for both male and female subjects was the same as their gender (35.3% and 31.6% respectively). Eighteen males and 18 females (33.3% of total sample) saw themselves as sex-typed. Thirteen males and 14 females endorsed androgyny (25.2% of the male sample and 24.6% of the female sample; 25.0% of the total sample) but not to the same degree as those who chose the sex-typed gender stereotype. Cross-sex preference (19.6% for males and 19.3% for females) was the last choice for both groups. The subjects were primarily responding in a traditional way; one that was consonant with the demographic data.

Whereas these clinicians generally responded in a traditional manner for themselves, they were less traditional in their choice of sex-role preference for the target person. As a group, they selected androgyny as the sex-role preference of choice for a "healthy man." This was followed by the undifferentiated category, masculine and feminine respectively. Almost half of the female subjects choose androgyny for the "healthy man" while less than one third of the males made the same choice. Males choose the undifferentiated category to the same degree as they choose androgyny. Masculine was the last choice of male subjects and feminine was the last choice of female subjects for the "healthy man" target.

Androgyny and feminine were selected equally for the "healthy woman." However, the first choice for male subjects was feminine for this target (38.9%) and the first choice for female clinicians was masculine (38.9%). This was the last choice for male subjects (11.1%). For the "healthy man and woman" categories, it appeared that male clinicians were endorsing the feminine characteristics and female subjects were doing the opposite, i.e., endorsing the masculine characteristics. This is confirmed in the "healthy adult" category where again androgyny is the first choice of sex-role preference for all subjects with each gender group endorsing the cross-sex category to a greater

degree than they choose their same-sex category. In fact, the same-sex choice was least for each group (i.e., females choosing feminine and males choosing masculine). It is fascinating that the concept of sex-role congruity (Douvan & Adelson, 1976) would explain the choice that these subjects made for themselves, but it is not the model of choice when it came to choosing a sex-role preference for a target person. In this case the subjects made the androgyny model (Bem, 1974) the construct of choice. It also appeared that their first androgynous act was to choose the cross-sex-role category as preferable to their own gender sex-role description.

These sex-role preference categories were broken down further to examine the sex-role preference for the target by the sex-role preference for the subjects. This was examined separately for male and female subjects. Male subjects who saw themselves as sex-typed masculine, saw a "healthy man" and a "healthy adult" as undifferentiated but they saw a "healthy woman" as feminine. Female subjects who saw themselves as sex-typed feminine choose androgyny for a "healthy man, woman or adult." Traditionally feminine female clinicians had a more definite idea of their views, whereas the choice of undifferentiated by traditionally masculine male clinicians exhibited a similar although weaker response (i.e., androgyny above the median

and undifferentiated below the median). Both male and female clinicians who saw themselves as androgynous, saw the "healthy man" and the "healthy adult" as androgynous. They were less definite in their description for the "healthy woman" with males choosing the undifferentiated category and females equally choosing the androgynous, feminine, or masculine categories. Both sex-typed and androgynous subjects showed a trend to choose androgyny as the sex-role of choice for the target category. This was particularly true for the female subjects.

Chi square and Fisher's Exact tests were inappropriate for these data. However, since the demographic data indicated the assumption of normality and Shaw (1982) had devised a continuous scoring system for masculinity, femininity and androgyny, further analysis was done with student t-tests; two-tailed.

In the earlier Broverman, et al (1970), work, there were no differences in the male and female subjects' perceptions of the target person. Male and female clinicians agreed on the assignment of traditional sex-role stereotypes that existed at that time. Today they do not. In the current study, a difference was found in the "healthy adult" category. Female subjects had a stronger perception of masculinity for a "healthy adult" than did male subjects. There was also a trend ($p < .06$) for the

female subjects to have the same view for a "healthy woman." In most instances the mean scores for female subjects was higher than for male subjects; it appeared that the female subjects had a stronger feeling about the characteristics that constituted masculinity and femininity and thus, androgyny. In this regard, this finding was similar to the result in the work of Brooks-Gunn and Fisch (1980) in that there were differences in the perceptions of male and female subjects in how they rated the "healthy other."

This study, like the earlier Broverman, et al, (1970) work, found differences in male and female subjects' perceptions of a "healthy man" and a "healthy woman." Both groups of subjects ascribed a higher femininity score to a woman than a man. However, in this study, there was also a difference for male and female clinicians in their perception of femininity between a "healthy man" and a "healthy adult." An adult was perceived as more feminine than a man. Neither group of subjects saw any difference between a "healthy woman" and a "healthy adult." A "healthy man" is seen as different from a "healthy woman" and a "healthy adult." Now the "healthy adult" (i.e., sex unspecified; the 'ideal' model of mental health) is seen to be the same as a "healthy woman!" After 16 years, the pendulum has made a full swing and now it is the "healthy

man" who is in a double bind; catch-22!" For many years, women have expressed their dissatisfaction with their traditional life and career choices, but Canter (1984) has stated that now it was the man who was experiencing the feelings of pervasive discontent in not fitting society's expectations. If a person received positive feedback from society for her/his achieved (professional) role and her/his ascribed (sex-role) role there would not necessarily be any feeling of discontent but if a person received positive feedback from people for her/his achieved role and not for her/his sex-role then the person could experience feelings of cognitive dissonance. Festinger (1957) has stated that a person is likely to change her/his personal beliefs to match current attitudes. In the past, when women experienced this form of cognitive dissonance, they were able to turn to the Women's Movement as a reference group. This organization was able to validate the new feelings and perceptions of women and provide collective support for them. Unfortunately, at this time, men who have changed their current attitudes about sex-role preference are not able to avail themselves of such a supportive group and this could contribute to their generalized feelings of discontent. The data of this study confirm the shifting perceptions of the stereotyped sex-role preferences and by implication, their changing expectations.

The choice of psychologists who are practicing psychoanalysts as subjects for this research was made because of the findings of the APA Task Force on Sex Bias and Stereotyping of Women in Psychotherapeutic Practice (1975). If they were actively biased against women, one would not have expected to get the results obtained in this study. Yet, another way to explore bias was to investigate if these psychoanalysts saw the "healthy" other as they saw themselves. In other words, was the already analyzed person (the psychoanalyst) the model of mental health (the "healthy adult")? The comparisons between self and other for male clinicians did reveal that they saw the "healthy adult" as they saw themselves. Male psychoanalysts saw themselves as more feminine and androgynous than a man and more masculine and androgynous than a woman. This was not the case for female psychoanalysts. They too saw themselves as more feminine and androgynous than a man. But they saw themselves as more feminine than a woman and they saw a "healthy woman" as more masculine than themselves. In addition, they saw themselves as more feminine than a "healthy adult." Thus it appeared for female psychoanalysts, that they saw a "healthy woman" and a "healthy adult" similarly (as they did in the direct comparison of woman/adult) but they saw a difference between themselves and a "healthy woman" and themselves and

a "healthy adult." They appeared to define an 'ideal' model of mental health that they did not subscribe to themselves. Their 'ideal' was more masculine and less feminine than they were. These two findings have importance implications for the therapeutic dyad because as Hans Strupp (cited by Chance, 1986) has stated, "...progress in psychotherapy depends more upon the relationship between therapist and client than it does upon the therapists' technical skill." (pg. 72). If male psychoanalysts perceive themselves as the 'ideal', this could be restrictive for their patients in that the clinician could expect the "healthy" other to become like himself. Almost fifty years ago, Schildeberg (1938) stated; "It is gratifying to the analyst if the patient as a result of analysis not only gets rid of his symptoms but advances in his whole development. One should not be too ambitious for him and above all not judge him by one's own standards. He should live his own life and conform to his own ideals and not those of the analyst. The best result that one can expect from psychoanalysis is for the patient to become just like anyone else" (pg. 141-42). (It is assumed that the 'him' is used editorially and the remarks are equally applicable to women.) This statement would be relevant to other forms of psychotherapy also. The perception by the male analysts in this study of seeing the "healthy adult"

as they see themselves could be problematic for either gender and could be considered bias against both male and female patients. The female psychoanalyst, in all likelihood, is giving out another message; one that suggests that the patient need not be like her. In this case, a patient of either gender may find the therapeutic relationship with a female analyst to be more flexible and the possibility for growth and self-actualization more likely. Furthermore, there may be countertransference issues that are connected to these results. Male psychoanalysts could possibly feel conflict within themselves regarding their feelings of perceiving themselves as more feminine and androgynous than their male patients, more masculine and androgynous than their female patients and expecting the "healthy adult" (sex unspecified) to be like himself. Female psychoanalysts, on the other hand, may have conflict about femininity issues with their male and female patients. They could possibly be envious of the new found freedom from sex-role stereotypes (to be less feminine and more masculine) that would be exhibited by their female patients. These are important concerns because, as the demographic data shows, more women than men are a part of the patient population and more female psychoanalysts have a caseload that is primarily female. It is also of concern for male

psychoanalysts because they see in treatment a large percentage of the male patients and may have the restrictive expectation of the "healthy adult" being like himself. In 1979, Kelly and Kiersky (cited by Denmark, 1980) presented a study of clinicians' judgements of in-role and out-of-role behavior of male and female psychotherapy patients. They found that male clinicians evaluated deviant (i.e., out-of-role) behavior of male patients more harshly than the deviant behavior of female patients. Female clinicians were less likely to adhere to a sex-role stereotype when evaluating in-role or out-of-role behavior. Since the male analyst in this study saw himself as similar to a "healthy adult" and if the male patient were to be like the male psychoanalysts (i.e., more feminine and androgynous than the "healthy man" and more masculine and androgynous than the "healthy woman") then the male patient may find himself being judged harshly by others for out-of-role behavior. On the other hand, if the male patient was different from the male analyst (i.e., the patient being more masculine and less feminine and androgynous than the analyst) he may be judged harshly by his psychoanalyst for deviating from the 'ideal' model of mental health (the "healthy adult" and the analyst). Conversely, there are other plausible explanations for the male analyst seeing himself as similar to the "healthy

adult." These days it is not socially acceptable to express sexist or biased views publicly. If this proscription holds for the general public, it certainly would be applicable to the mental health community. Therefore, the male analyst may be responding accordingly by seeing himself as similar to the "healthy adult" who is seen by all subjects to be similar to the "healthy woman." It could also show a sensitivity to feminist concerns. In fact, the male analyst may truly be in touch with the feminine aspects of his personality structure. This last explanation is compelling because the male analysts did see themselves as more masculine and androgynous than a "healthy woman," more feminine and androgynous than a "healthy man" and the same as the "healthy adult." Female psychoanalysts in this study, as in the 1979 work of Kelly and Kiersky (cited in Denmark, 1980), were not influenced by sex-role stereotypes. For female patients, their message from the female psychoanalyst was don't be like me; be less feminine and more masculine than I am. For male patients, their message was more traditional in that the "healthy man" should be more masculine and less feminine and androgynous than they were. Male and female psychoanalysts may both be tolerant to alternate forms of behavior and choices but from different perspectives. However, the male analyst would have to be particularly

sensitive not to expect the "healthy other" to be like himself because he (the analyst) is the model of mental health.

A major criticism of the Broverman, et al, (1970) study was that there was no analysis of the individual personality characteristics of the scale on which they found significant differences. There was no way of knowing the degree of difference that subjects found for each characteristic because they were asked to choose a pole on the masculine- feminine continuum and indicate towards which extreme the target person would be closer. It was an 'either/or' choice. Since the BSRI uses a Likert scale, it was possible to examine the individual differences on each characteristic for self, the target person, man/woman, man/adult, woman/adult, self/man, self/woman and self/adult.

Interestingly, in the self category, male subjects differed from female subjects in how they saw themselves on only one characteristic: masculine. Female subjects saw themselves as more feminine, sympathetic and compassionate than male subjects. Female subjects saw a "healthy man" as more flatterable, likable and having leadership abilities than did male subjects. Female subjects also saw a "healthy adult" as more feminine, self-reliant, independent and assertive than did male subjects. In the "healthy

woman" category, female subjects to a greater extent than male subjects saw a woman as more independent, self-sufficient, willing to take a stand and act as a leader. Male subjects saw a "healthy woman" in a more traditional manner; as more flatterable, soft-spoken, gullible, loves children, gentle and conventional. Thus, male subjects are still subscribing to the traditional stereotype for women whereas female subjects are seeing the woman and the adult in a newer more active and androgynous description.

This conservatism for male subjects was evident in the comparisons of the scale items for man/woman and woman/adult, but the man/adult comparison was slightly different. Male subjects perceived a man to be more dominant and masculine than a woman. These were the only two characteristics from the masculine scale on which there was a difference. The other 13 differences were on the feminine and neutral scale with the woman score being higher than the man in all cases. Of the five differences in the woman/adult comparison, only one masculine characteristic, masculine, was higher for an adult than a woman. In the man/adult comparison, masculine was also the only difference found with the man being perceived as more masculine than the adult. The other 13 differences were in the other direction; the adult was higher on them than

the man. Male subjects primarily differentiated the target on the basis of the feminine characteristics. This was so mostly in the man/woman and man/adult categories. However, it must be remembered that all subjects (males and females) saw no difference between a "healthy woman" and a "healthy adult." The direction of difference for male subjects substantiated this finding.

Female subjects concurred with their male colleagues in the differences found on the scale items for all three comparisons (man/woman, woman/adult and man/adult). But, even though the direction of difference was the same for male and female subjects, the female subjects perceived differences on more characteristics (primarily the masculine ones) than did the male subjects. The only characteristics that the female subjects saw as higher for a man than a woman were athletic, masculine (both from the masculine scale) and conventional (neutral (-) scale). Athletic and masculine were items of difference in the woman/adult comparison; thus, it seemed to imply that female subjects may be perceiving the adult as a man. However, there was no difference in the direct comparison of the woman/adult category and there was a significant difference between the man/adult category.

There were 9 characteristics from the masculine, feminine and neutral scales on which male and female

subjects agreed in their perception of difference for the three comparisons; man/woman, woman/adult and man/adult. Only the characteristics masculine and feminine overlapped all three categories.

An item analysis for the scale characteristics was conducted for the self/man, self/woman and self/adult categories for male and female subjects. For male subjects, there were 21 characteristics on which they saw a difference between themselves and a man. Male subjects perceived a man as more aggressive than themselves. On the 20 other items, they saw themselves as different from the man. This included three masculine, 11 feminine and six neutral (all +) scale items. They saw themselves as more feminine and androgynous than a man and this is exhibited in the numerous feminine characteristics in which there was difference.

There were nine items on which there was a difference between themselves and a woman and of these only feminine was seen as greater for a woman than themselves.

Male subjects saw no difference between themselves and a "healthy adult" on the masculinity, femininity and androgyny score but they did see many differences between themselves and the "healthy adult" on the specific characteristics. The adult was seen as higher than themselves on only four items: makes decisions easily

(masculine scale), feminine (feminine scale) and adaptable (neutral (-) scale) and happy (neutral (+) scale) but on 13 others they rated themselves higher than the adult. It is of interest that five of the neutral scale items on which men rated themselves higher were negative ones (i.e., moody, theatrical, jealous, secretive and conceited).

For female subjects, a similar pattern to the male subjects was exhibited between themselves and a "healthy man." There were difference found on 22 characteristics. A "healthy man" was seen as more assertive, forceful and masculine (masculine scale) and conceited (neutral (-) scale). On the 18 other characteristics they rated themselves higher than the "healthy man."

There were 12 items for which female subjects saw a difference between themselves and a "healthy woman." Seven of them were perceived as the woman higher than themselves and five were perceived as themselves higher than the woman. Female subjects saw a difference between self and woman on masculinity (woman greater than self) and femininity (self greater than woman) and, again, the item analysis substantiated the direct comparisons of each group. In the neutral category the woman was seen a higher on two items: theatrical and conceited (both -).

Female subjects saw a difference on femininity in the self/adult comparison with themselves as more feminine

than an adult. In the item analysis, female subjects saw the adult as higher on athletic, makes decisions easily and masculine (all masculine scale).

For male and female subjects in the self/other comparisons, there was agreement on 14 items and on the direction of the differences that were found. It is of particular interest, that it was only in the self/woman comparison that male and female subjects agreed that a woman was more feminine than they were. They did not agree on femininity in the other two comparison nor on masculinity in any category. In all three categories, both male and female subjects saw themselves as more analytical and conscientious. This is not surprising because they are psychoanalysts who, by the nature of their particular psychotherapeutic orientation, are expected to be analytical and conscientious.

It was not the intent of this study to make a detailed analysis of the characteristics of the BSRI with the purpose of improving the scale. No doubt that could be done but this author has left that task to someone else. The following aspects of the findings are interesting and could prove to be valuable areas of additional research: the items on which a difference was found, the direction of the differences, which subjects saw a difference and the cluster of attributes that subjects saw as describing

themselves or the "healthy other." Many of the items on the masculine, feminine and neutral scales are those that would describe the professional characteristics of mental health practitioners. In the case of this study, they are as much descriptors of the psychotherapeutic (i.e., psychoanalytic) profession as they are related to sex-role preference.

Additional t-tests were conducted on demographic information such as age, graduation date of doctoral and analytic program, years of clinical experience, orientation of self and institute mother's occupation and membership in APA's Division 35. It was felt that there could be differences between those who were older and younger, those who graduated before and after the publication of the Broverman, et al, (1970) and Bem (1974) studies, those whose mothers were employed versus those whose mothers were homemakers, orientation of self and institute (psychoanalytic versus interpersonal) and membership in APA's Division 35 (Psychology of Women). No differences were found in any of these comparisons. The lack of difference between the subjects on any of the demographic data examined lent credibility to the fact that this group of psychoanalytic psychologists was a homogeneous sample as far as their background, training and experience was concerned.

REVIEW_OF_PSYCHOANALYSTS'_PERCEPTIONS

The purpose of this study was to investigate psychoanalysts' perceptions of their stereotypic sex-role preference for a "healthy man, woman or adult" and their sex-role preference for themselves. Five areas of concern were raised and explored in reference to this purpose.

AREA_____1--How did male and female psychoanalytic psychologists rate a "healthy man, woman or adult" (sex unspecified) on the BSRI? Which model of mental health (i.e., a gender sex-typed model, a masculine model or an androgynous model) would be endorsed by these clinicians for a "healthy man, woman or adult?" Did male and female psychoanalysts concur or differ in their perceptions of a "healthy man, woman or adult?"

For a "healthy man," male clinicians equally choose androgyny or undifferentiated as the sex-role of preference while female clinicians choose androgyny as the sex-role of preference. In total, androgyny was the primary preference of all subjects.

For a "healthy woman," male subjects perceived the stereotypic sex-role preference as feminine and female

subjects chose masculinity as the sex-role preference of choice. As a group, they chose androgyny and femininity equally.

For a "healthy adult," male and female clinicians subscribed to androgyny as the sex-role preference of choice.

When the separate means for masculinity, femininity and androgyny were examined in each category, male and female subjects did not differ from each other in their perceptions of a "healthy man" and a "healthy woman." However, male and female subjects did differ from one another in their perception of masculinity for a "healthy adult." Female clinicians gave a "healthy adult" a higher masculinity rating than did male subjects. In this study, as in the one by Brooks-Gunn and Fisch (1980), male and female subjects did not concur in their perception and rating of the healthy target as they had done in the Broverman, et al, (1970) work. Therefore further analysis of the data had to be conducted separately for male and female subjects.

The comparison of man/woman, man/adult and woman/adult was conducted for male and female subjects. Both male and female subjects saw a difference in the man/woman and man/adult comparisons but both groups of subjects did not perceive any difference in the woman/adult

comparison. This study was similar to the Broverman, et al, (1970) one in that male and female practitioners saw a significant difference between a man and a woman. However, it differed from the earlier work in that both male and female psychologists saw a significant difference between a man and an adult but not any difference between a woman and an adult. In 1986, a man is caught in a double bind; just as the woman was sixteen years ago. If a man subscribed to the sex-role of a "healthy man" he would be seen as deviant from the "healthy adult" model and if he saw himself as a "healthy adult," he would be perceived as similar to the "healthy woman" and deviant from his own gender sex-role model. In accordance with the findings of Kelly and Kiersky (cited in Denmark, 1980) that a male may be judged harshly for out-of-role behavior, it could be psychologically and emotionally costly for a man to subscribe to the "healthy adult" or "healthy man" model. He would now experience the double-bind that women have consistently experienced.

AREA_2--What was the personal sex-role preference of the male and female clinicians on the BSRI?

Thirty-six male and female psychoanalysts (i.e., 33.3% of the total sample) chose their same gender sex-role

for themselves: males perceived themselves as masculine while females saw themselves as feminine. A gender based sex-role preference for males and females would have been predicted from psychoanalytic theory as suggested by Freud in his 1925 paper. Twenty-seven male and female psychoanalysts (i.e., 25.0% of the total sample) chose an androgynous sex-role preference for themselves. An androgynous sex-role preference by these subjects would have been predicted from Freud's 1937 paper expanding sexual identity theory by including the "bisexual" nature of the human being. There were no significant differences between male and female clinicians in their choice of the masculine, feminine, androgynous or undifferentiated categories.

AREA__3--Was there a relationship between how male and female psychoanalytic psychologists rated a "healthy man, woman or adult" and how they perceived themselves?

It could be predicted from Freud's earlier paper that sex-typed men and women would see the "healthy man" and "healthy woman" in the traditional sex-typed manner. Sex-typed male subjects saw the "healthy man" as undifferentiated but they did see the "healthy woman" as feminine. Sex-typed female subjects saw a "healthy man,

woman and adult" as androgynous. From Freud's later paper, it could be predicted that androgynous men and women would see the the "healthy man" and "healthy woman" as androgynous also. This prediction held true for female psychoanalysts in all three categories. Androgynous male subjects saw a "healthy man" as androgynous or feminine, a "healthy woman" as undifferentiated and a "healthy adult" as androgynous. It seemed that this later theory was more predictive for female subjects than male subjects. An androgynous sex-role preference was the first choice in all target categories for sex-typed and androgynous female subjects.

Male subjects saw differences between themselves and a "healthy man" and between themselves and a "healthy woman." However, they did not see any difference between themselves and a "healthy adult." This was not the case for female clinicians. They saw differences between themselves and the "healthy man, woman and adult." It appeared that the male analysts were seeing the 'ideal', the "healthy adult" as they saw themselves. Female analysts, on the other hand, were perceiving an 'ideal', one that was more masculine and less feminine than themselves but it was not a model they ascribed to themselves. This finding has important implications for outcome goals, transference and countertransference in the therapeutic dyad.

AREA__4--What, if any, were the demographic characteristics that may have contributed to the current findings?

There were no differences found in any of the comparisons of the demographic data. This sample was well educated, highly trained and had many years of clinical experience. They were a mature group of people who were rather conventional in their political and social orientation. They did not appear to be aware of the fact that this was a variation on a theme of a prior study; therefore, it was not likely that subject recognition influenced the results obtained.

AREA__5--In a general way, did the results of this 1986 study relate to the Broverman, et al, (1970) findings?

If one asked today if there was a stereotyped perception of a "healthy man, woman or adult," the answer would be, yes there is but it has changed since 1970 when that question was asked originally. In 1986, a stereotype of a "healthy man, woman and adult" still exists but now, it was the "healthy man" who was caught in 'catch-22.' He was seen as different from a woman and different from an adult. Thus, he was perceived as deviant from his gender sex-role or from the adult model. This was the way a woman was seen in 1970.

In more specific ways, this study is not comparable to the prior work in that the assessment measure used was not in existence in 1970 and thus, sex-role preference was only seen as an either/or choice of masculine or feminine. The BSRI used in this study permitted subjects to view masculinity and femininity as orthogonal choices, thereby being able to chose masculine, feminine, androgyny or undifferentiated as a sex-role preference. Since the prior work did not use a graded choice response scale, it was impossible to ascertain the degree of difference on any particular characteristic. This time an item analysis of the differences for the characteristics of the scale was conducted so that now it was possible to know not only on which items subjects saw differences but if those differences were statistically significant. The BSRI was given to each subject to fill out for the target person and for themselves. Therefore, it was possible to see if there was a connection between how the clinicians saw themselves and how they saw the other. This was not done in the earlier study. Finally, there were differences in the subject pool in this study which did not exist in the prior one. Firstly, male and female subjects did not agree on how they perceived a "healthy adult." In the Broverman, et al, (1970) work, the male and female subjects did agree on how they saw all the target

persons. Additionally, whereas the 1970 work included a varied mental health spectrum of clinicians, this study was composed of only Ph.D. or Ed.D. psychologists who had experienced additional years of psychoanalytic training. The current sample was older, more highly educated and professionally experienced than the prior one.

So, the underlying question was the same but the methodological particulars and results were different; a variation on a theme by Broverman, et al, (1970).

COMMENTS_OF_RESPONDENTS

The demographic questionnaire had space for comments if the respondent so desired. Approximately a dozen people took the opportunity to share their thoughts with me and their comments went directly to the major conceptual issue of the study; stereotypes.

"...there is a great variety of normal and there is no way to express this. I have no problem with stereotypes but it leaves out the complex attitudes people have about these matters."

"...difficulty answering because of the wide range of normal. I would have diverse responses dependent upon who I was thinking about."

"I spent 30 years learning that terms and concepts like normal, mature, healthy and socially competent are pejorative value judgements."

"...I feel there is a wide range of possible answers to most of these items that could describe a mature adult--there is no single profile of maturity that people need to conform to in order to be described that way by me or most psychologists."

The above comments indicated that some people were willing to elucidate their difficulties with the request to stereotype a target person. That was understandable in this time of heightened awareness of gender, racial and ethnic sensitivity to bias. However, stereotyping is a necessary cognitive process to organize, retain and retrieve information in and from memory and is most likely

to occur when generic groups are rated and least likely to occur when specific individuals are rated.

Another person who was in the "healthy adult" category and did not complete the forms displayed his ambivalence about stereotyping in the following manner.

"I do not conceptualize one model of a mature, socially competent adult, but several, thus the rating would vary considerably depending on which model used. Also I believe gender is another significant factor in the description of healthy people, which is not addressed in your question."
(my emphasis).

His comments are an example of the type of countertransference issues that some clinicians experience and the type of sex-role bias that some patients must endure. This would affect both males and females but the impact would be more significant for females as they are the greater number in the patient population.

Another respondent expressed difficulty in knowing if the terms "masculine" and "feminine" referred to gender or the qualities thereof. This is one of the problematic issues with the BSRI. Gaudreau (1977) found four factors

from the BSRI: masculinity, femininity, gender and maturity. "Masculine," "feminine" and "athletic" were highly correlated with gender (male/female) rather than with masculinity or femininity. This makes differences on these three items difficult to interpret. In addition, there is always the inaccurate assumption that these terms are synonyms for each other (male, masculine, masculinity; female, feminine, femininity). They are not.

A few female subjects in the "healthy woman" category made the assumption that the study was "dealing with women's issues" or were curious "what was my interest in professional women." These comments may have been elicited by the instruction on the scale or they may be saying more about the respondent than the study (i.e. they were professional women). It was not believed that this assumption influenced their responses in any systematic manner.

One subject mentioned that "she enjoyed my sense of humor but that characteristic, humor, was not on the scale." Firstly, I cannot imagine what I said that she took to be humorous for dissertations are not usually funny! But her suggestion for the inclusion of humor on the BSRI is relevant and interesting for future research by those others who would be interested in test construction.

METHODOLOGICAL_ISSUES

There are some methodological issues that may have contributed to the different findings of this study in comparison to the Broverman, et al, (1970).

Whitely (1979) suggested that the use of the newer androgyny scales (i.e. BSRI) may elicit different results than those found by the Broverman group. This suggestion was substantiated in this study and it is very possible that, in addition to the androgyny measure, the more flexible choice of a Likert scale used in its scoring also contributed to the results.

The subjects in this study were older than the earlier sample. Nash & Feldman (1981) found that men and women take on the personality characteristics of the opposite gender as they proceed through the life cycle. This is not exhibited by young adults but is by mature persons. The mean age of this sample was 52.6 years; certainly an age that would be considered part of a mature group.

It has been sixteen years since the original research was published and the people in this country have gone through many changes due to the Women's Movement, the advances in technology and basic economic conditions. It

would be hard to believe that perceptions of self and other had not changed also. Most of the results found in this study are encouraging for women, but leave something to be desired for men.

The sample size was not large enough to conduct a Chi Square analysis of the comparison of sex-role preference for self versus the sex-role preference for the target person. Therefore, the data had to be discussed in percentages. A very much larger sample would have made this type of statistical analysis possible. The sample was not drawn randomly from the total population of practitioners who were psychoanalytically trained psychologists. The sample was solicited by mail and could be influenced by the self-selection process of the respondents. The likelihood of a biased self-selection is a clear possibility; however, since the sample appeared to fit a normal curve for age and years of experience, it was assumed that the group did, in fact, reflect the total solicited population of psychoanalytic psychologists.

A question could be raised about asking the clinicians to fill out the same androgyny measure for themselves and for the target person. Optimally, it would have been best to use different measures but then the direct comparison between self and other would have become problematic because the BSRI and the other androgyny scales

do not necessarily have equivalent dimensions. The presentation of the BSRI scale for self and other was counterbalanced for male and female subjects within each category ("healthy man, woman or adult").

It was impossible to know if the mailing was sent to the subjects' homes or offices and therefore it was unknown in what location the subjects filled out the forms. The mind-set of the subjects could have influenced their responses. This is of particular importance for the females in the study since traditionally they are more likely to see themselves in multiple roles.

RECOMMENDATIONS FOR FUTURE RESEARCH

Because location could possibly have influenced the subjects' responses, it would be relevant to control for location in future research by sending all material to the subjects' offices. Certainly it would be a logical question to include in a demographic form and then see if this element made any difference in the subjects' perceptions.

The BSRI, like many personality measurement instruments, could be improved by updating and altering the

selection of characteristics in the masculine, feminine and neutral scales. (For example, as one respondent suggested by the inclusion of "sense of humor.") The BSRI was created by asking thousands of college students to determine if particular characteristics were masculine, feminine or neutral (positive or negative). It would be interesting to replicate this procedure to see if the characteristics chosen now for each scale would be the same or different from the ones that were chosen in 1974. It is very possible that the dimensions of androgyny, masculinity and femininity are still conceptually valid but the characteristics that define these dimensions have changed. If the personality characteristics of the individual scales were different, would that change the findings of a study such as this one?

This particular study could be replicated with another androgyny measure (eg. Personality Attributes Questionnaire by Spence, et al, 1975). If the results were the same, that would help substantiate the validity of the current findings. It would be equally interesting to replicate the study with a practitioner sample of a different orientation (eg. behavioral psychologists) which would add to the reliability of the findings.

One of the major concerns of this study was to investigate the possibilities of subjects seeing the

"healthy other" (eg. especially the "healthy adult," the 'ideal' model of mental health) as they saw themselves. Male clinicians did see the "healthy adult" as they saw themselves; female clinicians did not. To ascertain if this similarity of perception was perceived as growth enhancing or restrictive (bias) one would have to ask the patient population of the subjects involved. In all likelihood the psychoanalyst would see this type of intrusion during the course of therapy as a pollution of the transference and not be willing to entertain this type of research. It is possible, however, that they would be willing to participate in follow-up research after the completion of treatment. If that was a possibility, then investigation of post-analytic patient/analyst perceptions of self and other may yield some insight into just how similar the perceptions of the individuals in the dyads were. It must be remembered that at the conclusion of a lengthy analysis, the patient has identified with and internalized many aspects of the psychoanalyst and may not perceive similarity as bias. Nonetheless, this is a fertile area for future research.

In this study, male and female clinicians did not agree in their perception of a "healthy adult" nor did they agree in their perception of self/"healthy adult." They did concur in their perception that a "healthy woman" was

similar to a "healthy adult." These differences between the subjects could influence the therapeutic relationship of same-sex and cross-sex dyads. This, too, is an interesting area for future research but more importantly, it is an area that should be part of a practitioner's graduate and professional training. There are many papers in the psychological and psychoanalytic literature that emphasize the importance of gender (biological sex) on transference and countertransference issues in same-sex and cross-sex therapeutic dyads (Felton, 1986; Meyers, 1986; Mogul, 1982; Persons, 1986; Tower, 1956). However, there is not the equivalent attention paid to the importance of sex-role preference in these same relationships. The understanding of the nature and function of sex-roles from a developmental perspective could be a very salient component of a practitioner's education and would sensitize the clinician to changing expectations and goals that women and men are experiencing these days in both their personal and professional lives.

A few final words. I find some personal satisfaction that now a woman has been released from 'catch-22' and is perceived similarly to an adult. Being a woman, I knew it all the time. I told a colleague of these

results and her response was, "Good. That's the way it should be." I agreed, but now that I've been living with this work for many months, I have become disturbed that presently a man is perceived in the same double bind that a woman has been up until recently. In addition, I have some question about psychological androgyny being endorsed as a model of mental health. To strive for an androgynous orientation towards the world may be more restrictive than gender congruent sex-roles; in fact, it may be twice as oppressive! If we, as women and men, males and females, could feel free within ourselves with our own masculinity and femininity so that we could tolerate and appreciate our similarities and differences, then I would feel that we have approached the best of all worlds.

Appendix A

November, 1985

Dear Prospective Participant,

I am preparing my doctoral dissertation in the psychology department of the Graduate Center of the City University of New York. I am sending this packet of forms to you with the hope that you will be willing to give approximately twenty minutes of your time in helping me complete this task. If you choose to be a participant, your completion of the forms will be considered an acknowledgement of consent and therefore, no formal consent sheet need be signed. These forms are coded but it is for assignment purposes only. In this way, your anonymity will be protected.

The study is straight-forward in that I am interested in knowing your perception of how particular personality characteristics pertain to you and your thoughts of how these characteristics pertain to others. Please complete the forms in the order in which they are presented to you and then, mail them to me in the stamped envelope provided.

My sincere thanks for assisting me in the completion of this seemingly endless task.

Sincerely,



Louisa Katz

Appendix B1

Think of yourself and then indicate for each item the number that would most accurately describe your perception of yourself. Please answer every item. DO NOT LEAVE ANY BLANKS.

1	2	3	4	5	6	7
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE	OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE
Self-reliant		Reliable		Warn		
Yielding		Analytical		Solemn		
Helpful		Sympathetic		Willing to take a stand		
Defends own beliefs		Jealous		Tender		
Cheerful		Has leadership abilities		Friendly		
Moody		Sensitive to the needs of others		Aggressive		
Independent		Truthful		Gullible		
Shy		Willing to take risks		Inefficient		
Conscientious		Understanding		Acts as a leader		
Athletic		Secretive		Childlike		
Affectionate		Makes decisions easily		Adaptable		
Theatrical		Compassionate		Individualistic		
Assertive		Sincere		Does not use harsh language		
Flatterable		Self-sufficient		Unsystematic		
Happy		Eager to soothe hurt feelings		Competitive		
Strong personality		Conceited		Loves children		
Loyal		Dominant		Tactful		
Unpredictable		Soft-spoken		Ambitious		
Forceful		Likable		Gentle		
Feminine		Masculine		Conventional		

Appendix B2

Think of normal, adult men and then indicate for each item the number that would most accurately describe a mature, healthy, socially competent adult man. Please answer every item. DO NOT LEAVE ANY BLANKS.

1	2	3	4	5	6	7
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE	OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE
Self-reliant____		Reliable____		Warn____		
Yielding____		Analytical____		Solemn____		
Helpful____		Sympathetic____		Willing to take a stand____		
Defends own beliefs____		Jealous____		Tender____		
Cheerful____		Has leadership abilities____		Friendly____		
Moody____		Sensitive to the needs of others____		Aggressive____		
Independent____		Truthful____		Gullible____		
Shy____		Willing to take risks____		Inefficient____		
Conscientious____		Understanding____		Acts as a leader____		
Athletic____		Secretive____		Childlike____		
Affectionate____		Makes decisions easily____		Adeptable____		
Theatrical____		Compassionate____		Individualistic____		
Assertive____		Sincere____		Does not use harsh language____		
Flatterable____		Self-sufficient____		Unsystematic____		
Happy____		Eager to soothe hurt feelings____		Competitive____		
Strong personality____		Conceited____		Loves children____		
Loyal____		Dominant____		Tactful____		
Unpredictable____		Soft-spoken____		Ambitious____		
Forceful____		Likable____		Gentle____		
Feminine____		Masculine____		Conventional____		

Appendix B3

Think of normal, adult women and then indicate for each item the number that would most accurately describe a mature, healthy, socially competent adult woman. Please answer every item. DO NOT LEAVE ANY BLANKS.

1	2	3	4	5	6	7
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE	OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE
Self-reliant____		Reliable____		Wary____		
Yielding____		Analytical____		Solemn____		
Helpful____		Sympathetic____		Willing to take a stand____		
Defends own beliefs____		Jealous____		Tender____		
Cheerful____		Has leadership abilities____		Friendly____		
Moody____		Sensitive to the needs of others____		Aggressive____		
Independent____		Truthful____		Gullible____		
Shy____		Willing to take risks____		Inefficient____		
Conscientious____		Understanding____		Acts as a leader____		
Athletic____		Secretive____		Childlike____		
Affectionate____		Makes decisions easily____		Adaptable____		
Theatrical____		Compassionate____		Individualistic____		
Assertive____		Sincere____		Does not use harsh language____		
Flatterable____		Self-sufficient____		Unsystematic____		
Happy____		Eager to soothe hurt feelings____		Competitive____		
Strong personality____		Conceited____		Loves children____		
Loyal____		Dominant____		Tactful____		
Unpredictable____		Soft-spoken____		Ambitious____		
Forceful____		Likable____		Gentle____		
Feminine____		Masculine____		Conventional____		

Appendix B4

Think of normal adults and then indicate for each item the number that would most accurately describe a mature, healthy, socially competent adult. Please answer every item. DO NOT LEAVE ANY BLANKS.

1	2	3	4	5	6	7
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE	OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE
Self-reliant____		Reliable____		Warn____		
Yielding____		Analytical____		Solemn____		
Helpful____		Sympathetic____		Willing to take a stand____		
Defends own beliefs____		Jealous____		Tender____		
Cheerful____		Has leadership abilities____		Friendly____		
Moody____		Sensitive to the needs of others____		Aggressive____		
Independent____		Truthful____		Gullible____		
Shy____		Willing to take risks____		Inefficient____		
Conscientious____		Understanding____		Acts as a leader____		
Athletic____		Secretive____		Childlike____		
Affectionate____		Makes decisions easily____		Adaptable____		
Theatrical____		Compassionate____		Individualistic____		
Assertive____		Sincere____		Does not use harsh language____		
Flatterable____		Self-sufficient____		Unsystematic____		
Happy____		Eager to soothe hurt feelings____		Competitive____		
Strong personality____		Conceited____		Loves children____		
Loyal____		Dominant____		Tactful____		
Unpredictable____		Soft-spoken____		Ambitious____		
Forceful____		Likable____		Gentle____		
Feminine____		Masculine____		Conventional____		

Appendix C

PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS. IF A QUESTION DOES NOT PERTAIN TO YOU, PLEASE MARK IT N/A (NOT APPLICABLE). THANK YOU FOR YOUR COOPERATION.

1. Sex _____
2. Age _____
3. Marital status (check one)
married _____
single (never married) _____
single (spouse deceased) _____
single (divorced or separated) _____
4. City/Town and State of
professional practice _____
5. Discipline of practice
Psychology _____
Psychiatry _____
Social Work _____
Nursing _____
Other (please specify) _____
6. Highest earned degree (Please check appropriate degree
by giving the year it was attained.)
PH.D. _____
Psy.D. _____
Ed.D. _____
M.D. _____
M.S.W. _____
B.A. _____
B.S. _____
M.S.N. _____
B.S.N. _____
R.N. _____
other (please specify degree and year attained) _____
7. Degree granting institution: Name and location
(City/State) _____

8. Postgraduate training, if any (please specify)

Number of years attended _____ (from _____ to _____)
Location (City/State) _____
Training institute's orientation towards
psychotherapy _____

9. Number of years of clinical experience _____
10. Are you currently engaged in clinical practice?
 Yes _____
 No _____
11. Current employment (please be specific and brief) _____

12. Approximate hours per week spent at the following tasks:
 Employed by others _____
 Self-employed _____
 Research _____
 Postdoctoral training _____
 Meetings and/or study groups _____
 Other (please specify) _____
13. Approximate hours per week spent doing the following:
 Individual therapy _____
 Couple therapy _____
 Family therapy _____
 Group therapy _____
 Supervision _____
 As the supervisor _____ as the supervisee _____
14. Does your caseload include:
- | | age range | percentage of caseload |
|-------------|-----------|------------------------|
| Children | _____ | _____ |
| Adolescents | _____ | _____ |
| Adults | _____ | _____ |
15. Please give approximate percentage of males and females you are currently treating.
 Males _____
 Females _____
16. What is the psychological orientation of your psychotherapeutic work?
 Psychoanalytic _____
 Psychodynamic _____
 Behavioral _____
 Cognitive-behavioral _____
 other (please specify) _____

17. Are you a member of the American Psychological Association?
 Yes _____ No _____
 To which divisions do you belong? _____

18. How many years have you been actively practicing psychotherapy?

- | | |
|-------------------|------------------------|
| 1-5 years _____ | 36-40 years _____ |
| 6-10 years _____ | 41-45 years _____ |
| 11-15 years _____ | 46-50 years _____ |
| 16-20 years _____ | 51-55 years _____ |
| 21-25 years _____ | 56-60 years _____ |
| 26-30 years _____ | more! (how many) _____ |
| 31-35 years _____ | |

19. Why did you choose your current profession? (Please be specific and brief) _____

20. Would you describe yourself as having a strong religious conviction?

Yes _____

No _____

To which religion do you subscribe? _____

21. Would you describe yourself as having strong political beliefs?

Yes _____

No _____

Do you belong to a political party? Yes ___ No ___

To which party do you belong? _____

Would you describe yourself as

liberal _____

middle-of-the-road _____

conservative _____

22. What are/were your parents' occupations?

Mother _____

Father _____

23. In most instances, when people receive research requests in the mail, they throw them away. You have obviously not done that! Would you please give a brief description of why you filled this out? _____

24. Comments (Please use the space below for any comments.)

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