ATTRIBUTIONAL CUES EMPLOYED BY OBSERVERS IN ASSESSING MALADJUSTMENT

by

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Abstract

Attribution theorists have begun to explore the relationship between causal attributions and ascriptions of maladjustment. The attributional approach assumes that one will react differently to behavior (e.g., anxiety) perceived as caused by personal factors (e.g., personality traits) than to behavior perceived as caused by situational factors (e.g., marital stress). The present study explored the importance of three social factors on observers' attributions regarding the cause of a client's problems, their perceptions of maladjustment, and their tendency to socially reject the client.

It was assumed that in the absence of precise behavioral information and well-defined rules as to the interpretation of such behavior, observers would rely heavily on non-behavioral cues. Two sources of such information in the instance of psychological help seeking are the professional label of the help source (psychiatrist versus social worker) and the treatment decision by this "expert" (psychotherapy, counseling, no decision, or no treatment). A third factor in the present study was the influence of attributors' degree of help seeking similarity on subsequent attributions. That is, observers were divided

into those who had seriously considered seeking help themselves versus those who had not.

All subjects (undergraduate students) listened to a five minute audiotape of a simulated initial clinical interview. In addition to the measures of causal attribution, perceived maladjustment, and social rejection, measures as to the extent of role identification (i.e., with client or interviewer), problem identification, and perceived interview typicalness (i.e., representativeness of clinical interviews in general) were taken.

The social factors of professional label of help source and help seeking similarity or dissimilarity did not have any significant effect on observers' causal attributions, perceptions of maladjustment, and social rejection of the client. As expected, the decision by an expert, as to whether or not the client requires treatment, was an important communicator of maladjustment information (i.e., with "no treatment required" resulting in the least perceived maladjustment).

Surprisingly, perceptions of maladjustment and social rejection were not found to involve an attributional component. The absence study of a causal attribution/perceived maladjustment relationship in the current study was discussed in terms of the use of structured versus unstructured measures and professional versus non-professional populations. The expected positive correlation

between perceived maladjustment and social rejection was observed, but this was also surprisingly low.

Help seeking similar subjects were found to identify to a greater extent both with the client and the nature of the problem. Discriminant analysis suggested, however, that the underlying relationship was one of help seeking similar observers' being more interested in, or focusing attention on, the client rather than their being necessarily more (attributionally) empathic as was expected.

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CHAPTER I: INTRODUCTION

In addition to the traditional etiological factors associated with mental illness, classifiable either as medical (e.g., genetics and biochemical factors) or as psychological (e.g., psychodynamics and conditioning), many clinical practitioners and researchers have considered subjective, phenomenological processes (Bandura, 1977; Beck, 1976; Ellis, 1973; Kelly, 1955; Meichenbaum, 1977; Storms & McCaul, 1976; Valins & Nisbett, 1972) or social factors (Edgerton, 1969; Goffman, 1961; Sarbin and Marcuso, 1970; Scheff, 1975) to be at least equally contributory. This perspective considers cognitive - interpretive processes, both within the potential "patient" (i.e., the actor) and on the part of potential labelers (i.e., observers), to be critical aspects of the complex interpersonal "negotiation" (Edgerton, 1969) that precedes any perception of mental illness.

Within this context, one would expect that attributions made by observers (e.g., by professionals, family, co-workers, etc.) as to the cause of an actor's deviant or problem behavior will play an important mediating role in determining the perception of maladjustment or mental illness. For example, viewing a particular problem behavior (e.g.,

sadness, tension) as due to one of several potential causes such as biological predisposition, personality, attitudes, family events, or job pressures, alters the perception of that problem behavior in terms of its significance, typicalness, and severity. Furthermore, in making causal attributions and ascriptions of maladjustment, observers likely rely on various behavioral cues (e.g., consistency of the behavior; Kelly, 1972) and social cues (e.g., the reactions and judgments of other observers). When an intimate knowledge of all aspects of the behavior is lacking, as is often the case, social cues will likely play a dominant role in making such ascriptions.

The major focus of the present investigation concerns the interrelationships among causal attributions, perceived maladjustment, other related observer reactions (e.g., social rejection of the "problem" person) and some of the social cues employed by observers in arriving at these perceptions. Thus the following sections will include a brief review of attribution theory; a discussion of the relationships among causal attributions, perceived maladjustment, and social rejection; and a review of studies exploring behavioral and social cues affecting these judgments.

Attribution Theory: An Overview

Attribution theory is a cognitive theory or collection of theories of the perception of causation. More precisely, it is the study of the rules employed by the average person in making causal judgments concerning his own or another person's behavior. The significance of any behavioral event is determined, at least in part, by the perceived causes of that event. Thus, attribution theory is not concerned with determining the "scientific," objective cause-effect structure of events, but is concerned with the determinants and consequences of individuals' "common sense" perception of causal forces. Philosophically, attribution theory views

> . . . the actor as a constructive thinker searching for causes of events confronting him and acting upon his imperfect knowledge of causal structures in the ways he considers appropriate. (Jones, Kanouse, Kelley, Nisbett, Valins & Weiner, 1972, p. 4)

The task of formal attribution theory is to systematize these naive, common sense, unformalized "theories" of causations.

Dimensions of causal attribution. An important aspect of this systematization has been to identify the major dimensions on which causal attributions vary. It is not necessary for the attributor to be acutely aware of the dimensions along which his causal judgments vary, for these

dimensions are often implicit. Nevertheless, these dimensions are viewed by attribution theorists as exerting an influence on the accompaning reactions to a given behavioral event. However, the basic attributional distinction between causes residing within the person and causes external to the person, and thus an aspect of the environment or situation (Heider, 1958), represents a distinction people often explicitly and consciously consider. The vast majority of attributional research has centered around this person-situation or internal-external dimension.

Several other attributional distinctions or dimensions have been suggested by researchers. These include (a) the distinction between attributions to stable and enduring causal factors and attributions to variable and fluctuating causal factors (Weiner, Frieze, Kukla, Reed, Rest, & Rosenbaum, 1972); (b) the distinction between stimulus and circumstance attributions, representing separable causal aspects of the situation (Nisbett & Valins, 1972); (c) the dimension of intentionality, or more precisely the perceived controllability or uncontrollability of the attributed cause (M. Snyder, 1976; Weiner, Russell, & Lerman, 1978); (d) the dimension of global versus specific causal forces, suggested as important for an attributional model of learned helplessness (Abramson, Seligman, & Teasdale, 1978); and, (e) the distinction between causes and reasons (Buss, 1978).

Attribution theory and the mental illness process.

The applications of attribution theory have been exceedingly numerous and varied, covering a range from achievement (Weiner et al., 1972) to helping behavior (Ickes & Kidd, 1976). Excellent collections of this literature can be found in Harvey, Ickes, & Kidd (1976, 1978).

Numerous researchers have also applied attribution theory to various stages in the cause of emotionally disturbed behavior and therapeutic interventions. The personal or situational causal ascription given by the actor for his own clinically relevant behavior (i.e., any behavior for which a mental illness label or perception of maladjustment could potentially occur) is likely to be a determinant of (a) the initial self-perception of the behavior as being abnormal (Valins & Nisbett, 1972); (b) the exacerbation and continuance of the "undesirable" behavior (Storms & McCaul, 1976); (c) the decision to seek treatment and the individual's attitudes and behavior during treatment (Johnson, Ross & Mastrina, 1977; Kopel & Arkowitz, 1975; Moser, 1975; Skilbeck, 1975; Strong, 1970, 1976; Valins & Nisbett, 1972), and (d) the post-treatment stability of therapeutic gains (Davison, Tsujimoto, & Glaros, 1973; Winett, 1970).

Similarly, the causal attributions for an individual's clinically relevant behavior made by significant observers such as family members, friends, co-workers, and mental

health professionals should also be critical at each of these stages. Different causal attributions are likely to lead to differential community tolerance for the behavior, and to determine to a large extent professionals' perceptions of the severity of the disorder (C. R. Snyder, 1977) and treatment decisions (Batson, 1975).

A particular critical moment in the course of a mental illness is the actor's (i.e., potential client or patient) first contact with the mental health system. The causal attributions made by a mental health professional at this point, and conveyed directly or indirectly (i.e., via diagnostic labels, treatment decisions, level of concern, etc.) to the actor and other observers (e.g., other professionals, family, etc.), and are likely to have far reaching consequences. This critical, initial attributional definition of the problem may take place during a routine intake or admission interview, or in the context of a crisis intervention (Skilbeck, 1975). Both the actor and other significant observers can be viewed as highly suggestible at this point (Scheff, 1975), with the "logical" causal attributions and resulting labels and decisions (Weiner, 1975) made by an "expert" leading to potentially destructive (Goffman, 1961; Rosenhan, 1973) or beneficial (Johnson et al., 1977; Skilbeck, 1975) consequences.

Perceptions of observers. As discussed previously, attribution theory views people as making a distinction (implicitly or explicitly) between behaviors which are caused by personal versus situational factors (Heider, 1958). It has been contended (e.g., by Snyder, 1977) that such an attributional distinction is an important component of the perception of a behavior as representing maladjustment or emotional disturbance. A brief review of the "common sense" rules employed by observers in making this attributional distinction elucidates the "obvious" nature of this relationship. A situational attribution generally occurs when the behavior is seen as common, typical, and in-role (Heider, 1958; Jones & Davis, 1965; Kelley, 1972). In other words, a situational attribution implies that the behavior is seen as a "normal" consequence of the situation, at least in the sense of being a frequent behavior found in such situations. Conversely, an attribution to personal factors usually reflects the perception of that behavior as nonaverage or idiosyncratic (Heider, 1958), out-of-role (Jones & Davis, 1965), or distinctive to that person (Kelley, 1972). In other words, a personal attribution involves the perception of the behavior as unusual or abnormal. Thus, one would expect that causal attributions for a problem behavior (e.g., tension) to personal factors (e.g., internal conflicts) would result in a greater ascription of maladjustment than an attribution of the same

behavior to situational factors (e.g., marital stress), implying that a greater responsibility for the problem is being assigned to the person himself.

Empirical studies have tended to confirm this intuitive relationship between causal attributions and perceived maladjustment. Snyder (1977), in a re-analysis of a study by Langer and Abelson (1974), found a very strong positive correlation (r=.64) between professional clinicians' causal attribution of a target person's difficulties to personal factors and their perception of maladjustment. Similarly, two studies employing a non-professional population have found that case descriptions implying personal factors as the cause of the problem behavior led to greater ascriptions of psychological disturbance and mental illness than similar case descriptions containing attributions to situational factors (Calhoun, Pierce, Walters, & Dawes, 1974; Calhoun, Selby, & Wroten, 1977). Shenkel, Snyder, Batson, & Clark (1979) found that personal attributions contained within a clinical report led clinical trainees to rate the problem as more severe than did situational attributions. A study by Batson (1975) supported this relationship from the reverse perspective. This study found that the presence of a mental illness label led professional and non-professional observers to make a significantly greater number of personal attributions.

Causal Attributions for Problem Behavior

Given the potential importance of attributional processes in the perception of maladjustment, several researchers have investigated some of the possible behavioral and social cues employed by observers for causal attributions of problem behavior. Studies of this type have employed a fairly consistent methodology. Generally subjects are given a brief description of the person and the problem behavior, and are occasionally provided with a short audiotape of a clinical interview with the person (such interview tapes are created by role players, kept constant across conditions, and are included to increase the sense of one's making attributions about an actual person, e.g., Snyder, Shenkel, & Schmidt, 1976). The case description contains several manipulations of the person's characteristics and behavior depending on the hypothesis being tested. These studies have found that attributions to personal factors increase as a function of increases in behavioral inappropriateness (Calhoun et al., 1977), problem severity (Calhoun, Johnson, & Boardman, 1975; Johnson, Calhoun & Boardman, 1975), problem atypicalness (M. L. Calhoun, 1975; Calhoun et al., 1975; Johnson et al., 1975), consistency of problem occurrence (Calhoun et al., 1975; Johnson et al., 1975), and history of previous psychiatric treatment (Snyder et al., 1976).

Two observations might be made about this set of findings. First, the behavioral cues (atypicalness, consistency, and inappropriateness) employed in problem behavior attributions are consistent with the previously discussed "common sense" rules employed for non-problem behavior (Heider, 1958; Jones & Davis, 1965; Kelley, 1972). Second, the social cues (problem severity, history of previous psychiatric treatment) are consistent with and supportive of the previously discussed converse of the attribution-perceived maladjustment relationship. That is, these variables are likely contained within an underlying severity of maladjustment factor, with greater maladjustment resulting in greater personal attributions.

The Snyder et al. (1976) study also indicated that causal attributions for a patient's problem could be altered by the perceptual set given to observers. Subjects asked to listen to a five minute taped clinical interview from the counselor's position (i.e., "as if you actually were the counselor") were found to ascribe more causality for the problem behavior to personal factors than subjects asked to take the client's perspective. This finding parallels similar research in other areas which has found that attributions can be altered by physically reorienting the subject's point of view through the use of videotape (Storms, 1973).

Perception of Maladjustment and Social Rejection

Complementing the above attributional research is a parallel set of studies, employing similar methodologies, investigating social cues employed by observers in the perception of maladjustment. Variables found to influence the ascription of mental illness or greater maladjustment (the dependent measure employed varies from study to study) include the presence of a mental illness label (DiNardo, 1975; Paquin & Jackson, 1977), an appropriately high interest shown by a clinician during an interview (Yaffe & Mancuso, 1977), and being described as a patient (Langer & Abelson, 1974), female (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; LaTorre, 1975), lower social class (DiNardo, 1975), or physically unattractive (Jones, Hansson, & Phillips, 1978).

Researchers have also investigated an important potential consequence of perceived maladjustment, namely social rejection. The stigmatization and social rejection that result from a perception of maladjustment or mental illness has been well documented (Brady, 1976, Cumming & Cumming, 1957; Nunnally, 1961; Phillips, 1963, 1964; Sarbin & Mancuso, 1970; Yamamoto & Dizney, 1967). In addition Phillips (1963, 1964) has consistently found that "individuals described as exhibiting identical behavior are increasingly rejected as they are described as seeking no help, consulting a clergyman, a physician, a psychiatrist, or a mental hospital" (1964, p. 674). Males also tend to be more

severly rejected than females for the same behavior (Phillips, 1964). However, in both of these studies comparatively greater social rejection occurred as a result of the degree of behavioral social deviancy than as a result of where help was sought. Research attempting to demonstrate a relationship between the presence of a mental illness label has found similar results. That is, social rejection has consistently been found to be more a function of behavioral inappropriateness or impairment than the presence of a mental illness label (Kirk, 1974, 1976; Lehmann, Joy, Kreisman, & Simmons, 1976; Schwartz, Myers, & Astrachan, 1974). However, by employing a less extreme and less stereotypic description of deviant behavior, Loman and Larkin (1976) were able to reverse this tendency, finding a larger effect size for the mental illness label than for the deviancy of the behavior.

Two studies by Calhoun et al. (1974, 1977) have looked at the relationship between causal attributions and social rejection. In both studies attribution to personal factors led to greater social rejection than an attribution to situational factors. Social rejection was also found to correlate positively with measures of perceived mental illness (.47 and .36) and psychological disorder (.28).

Present Study : Overview and Development of Hypotheses

The present study attempted to extend the literature reviewed above by investigating the influence of three potentially important social determinants of causal attributions, perceived maladjustment, and social rejection. Specifically, the social factors investigated were (1) the treatment decision, (2) the professional label of the helper, and (3) the similarity or dissimilarity of the observer to the target person for help seeking behavior. Three additional dependent measures were also included in the study (degree of role identification with the client or mental health professional, degree of identification with the client's problems, and the perception of the interview as typical of interviews in general).

Treatment decision. An obvious source of observers' causal attributions and perception of maladjustment are the judgments made by an "attributional expert" such as a mental health professional. One way in which mental health professionals convey attribution and maladjusment information to other observers is through the previously discussed diagnostic label. However, often such labels are either omitted or not made public. In such instances important attributional information may be conveyed by the treatment decisions that are made. For instance, an "intake" interviewer's decision to recommend further treatment likely conveys a judgment of greater personal causation and

maladjustment than a decision that "no treatment is required." That is, continued treatment (e.g., counseling) not only implies that a problem exists, it likely conveys the notion that the problem is within the person since this is the usually assumed focus of psychological treatment.

A further, more subtle social cue may be conveyed by the choice of a treatment label. The terms "psychotherapy" and "counseling" are often used synonymously in the sense of referring to the same activity. However, the term "psychotherapy" appears to convey a stronger sense of severity and in-depth person focusing than does "counseling." Given these considerations, one would expect that "psychotherapy" would lead to greater personal attributions, perceived maladjustment, and social rejection than "counseling." Unsystematic observation by the author would indicate that clients often prefer the latter term to the former, or at least appear to be more comfortable with it. Such a self-esteem enhancing preference would be consistent with the above formulations.

A possible control for the above treatment decisions would be a "no decision concerning treatment" condition. Clinicians occasionally terminate an initial session with ambiguous or non-decisions. One would expect the information concerning causal attributions and maladjustment conveyed by "no decision" to be intermediate between the "treatment" and "no treatment" conditions.

Professional label of helper. As was indicated by the previously discussed Phillip's studies (1963, 1964), attributional information appears to be gleaned by observers from the source of help (i.e., psychiatrist, clergyman, etc.). In these two studies sources of help associated with greater maladjustment led to greater social rejection. The inclusion of a similar variable in the present study was intended to serve as a replication of these studies, and extend the understanding of the help source effect by including the attributional and maladjustment measures.

In the Phillips' study, the sources of help varied along several dimensions, among them being mental health professional (e.g., psychiatrist) versus non-mental health professional (e.g., clergyman, physician); professional (e.g., psychiatrist, etc.) versus institution (e.g., mental hospital). The two sources of help included in the present study, psychiatrist and social worker, were chosen since they vary, as much as possible, along a single dimension. That is, they both are easily recognizable professional groups associated with mental health issues, but vary considerably in their perceived association with the treatment of serious mental health problems. Previous research (Sexton, Note 1) has shown that psychiatry is clearly seen as the professional group most associated with the treatment of severe disorders (e.g., two female samples gave psychiatry an average rank order of 2.1 and 1.9 respectively in comparison with five other professional

groups). Social Work, on the other hand, is consistently seen as comparatively unassociated with the treatment of severe disorders (average rank orders of 4.1 and 4.3 in the same samples).

The rationale for the hypothesis concerning the manipulation of the professional label of the help source overlaps with the rationale for treatment decisions. Since a psychiatrist is commonly associated with the treatment of severe forms of pathology, seeking help from a psychiatrist should itself be a social cue employed by observers in ascribing higher levels of maladjustment. Social workers, being comparatively quite unassociated with severe pathology (e.g., less associated with severe pathology than all other professions except nurses in the above study), should be a cue for ascriptions of less maladjustment even in the case of the same problem behavior. Attributionally, it would also appear reasonable to expect that the label "psychiatrist" is associated with a focusing on personal factors, i.e., on person-based problems. Conversely, social workers may be viewed as having a relatively more situational professional focus, i.e., dealing mostly with problem situations.

Help seeking similarity. Several studies in the general attribution theory (Banks, 1976; Goethals, 1976; Singer, 1974) and maladjustment perception literatures (Bennett, 1973; Peters, 1975) have looked at the influence

of observer to target person similarity-dissimilarity. Typical definitions of similarity employed by these studies include attitude similarity, similar experiences and social preferences, and similarity on task performance. Bennett (1973) found that dissimilar task performance resulted in greater perceived mental illness. Peters (1975), on the other hand, found that the variability in social rejection responses towards ex-mental patients was increased when patients were perceived as having dissimilar rather than similar attitudes. Reflecting the potential importance of perceived similarity as a social determinant of clinical phenomena, additional research has shown that psychotherapists who are treating clients similar to themselves (e.g., in social class, interests, values, etc.) tend to exert a greater helping effort (based on laboratory analogue studies reviewed by Wills, 1978), and have lower dropout rates and more positive outcomes than with dissimilar clients (Luborsky, Chandler, Auerbach, Cohen & Bachrack, 1971; Smith & Glass, 1977; Wills, 1978). Results of studies in the general attributution theory literature are generally consistent with these findings. For example, Goethals (1976) has found in studies of social influence that disagreeing opinions are attributed more to the person when that person is perceived as dissimilar.

The operational definitions of similarity-dissimilarity employed in the above studies are noteworthy in that they tend to involve global and nonspecific manipulations of the

variable. Several studies in related attributional areas (to be reviewed below) can be interpreted as indicating that a more specific, task relevant definition of the similarity variable could be fruitfully employed. As stated by Lerner and Matthews (1967), "Identification with a . . . [target person, actor] requires the perception of the same possible common fate and not the perception of similar attributes" (p. 324).

Attributional research has shown that, in most instances, actors tend to invoke relatively more situational explanations for their behavior than do observers (Jones & Nisbett, 1972). Thus, it would be expected that observers who identify with the actions or fate of the actor will tend to shift towards a similar situational viewpoint. For instance, several studies have found that observers who have had prior experience with the task or anticipate having to perform the same task (i.e., "active" as opposed to "passive" obsrvers) make more situational attributions for the actor's behavior and outcome (Garrett, 1976; Wolfson & Salancik, 1975). Similar research by Chaikin and Darley (1973) indicates that observers ascribe less blame to a victim of an injustice (i.e., less personal attribution) and more to the harm doer (i.e., more situational attributions for the victim's fate) when these observers anticipate suffering the same fate.

Thus, a task-specific similarity appears to lead observers to put themselves in the position of the actor and view the sequence of events from the actor's perspective. Consistent with this interpretation, several studies have found that instructions to "empathize" with the actor also lead observers to make more situational attributions (Brehm & Alderman, 1977; Galper, 1976, Gould & Sigall, 1977; Regan & Totten, 1975). The previously discussed finding that instructions to view a therapeutic interaction from the client's perspective leads to more situational problem attributions (Snyder el al., 1976) lends further support to this approach.

Thus, the dimension of actor-observer similarity is likely to have the greatest effect to the extent that the nature of the similarity is task relevant, resulting in active, empathizing, and identifying observers. In a clinical paradigm, the dimension of similarity-dissimilarity that is most relevant and thus the most salient would be the extent to which the observer is similar to the actor for the behavior of seeking help for a personal problem. That is, it would be expected that observers who have sought professional help, or strongly considered seeking help, should identify or empathize with the target person. Specifically, help seeking similar observers should identify more closely with the "client" while observing a clinical interview, and identify more strongly with the client's

problems than a help seeking dissimilar person (measures of these two aspects of actor-observer identification were included in the present study to verify this assumption).

In addition, given the previous findings concerning empathy instructions and observers' role perspective, one would expect help seeking similar observers, viewing the situation from the target person's perspective, to shift towards a more situational explanation of the problem behavior. Conversely, observers who have not considered seeking help for personal problems, and thus are dissimilar for this specific behavior, should function as typical "passive" observers, favoring personal factors as explanations for others' behavior.

Hypotheses

On the basis of the literature reviewed above, the following five specific hypotheses were tested concerning observers' perceptions of a help seeker:

1. Effect of treatment decision: The attributional information conveyed by knowledge of treatment decision was expected to result in the greatest personal (as opposed to situational) attributions in the condition of a "psychotherapy" treatment decision, followed in descending order by "counseling," "no decision," and "no treatment." Similarly, "psychotherapy" was expected to lead to the greatest perceived maladjustment and social rejection, followed by

the remaining conditions in the same order as for attributions.

2. Effect of professional label of helper: Seeking help from a psychiatrist was expected to lead to more personal attributions (as opposed to situational attributions), greater perceived maladjustment and social rejection than seeking help from a social worker.

3. Effect of help seeking similarity: Observers who rated themselves as having seriously considered seeking help (i.e., similar to the target person for this behavior) were expected to make less personal attributions (as opposed to situational attributions), ascribe less maladjustment, and be less social rejecting than observers who rated themselves as low for this behavior (i.e., dissimilar from the target person). In addition, help seeking similar observers were expected to identify more closely with the role of client and more strongly with the client's problems than help seeking dissimilar observers.

4. Effect of causal attributions: Causal attributions of the target person's problem to personal (as opposed to situational) factors was expected to be a significant element on the perception of maladjustment and social rejection. Personal attributions were expected to correlate positively with both perceived maladjustment and social rejection. Similarly, identification with the role of client and with the problems of the client were expected to

mediate causal attributions, with high identification in both cases being associated with high situational attributions.

5. Perceived maladjustment and social rejection: Consistent with previous research, perceived maladjustment and social rejection should be positively correlated.

CHAPTER II: METHOD

Design and Overview

A 4 x 2 x 2 factorial design was employed in which treatment decision, professional label of helper, and help seeking similarity were the independent variables and causal attributions to situational or personal factors, perceived maladjustment, and social rejection were the main dependent variables (additional dependent measures of role identification, problem identification, and perceived interview typicalness were also included). Subjects were instructed that the researchers were interested in how accurately people perceive the cause of another person's problems on the basis of brief or minimal information. Subjects received an information sheet describing the person as experiencing "several problems or difficulties" and as "upset." This was followed by a five minute audio tape excerpt of a clinical interview. The function of this audio tape, which remained constant across the experimental conditions was to (a) minimize the artificiality of the experimental situation, and (b) have the subject respond to a "person" and not simply make verbal responses on the basis of word associations.

Subjects

A final sample of 176 (creating equal cell sizes, N = 11) was selected from an original sample of 230 female volunteers from regular winter session (N = 182), intersession (N = 22) and summer session (N = 26) introductory psychology classes at the University of Manitoba. (Subjects obtained partial credits towards course requirements for participation.) To maintain a general equivalency across the three sources of subjects, subjects from intersession and summer session were only included if they had attended university the previous regular winter session or were 90% sure of attending the forthcoming winter session. (The "academic history" questionnaire employed for this purpose is contained in Appendix A). Ten subjects did not satisfy this criterion.

In addition, the sensitivity of the self-disclosure information employed in making the help seeking similarity - dissimilarity distinction required the controlled condition and confidentiality of the laboratory setting. Thus a prior selection on the variable was not possible, resulting in a random distribution (i.e., unequal cell sizes) across the remaining experimental conditions. Forty-one subjects were randomly eliminated from selected cells in order to provide equal cell sizes for the multivariate analysis.

Finally, three subjects were eliminated due to their having not responded to one or more questions.

Procedure

The experiment was conducted in a moderately sized (15' x 30') room in the psychology department at the University of Manitoba. Subjects were in groups of eight. The room contained nine well-spaced chairs surrounding a tape recorder. Subjects were given the experimental booklet (containing all instructions and dependent measures) entitled "Interview Judgment Study." Beneath this title on the cover page the subject was given a brief written description of the purpose of the study. (A copy of this sheet is contained in Appendix B.)

At this point in the study subjects were asked to complete a "Personal Information Questionnaire" (see Appendix C). This questionnaire contained numerous filler items asking for age, sex, marital status, size of parental family, expected college major, etc., and finally a self-rating scale designed to measure the extent to which subjects have seriously considered seeking help themselves (see "Help seeking similarity" below).

Following completion of the "Personal Information Questionnaire" subjects received an expanded set of written instructions, which were also read by the experimenter as

follows (with psychiatrist and social work instructions in Appendices D and E respectively):

> We are interested in learning about how accurately people are able to use information, occurring during the first few minutes of an interview, in making judgments about others who are seeking help for certain problems they have. In particular, we want to find out how accurately you can make judgments about people who are experiencing problems when given minimal information about that person and an interview with them, and on the basis of listening to the first few minutes of that interview. That is, you will initially be given a brief description of the person and the interview they had with a social worker/psychiatrist. You will then listen to a tape recorded five minute excerpt taken from the beginning of this interview. Please concentrate fully so you are able to accurately use the information presented to you. Your task is, on the basis of the available information, to derive as accurate a perception of the person as possible, in particular considering the <u>likely cause</u> of the person's problems.

The subject was then provided with an "Information Sheet," which remained available to the subject for the duration of the experiment. Eight separate versions of this

information sheet were employed, one for each of the treatment decision x professional label of help source conditions (see Appendices F through M for copies of these sheets). The information sheet contained a neutral name ("Ms. H."), the sex ("female") and age ("20") of the client and a general description of a clinical interview which formed the basis of the treatment decision and professional label of helper manipulations. The general description for the "psychotherapy-social worker" condition is provided below as an example:

> Mrs. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discussed these problems with the social worker who made a decision that Ms. H required treatment in the form of psychotherapy. (The underlined material varies from condition to condition with the underlining omitted.)

Subjects then listened to a prepared five minute excerpt from a supposedly longer interview and filled out the dependent measure questionnaire.

Independent Variables

Two independent variables, treatment decision and professional label of helper, were factorially manipulated by information conveyed during the instructions and contained on the "information sheet."

Treatment decision. This variable was manipulated by varying the last sentence of the "information sheet" as follows: (a) Psychotheraphy condition - "...who made a decision that Ms. H. required treatment in the form of psychotherapy"; (b) Counseling condition - "...who made a decision that Ms. H. required treatment in the form of counseling"; (c) No decision condition - "...who did not make a decision regarding treatment for Ms. H"; and, (d) No treatment condition - "...who made a decision that Ms. H did not require any treatment.

Professional label of helper. This variable was manipulated by identifying the help source (i.e., the interviewer) as either a psychiatrist or a social worker in both the instructions and the "information sheet" (see above).

Help seeking similarity. The third independent variable was based on a self-report measure for help seeking behavior potential, and was systematically varied with the above manipulated conditions. A scale was included in the "Personal Information Questionnaire" (see procedure section) for this purpose. Subjects were instructed:

> Often we find we cannot solve all our problems ourselves. How seriously in the past have you considered seeking help from someone else (such as a counselor, priest, teacher, psychiatrist, etc.)?

This was accompanied by a 7-point scale (1 = not seriously at all, 7 = very seriously). Help seeking similarity was based on a median split of this rating. The help seeking similar condition was constituted by subjects' indicating 4 through 7 on the accompanying scale (102 of the original 230 subjects sampled responded in this manner). The help seeking dissimilar condition was constituted by subjects indicating 1 through 3 on the accompanying scale (128 of the original 230 subjects responded in this manner).

Client Interview Tape

The five minute audio tape excerpt of the clinicial interview was created by employing two female role players (both were mental health professionals). The female - female pairing was employed to match the selection of female subjects, thereby holding sex constant throughout all aspects of the experiment (cf. Snyder et al., 1976). The verbalizations of the counselor involved both questions and nondirective reflections of feelings, and were designed to minimize this potential source of influence on subjects' perceptions of the client. The client presented a fairly ambiguous set of difficulties involving events at college and at home, employing as non-explicit and non-clinical a terminology as possible (e.g., "upset" or "tense" rather than "anxious"; "sad" rather than "depressed," etc.). The client role player was also instructed to convey a slightly situational self-attribution regarding the causes of her

problem, corresponding to the typical actor attributional tendencies (cf. Jones & Nisbett, 1972).

Nine interview tapes were created in this manner. Four of these tapes were considered as adequately representing a clinical interview by five mental health professionals (a psychiatrist, a social worker, and three psychologists). The subsequent selection and validation of the interview tape involved the ratings of these four tapes by nine graduate students in clinical psychology (blind to the purpose of the experiment). The graduate students were instructed that the tape represented an interview either by a social worker (N = 4) or a psychiatrist (N = 5) to test for the adequacy of the tapes under both experimental conditions.

Three ratings were involved in the final tape selection. (See Appendix N for a copy of the rating sheet employed by graduate students.) The first rating was for tape adequacy: "To what extent does the tape adequately portray a clinical interview" (1 = not at all, 3 = somewhat, 5 = moderately, 7 = good, 9 = excellent). A mean rating of 6.67 (social worker = 7.0; psychiatrist = 6.4) for the selected tape was interpreted as indicating a favourable rating. The second rating asked, "Regardless of your personal opinion, to what extent do you feel <u>the client</u> attributes her problems to situational versus personal

factors . . . ?" (1 = totally situational, 5 = equally situational and personal, 9 = totally personal). A mean rating of 4.44 (social worker = 4.5; psychiatrist = 4.4) reflected an ambiguous to slightly situational attributional stimulus value for the selected tape. Finally, the raters were asked to rate the client for level of disturbance: "Indicate how disturbed and maladjusted you would rate the client portrayed in this tape" (1 = well adjusted, 5= moderately disturbed and maladjusted, 9 = very disturbed and maladjusted). A mean rating of 4.89 (social worker = 4.9; psychiatrist = 5.2) reflected a moderate level of disturbance portrayed in the selected tape. (See Appendix O for graduate student ratings of the four test interview tapes.)

Dependent Variables

After listening to the interview tape, subjects were instructed to fill out the dependent variable questionnaires:

> On the following pages, you will be asked several questions about the person whose interview you have just heard. Take your time, and make your decision carefully.

All subjects completed the dependent variable questionnaires in the following order: causal attribution, perceived maladjustment, social rejection, role identification, problem identification, and perceived interview typicalness.

Causal attribution. In order to insure a common usage of the person-situation construct, the measure for causal attribution was introduced in the following manner, adapted from descriptions used by Galper (1976) and Storms (1973):

> Based on the information you have been given, and using the scale provided, describe the extent that you judge Ms. H's problems to be due to situation versus personal factors as defined below:
>
> A. Situational Factors: Such factors as Ms. H's social environment, the behavior of other people, events taking place around her, and external pressures.
>
> B. Personal Factors: Such factors as personality, traits, character, personal style, attitudes, mood, and internal pressures.

This was followed by a 9-point bipolar rating scale (a single bipolar scale rather than separate ratings for each factor was chosen in order to force the subject into making a direct comparison of the two causal sources) with the following anchor points: 1 = totally situational, 5 = equally situational and personal, 9 = totally personal (adapted from Snyder et al., 1976). (See Appendix P for a copy of the attribution questionnaire.)

Perceived Maladjustment. The second dependent measure, perceived maladjustment, was measured as follows:

> Based on the information you have been given, indicate how disturbed and maladjusted you believe this person to be.

A 9-point scale was again employed (1 = well adjusted, 5 = moderately disturbed and maladjusted, 9 = very disturbed and maladjusted; adapted from Cole, Pennington, & Buckley, 1974). (See Appendix Q for a copy of the perceived maladjustment questionnaire.)

Social Rejection. Social rejection was measured by a social distance scale, providing a measure of the closest relationship with the target person acceptable to the subject. The present measure was adapted from several sources (Calhoun et al., 1977; Koulack & Cumming, 1973; Lehmann et al., 1976; Loman & Larkin, 1976; Phillips, 1963, 1964; Yamamoto & Dizney, 1967). The social distance scale was introduced to subjects as follows:

> We are also interested in your personal reaction to this individual based on the information you have been given. There are probably some people with whom you would be willing to be very good friends, and others whom you would just as soon not even be around. We would like you to tell us how close a relationship you would be willing to have with this person. Check the space below each of the following statements which most closely corresponds to your feelings about the person. Guess if you aren't really sure.

The accompanying scale consisted of twelve items ranging from close acceptance such as "I would like to have this person as a close personal friend" to more distant relationships such as "I would like to sit next to this person in class." The remaining ten items involved the following relationships: going to the same party, living next door, eating lunch together, being a member of the same social group or club, and having the person as a roommate, babysitter, speaking acquaintance, co-worker on a project, a dinner guest, or married to a member of one's family. Each item was followed by a 5-point scale (strongly agree, agree, no opinion, disagree, and strongly disagree). Higher scores reflected greater social rejection, with lower scores reflecting social acceptance or tolerance. (See Appendix R for a copy of the social rejection questionnaire; see Appendix S for a factor analysis of the social rejection scale.)

Additional dependent measures. Subjects were also asked to make three additional ratings (each involving a 9-point scale) concerning their own reaction to the client and the interview tape. These were: (a) role identification - "With whom were you identifying while making your evaluation?" (1 = totally with interviewee, 5 = equally with interviewee and interviewer, 9 = totally with interviewer); (b) problem identification - "To what extent were you able to identify with the interviewee's problems?" (1 = not at

all, 5 = moderately, 9 = entirely); and, (c) interview typicalness - "To what extent do you feel that the interview you heard is typical of helping interviews in general?" (1 = not typical at all, 5 = moderately typical, 9 = entirely typical). (See Appendix T for a copy of the additional dependent measure questionnaire.)

Post-Experimental Questionnaire and Debriefing

Finally, subjects were given a brief presentation as to the purpose of the study, thanked for their participation and excused. (See Appendix U for a copy of the presentation read by the experimenter.)

Statistical Analysis

Hypotheses concerning independent-dependent variable relationships were tested by means of both multivariate and univariate analysis of variance techniques. The multivariate F test of mean vectors was employed as an omnibus Type I error control across the six dependent measures, with a significance level set a $p < .05$ for each test (Cramer & Bock, 1968; Gabriel & Hopkins, 1974). Empirical evidence by Hummel and Sligo (1971) indicates that multivariate analysis provides a conservative estimate of Type I error.

A significant multivariate F was followed by an examination of the univariate analysis of variance for specific hypothesis testing with regard to each separate dependent variable (significant levels were again set at

$p < .05$). However, interpretation of the univariate tests also included inspection of the discriminant function analysis for each significant hypothesis, thus allowing consideration of the dependent variable interrelationships. This is essentially the approach recommended by Spector (1977), but is also compatible with the recommendations of Borgen and Seling (1978).

Hypotheses concerning dependent variable interrelationships were tested by Pearson Product Moment Correlations among the six dependent measures.

CHAPTER III: RESULTS

Selection Bias : Help Seeking Responses

As discussed previously, the "Personal Information Questionnaire" contained a measure of how seriously each subject had considered seeking help for herself. This measure, employing a median split, was the basis of the help seeking similarity manipulation. (The help seeking scores resulted in a relatively flat distribution with a slight positive skew.) To ensure that subjects distributed themselves in an unbiased manner across the remaining conditions, a univariate analysis of variance (treatment decision x professional label x help seeking similarity) was employed. This analysis indicated a significant main effect for help seeking similarity as expected ($p < .001$) with no other significant effects (for all other tests, $p > .36$). Thus no systematic selection error appeared to occur for this measure. (A summary table of the help seeking analysis is contained in Appendix V.)

Independent-Dependent Variable Relationships

As discussed in the previous chapter, analysis of the independent variable hypothesis included (a) multivariate analysis of variance for control of omnibus Type I error,

(b) univariate analysis of variance for specific hypothesis testing, and (c) discriminant analysis as an aid in interpretation. (See Appendix W for table of observed cell means.)

Hypothesis 1: Effect of treatment decision. The multivariate and univariate analyses of variance for treatment decision are contained in Table 1. The multivariate F test for equality of mean vectors for the six dependent variables was significant ($p < .002$). The subsequent analyses of variance indicated treatment decision effects for the dependent variables of perceived maladjustment ($p < .002, W^2 = .0963$) and role identification ($p < .02), W^2 = .0912$). The remaining effects for the dependent vaiables of causal attribution, social rejection, problem identification, and perceived interview typicalness were nonsignificant.

The rating scale employed for perceived maladjustment was a 9-point scale, with higher scores reflecting greater maladjustment. The individual perceived maladjustment cell means for treatment decision were as follows: psychotherapy = 5.250; counseling = 5.341; no decision = 5.864; no treatment = 4.250. The Tukey Honestly Significant Difference (HSD) test for pairwise comparisons was employed, indicating a significant difference ($p < .05$) between the no treatment condition and each of the remaining three conditions. No significant differences occurred between "psychotherapy," "counseling," and "no decision." Thus, a

treatment decision of "no treatment" led to significantly lower estimates of maladjustment than treatment decisions of "psychotherapy," "counseling," or "no decision."

The rating scale for role identification was also a 9-point scale, with low scores reflecting identification with the interviewee or client and high scores reflecting identification with the interviewer or counselor. The individual role identification cell means for treatment decision were as follows: psychotherapy = 3.023; counseling = 3.795; no decision = 3.500; no treatment = 2.591. The Tukey HSD test indicated a significant contrast between "counseling" and "no treatment" ($p < .05$); all other contrasts were nonsignificant. Thus, a treatment decision of "no treatment" led to significantly more role identification with the client, whereas a treatment decision of "counseling" led to a greater identification with the counselor. The treatment decisions of "psychotherapy" and "no decision" were intermediate with no significant differences.

The discriminant analysis indicated one significant discriminant function ($x^2 = 40.2627$, $df = 18$, $p < .002$) with the remaining two discriminant functions being nonsignificant ($x^2 = 12.5838$, $df = 10$, $p < .25$; $x^2 = 2.6007$, $df = 4$, $p < .63$). Thus, the treatment conditions differ significantly along a single dimension. The raw and standardized

coefficients for the significant discriminant function are presented in Table 2. The standardized coefficients indicate that the dependent variable of perceived maladjustment has the highest weighting, with role identification also contributing strongly to the discrimination of the treatment decision conditions. The group centroids for the significant discriminant function are contained in Table 3. This appears to indicate that the primary discrimination is between no treatment and the remaining three conditions. Thus, no treatment appears to be significantly discriminated from the remaining conditions by subjects in this condition perceiving less maladjustment and identifying more strongly with the client role. The results of the discriminant analysis thus essentially parallel the results of the univariate analysis of variance for treatment decision.

Hypothesis 2: Effect of professional label of helper. The multivariate and univariate analyses of variance for professional label of helper are contained in Table 1. The multivariate F test for the six dependent variables was nonsignificant ($p < .44$). Thus, whether the help source was labeled a "psychiatrist" or a "social worker" did not appear to affect subjects' perceptions in terms of the measures taken in the present study.

TABLE 1

Multivariate and Univariate Analyses of Variance For Tests of Independent Variable Hypotheses

Source	df	MS	F	p
Treatment Decision (Treat)				
Multivariate			2.30	.0020 [a]
Attribution	3	0.5909	0.23	.8785
Maladjustment	3	19.9905	7.21	.0002
Social Rejection	3	52.5966	1.01	.3879
Role Identification	3	12.3788	3.67	.0136
Problem Identification	3	1.7330	0.48	.6948
Typicalness	3	1.8845	0.72	.5412
Professional Label (Label)				
Multivariate			0.98	.4440 [b]
Attribution	1	0.0909	0.03	.8525
Maladjustment	1	0.0511	0.01	.8922
Social Rejection	1	47.0511	0.90	.3424
Role Identification	1	0.0000	0.00	1.0000
Problem Identification	1	11.5057	3.21	.0753
Typicalness	1	1.6420	0.62	.4294
Help Seeking Similarity (Simil)				
Multivariate			2.36	.0326 [b]
Attribution	1	1.4545	0.56	.4573
Maladjustment	1	0.4602	0.17	.6843
Social Rejection	1	2.5057	0.05	.8264
Role Identification	1	29.4545	8.73	.0036
Problem Identification	1	18.4602	5.14	.0247
Typicalness	1	2.0511	0.78	.3772
Treat x Label				
Multivariate			0.71	.7993 [a]
Attribution	3	2.2273	0.85	.4683
Maladjustment	3	0.7027	0.25	.8589
Social Rejection	3	28.9148	0.56	.6440
Role Identification	3	5.5000	1.63	.1843
Problem Identification	3	4.8239	1.34	.2620
Typicalness	3	0.5360	0.21	.8929
Treat x Simil				
Multivariate			1.07	.3829 [a]
Attribution	3	0.6212	0.24	.8704
Maladjustment	3	5.9905	2.16	.0948
Social Rejection	3	14.5208	0.28	.8399
Role Identification	3	4.9242	1.46	.2275
Problem Identification	3	6.5663	1.83	.1440
Typicalness	3	0.8542	0.33	.8062

Label x Simil				
Multivariate			1.08	.3796 [b]
Attribution	1	0.3636	0.14	.7099
Maladjustment	1	3.5511	1.28	.2594
Social Rejection	1	18.4602	0.36	.5517
Role Identification	1	13.0909	3.88	.0506
Problem Identification	1	1.2784	0.36	.5516
Typicalness	1	1.6420	0.63	.4294
Treat x Label x Simil				
Multivariate			0.78	.7227 [a]
Attribution	3	0.4697	0.18	.9103
Maladjustment	3	1.9299	0.70	.5559
Social Rejection	3	62.9299	1.21	.3066
Role Identification	3	0.7727	0.23	.8761
Problem Identification	3	2.6572	0.74	.5297
Typicalness	3	4.5663	1.75	.1596
Subjects Within Groups				
Attribution	160	2.6182		
Maladjustment	160	2.7727		
Social Rejection	160	51.8613		
Role Identification	160	3.3727		
Problem Identification	160	3.5898		
Typicalness	160	2.6148		

[a] degrees of freedom for multivariate test = 18,438.8914

[b] degrees of freedom for multivariate test = 6,155

TABLE 2

Discriminant Analysis For Treatment Decision

Dependent Variable	Raw Coefficient	Standardized Coefficient
Attribution	0.179153	0.2899
Maladjustment	-0.487627	-0.8120
Social Rejection	0.013647	0.0983
Role Identification	-0.285268	-0.5239
Problem Identification	0.040275	0.0763
Typicalness	0.022712	0.0367

TABLE 3

Group Centroids For Treatment Decision

Independent Variable Group	Group Centroid
Psychotherapy	-1.6474
Counseling	-1.8886
No Decision	-2.0779
No Treatment	-0.9745

Hypothesis 3: Effect of help seeking similarity. The multivariate and univariate analyses of variance for help seeking similarity are contained in Table 1. The multivariate F test for the six dependent variables was significant ($p < .04$). The subsequent univariate analyses of variance indicated help seeking similarity effects for the dependent variables of role identification ($p < .004, \omega^2 = .0397$) and problem identification ($p < .03, \omega^2 = .0226$). The remaining effects for the dependent variables of causal attribution, perceived maladjustment, social rejection, and perceived interview typicalness were nonsignificant.

The significant effect for role identification indicated, as predicted, that subjects who have seriously considered seeking professional help identified more strongly with the client than did subjects who have not seriously considered seeking help. The means for the two conditions were as follows: help seeking similar = 2.818; help seeking dissimilar = 3.636. It should be noted that both of these means are closer to the client identification pole rather than the counselor identification pole.

The rating scale employed for problem identification was a 9-point scale, with higher scores reflecting stronger identification with the problem discussed by the client during the interview. The significant effect for problem identification indicated, also as predicted, that help seeking similar subjects identified more strongly with the

problems discussed by the client than help seeking dissimilar subjects. The means for the help seeking similar and dissimilar conditions were 6.432 and 5.784 respectively.

The discriminant function for the maximum separation of the help seeking similar and dissimilar groups was, of course, significant (x^2 = 13.7502, df = 6, $p < .0326$). The raw and standardized coefficients for the discriminant function are presented in Table 4. The standardized coefficients indicate that role identification has the highest weighting, with both causal attribution and problem identification also contributing strongly to the discrimination of the help seeking similar conditions. Thus, the optimal linear combination of variables separating help seeking similarity from help seeking dissimilarity would associate more person attribution, client identification, and problem identification with the former group.

Thus, for help seeking similarity, results of the univariate analysis of variance (for specific hypothesis testing) and the discriminant analysis are only partially parallel. In the univariate analysis of variance, causal attributions do not approach significance ($p < .46$) and the mean difference in attributions (scored in the person direction) were small (similarity = 5.182; dissimilarity = 5.0). Nevertheless, the discriminant analysis indicates that causal attributions play an important role in the

multivariate separation of the two help seeking groups. The nature of these causal attributions (i.e., personal attributions were associated with the help seeking similar condition) was the opposite to that predicted.

Interaction Effects. The multivariate and univariate analyses of variance for the second and third order interaction of treatment decision, professional label of helper, and help seeking similarity are contained in Table 1. Each of the four multivariate F tests for the six dependent variables was nonsignificant (all $p > .37$). No significant interaction effects were predicted.

Dependent Variable Interrelationships

A correlational analysis was performed to determine the degree of relationship among the dependent variable measures. Tests of two specific hypotheses are included in the analysis. A summary of these correlations is contained in Table 5.

The grand means and standard deviations for each dependent variable are contained in Appendix X. The means for causal attribution, perceived maladjustment, and social rejection are close to mid-range for these scales. The means for the three additional scales reflect some deviation from mid-range. The mean for role identification (3.23) indicated a general tendency to identify more with the client than the counselor, while there was a tendency to identify slightly more than "moderately" with the client's

problem (6.11). The mean for perceived interview typicalness (5.79) reflected a tendency for subjects to rate the interview slightly more than "moderately" typical of helping interviews in general.

Hypothesis 4: Role of causal attributions. A summary of the correlational analysis for causal attributions with the other dependent variables of perceived maladjustment, social rejection, role identification, problem identification, and perceived interview typicalness is contained in Table 5. The specific hypotheses of positive correlations for causal attributions with perceived maladjustment ($r = .005$) and social rejection ($r = .07$) were both disconfirmed.

The mediational role of identification in causal attributions was partially confirmed. A significant, but low positive correlation ($r = .20$, $p < .05$) was observed between role identification and causal attribution. As predicted, subjects who identified with the client made more situational attributions, while subjects who identified more closely with the counselor made more personal attributions. The predicted parallel correlation between problem identification and causal attributions was not observed ($r = -.04$). No significant correlation was predicted nor observed between causal attribution and perceived interview typicalness ($r = -.02$).

Hypothesis 5: maladjustment and social rejection. The expected correlation between maladjustment and social rejection was significant ($p < .05$), with greater perceived maladjustment leading to greater social rejection. The magnitude of the correlation ($r = .18$) was surprisingly small.

Other dependent variable relationships. Several other significant correlations were observed. As would be expected (though not explicitly hypothesized), greater identification with the client (and thus less with the interviewer) was associated with stronger identification with the client's problem ($r = -.26$, $p < .001$). Stronger identification with the client's problem was also associated with less social rejection ($r = -.27$, $p < .001$). Finally, stronger problem identification was associated with perceiving the interview as more typical of interviews in general ($r = .19$, $p < .05$).

TABLE 4

Discriminant Analysis For Help Seeking Similarity

Dependent Variable	Raw Coefficient	Standardized Coefficient
Attribution	-0.255223	-0.4130
Maladjustment	-0.078186	-0.1302
Social Rejection	-0.018876	-0.1359
Role Identification	0.422691	0.7763
Problem Identification	-0.247623	-0.4692
Typicalness	-0.054592	-0.0883

TABLE 5

Dependent Variable Correlation Matrix [a]

	Maladjustment	Social Rejection	Role Identification	Problem Identification	Typicalness
Attribution	.00	.07	.20 *	-.04	-.02
Maladjustment		.18 *	.14	-.01	.01
Social Rejection			.03	-.27 **	-.05
Role Identification				-.26 **	-.10
Problem Identification					.19 *

[a] N = 176 for all correlations

* $p < .05$

** $p < .001$

CHAPTER IV: DISCUSSION

The present study investigated hypotheses concerning the role of certain social factors in determining observers' perceptions of people who are seeking help from a mental health professional. The hypotheses concerning the role of treatment decision and help seeking similarity were, in part, confirmed; but the expected role of professional label of help source was not. In addition, although several predicted correlations among the dependent variables were observed, the expected relationship between causal attributions and perceived maladjustment was not observed.

Treatment Decision

As discussed in the introductory chapter, a general expectation of the current study (underlying hypothesis 1 to 3) was that in the absence of precise behavioral information, observers are influenced by the attributional and maladjustment judgment of others. That is, observers are likely to be influenced by the attributional information implied in the actions of other significant observers. Decisions by attributional experts, in this case mental health professionals, can be viewed as social cues for the perceptions of observers. Attributional and maladjustment implications are thus likely to be conveyed by experts'

decisions as to the need for and type of treatment, representing a common communication channel through which mental health professionals publicly make their views known.

This expectation was partially confirmed. A treatment decision of "did not require any treatment" resulted in considerably less perceived maladjustment than did corresponding treatment decisions of "psychotherapy," "counseling," or "no decision." No corresponding differences in causal attribution occurred for treatment decision. However, a significant difference did occur between "counseling" and "no treatment" for role identification, with the latter leading to greater identification with the client by observers.

Thus, the major effect for treatment decision concerns the impact on observers of a decision that no treatment is required. As shown by the discriminant analysis, the major separation occurred between "no treatment" and the remaining conditions. A decision that there is a need for treatment would thus appear to convey a greater sense of psychological disturbance, and in addition result in a greater distancing of oneself from the client. That is, actors for whom some treatment <u>is</u> or <u>might</u> be required are seen as more disturbed, and there is a tendency to separate oneself from them by identifying to a greater extent with the interviewer (i.e., in a self-protective manner).

Type of treatment did not result in any significant differences. For example, the term "psychotherapy" did not convey a greater sense of maladjustment (or a focus on personal issues) than did "counseling." Contrary to prediction, these terms appear to be used interchangeably, and do not carry significantly different implications. It should be noted that "psychotherapy" and "counseling" represent two labels for a similar type of treatment (i.e., verbal). Future research might fruitfully look at perceptual differences resulting from treatment decisions involving different modalities (e.g., biological treatments such as drugs versus verbal treatments).

In addition, it was surprising to find a lack of separation of no decision from either psychotherapy or counseling. No decision was hypothesized to be intermediate between "no treatment" and a need for treatment in its perceptual implications. Instead, as indicated by the group centroids (discriminant analysis), the no decision condition not only clustered closer to psychotherapy and counseling, but the greatest separation occurred between "no treatment" and "no decision." ("No decision" also resulted in the highest mean maladjustment, but this was not significantly different from the "psychotherapy" or "counseling" means.) This indicated that "no decision" did not imply to subjects a lack of severe disturbance, but rather might have implied that "no decision" was made because the person was puzzling or untreatable and thus quite maladjusted.

To provide some additional clues as to the comparative stimulus values of "no decision" and "no treatment," a classroom of 35 introductory psychology female students were asked to indicate what thoughts came immediately to mind (i.e., free association) in response to either the "no decision" (see Appendix Y) or "no treatment" stimuli (see Appendix Z). Responses were coded by the author (see Appendix AA for "no decision" responses; see Appendix AB for "no treatment" responses). The 17 "no decision" responses appeared to reflect the following associations (with frequency percentage): (1) "no decision" represents an uncertainty and/or incompetency on the part of the psychiatrist (59%); (2) there is a need for further assessment (35%); (3) there is a desire to have the person help herself (35%); (4) there is likely no real problem with the person (29%); and (5) this person cannot be helped (12%). The 18 "no treatment" responses appeared to reflect the following associations: (1) there is likely no real problem or it was of such minor magnitude that it is already solved (61%); (2) an error in judgment on the part of the psychiatrist (56%); (3) if a person seeks help there must be a reason (39%, but always occurring jointly with seeing the psychiatrist in error); (4) the problem that exists is not appropriate for treatment (11%); and (5) the patient would not be cooperative in treatment (5%). Thus, the major differences between these two sets of associations would appear to be the simple

presence or absence of the notion that no real problem exists. That is, a majority of subjects reacted to the stimulus of "no treatment" with the thought that "no real problem exists," but less than a third of the no decision subjects had a similar reaction. This fairly straight forward difference in stimulus value would account for the observed differences in perceived maladjustment in the current study.

Professional Label of Help Source

Despite the importance of help source in previous research (Phillips, 1963, 1964), no significant effects were observed for the use of either "social worker" or "psychiatrist" as the professional label of the interviewer and decision maker. The only test to "approach" significance was for problem identification ($p < .08$), which was in the direction of greater identification with the client's problems when the help source was a psychiatrist.

Thus, the greater association of psychiatry with the treatment of severe problems does not serve as a cue for observers to impute greater maladjustment, see the problem as internally caused, or result in greater social rejection. It would appear likely that psychiatry and social work are both sufficiently viewed as mental health professional groups to not alter observers perceptions of help seekers. Thus, while psychiatry is more associated with severely

disturbed behavior than is social work, the important factor may lie in whether the help source is or is not a mental health profession. Different results might have occurred had the comparison been between psychiatry and clergymen (who are not viewed primarily as mental health professionals but are seen as being involved with the treatment of severe problems to approximately the same extent as social workers).

Help Seeking Similarity

It was hypothesized that observers who had seriously thought of seeking professional help for themselves (i.e., help seeking similar) would identify more closely with the client and the problems of the client. Following this, the help seeking similar observer was expected to be more empathic, leading to perceptual reactions of less personal causation, maladjustment, and social rejection. The first part of this hypothesis was largely confirmed, but the second part was not. Help seeking similar subjects, as expected, rated themselves as identifying more closely with both the client and the problems of the client than did help seeking dissimilar observers. However, no further significant differences occurred between these two groups.

Interestingly, if the results are viewed in terms of the multivariate interrelationships between the dependent measures (i.e., employing discriminant analysis), causal

attributions appear to be an important factor (despite the lack of univariate significance) in distinguishing the perceptions of help seeking similar and dissimilar subjects. The multivariate literature supplies no consistent interpretation for such a univariate-discriminant function discrepancy. For instance, Spector (1977) suggests that this might indicate the occurence of a "moderator variable" (p. 162). That is, while causal attributions are not significantly different for the two help seeking groups, they may play an important mediational role in the differences for role and problem identification that do occur. A mathematically similar but conceptually different interpretation is to hypothesize a "suppression" relationship (Gabriel & Glavin, Note 2). This would assert that causal attributions account for a moderately large portion of the difference between help seeking groups unaccounted for by the remaining five variables. That is, the residual variance in causal attributions contributes significantly to group separation when the "suppressing" overlap in variance with the other dependent measures is removed. However, the author of the current paper would concur with Harris (Note 3) that such interpretations represent a limited and essentially still a univariate approach to discriminate function analysis. The value of discriminant analysis lies in the interpretive potential of identifying the underlying conceptual dimension that captures the "essence" of the differences between the two groups.

Employing the results of the discriminant analysis to identify the underlying single dimension separating the help seeking groups has some interesting possible interpretive implications considering previous attributional studies. As discussed in the introductory chapter, instructions to "empathize" with (Brehm & Alderman, 1977; Galper, 1976; Gould & Sigall, 1977; Regan & Toten, 1975) or to take the role of the actor (Snyder et al, 1976) tend to lead observers to make greater situational attributions for the actor's behavior. That personal rather than situational attributions are associated with help seeking similar subjects in the discriminant function would indicate that the underlying dimension, despite including differences in identification with the client and the problem, is not one of empathy.

Conversely, the single dimension represented by attributions to personal factors and greater client and problem identification (which distinguishes the help seeking similar subjects) may reflect as underlying dimension of "being interested in the client" or "focusing attention on the client," rather than the expected empathic sense of "to identify with." Evidence from objective self-awareness theory (Duval & Wicklund, 1972; Wicklund, 1975) indicates that causal attributions are often a function of attentional focus (Duval & Hensley, 1976), and that attention and causal attributions are usually both directed towards the more dynamic (i.e., moving, novel, etc.) features of the visual

field (Arkin & Duval, 1975). The results of the current study can be interpreted in this manner. That is, observers who have seriously considered seeking help themselves are likely to find the actions and problems of someone seeking help much more interesting and thus dynamic than help seeking dissimilar observers. Thus, the focus of attention for help seeking similar subjects is likely to consider the person (i.e., personal characteristics of the client) as the cause and to report themselves as identifying strongly (in the sense of being attentive) with the client and her problems. In comparison, help seeking dissimilar subjects are not necessarily actively distancing themselves from the client or less empathic, rather the behavior of the client is simply less salient for them, less dynamic or interesting, and thus less attended to.

Attribution-Perceived Maladjustment Relationship

Reflecting the expected pivotal nature of causal attributions in observers' reactions, several predictions concerning the relationship of causal attributions to the other dependent measures were made (hypothesis 4). Only the predicted relationship between role identification and causal attributions was confirmed. This indicates a tendency for subjects who identified with the role of interviewer to attribute more causality to personal factors for the client's problems. Conversely, identification with the client led to more situational attributions. Though the

magnitude of this correlation was small, it is consistent with previous research on the importance of role perspective (Snyder et al., 1976). It should be noted that, contrary to the results for help seeking similarity, this relationship is consistent with an empathy interpretation. Observers who identify with the client will tend to see events from the client's perspective, a perspective which emphasizes situational factors (Jones & Nisbett, 1972).

The most surprising and theoretically disturbing result of the present study is the absence of a significant correlation between subjects' ratings of causal attribution and perceived maladjustment. The hypothesis of a causal attribution x perceived maladjustment relationship is a basic aspect of researchers' interest in this area of research. As discussed in the introductory chapter, this relationship would indeed appear to be "intuitively obvious." That is, situational attributions should, theoretically, imply that the behavior is not highly unexpected and thus not especially "abnormal." Conversely, personal attributions are generally conceived to imply the very distinctiveness or deviancy from the expected which is inherent in the concept of maladjustment. Furthermore, and underlining the surprising nature of the current result, this hypothesized relationship was strongly supported by the correlation of .64 observed by Snyder (1977).

Three reasons should be considered as possible explanations for the absence of this correlation in the present study. These are (1) the adequacy of measures employed, (2) the comparative nature of structured and unstructured measures, and (3) the use of professional versus non-professional populations.

Adequacy of attribution and maladjustment measures. A doctoral dissertation by Ritzma (1977) similarly found no significant correlation between mental illness labeling and internal-external causal attributions, but viewed this as due to "an inappropriate conception of internal and external causality" (p. 5591). While the possibility should be considered in the present study, it should be pointed out that the current measures were constructed to explicitly avoid this possibility. Both the measure of perceived maladjustment (cf. Coie et al., 1974) and the measure of attribution (cf. Snyder et al., 1976) were based on previously used scales that have some empirical validation. Furthermore, to avoid any misunderstanding of the attributional distinction, the construct was explicitly defined for subjects in a manner similar to Galper (1976) and Storms (1973). It might be noted, however, that the current measure, consistent with those of other studies, conceptually separates problem and cause. That is, the subject is asked to ascribe a personal or situational cause for the problem rather than choosing between a personal problem and a situational problem. While the current separation of

problem and cause is, in the opinion of the author, the better conceptualization, the latter might be more likely to produce the attribution - maladjustment correlation.

Structured versus unstructured measures. The measure employed in the Snyder (1977) study, which generated the .64 correlation, differed considerably from the measure used in the current study. Because of the type of data collected by the original Langer and Abelson (1974) study, Snyder's (1977) attributional re-analysis of the study required the use of an unstructured, open-ended measure of both causal attribution and perceived maladjustment. That is, professionals' open-ended descriptions of the client were later rated as to the implied causal attribution and perceived maladjustment by trained raters (with different raters for the two measures). The current study used structured bipolar rating scales for both measures to which the subject responded directly. Unstructured, open-ended attributional measures have been described as psychometrically poorer and having lower inter-test valadity and reliability than structured measures (Elig & Frieze, 1979). This is due mainly to the second-order nature of unstructured measures, adding an extra error component. While Shenkel et al. (1979) have found a reasonably high correlation ($r = .47$) between unstructured and structured measures of attribution in an experimental paradigm highly similar to the current study, a large percentage (approximately 78%) of the shared variance between the structured and unstructured measure

remains unaccounted for. Thus, the possibility exists that the correlation generated by the unstructured measures is created by a semantic overlap in attributional and maladjustment language which does not reflect an overlap in the actual perceptions of the observer.

Professional versus non-professional populations. The populations employed by the Snyder (1977) study and the present study were radically different. The Snyder study employed experienced psychoanalytically oriented and behaviorally oriented clinical professionals, while the present study employed non-professionals (college students). It may be the case that mental health professionals are trained or sensitized to the dimension of personal-situational causality, resulting in a somewhat different use of this dimension and/or a greater entering of attributional factors into maladjustment considerations. Similarly, professionals and non-professionals may conceive of maladjustment in somewhat differing manners.

Perceived Maladjustment and Social Rejection

As was expected, greater perceived maladjustment led to greater social distancing or social rejection, but the magnitude of this relationship was surprisingly small. Those aspects of this relationship which might account for the small observed correlation should be mentioned. First, the concept of "mental illness" with its more explicit

implication of derangement might be more strongly linked to social rejection than the weaker, overlapping concept of "maladjustment." Second, social rejection may occur more as a function of the perceived presence or absence of maladjustment or mental illness, rather than the degree of maladjustment which the current rating was designed to measure. Finally, the maladjustment-social rejection relationship, as it is usually conceived, involves behavioral social rejection. The current measure represents a self-report of social distancing which may understimate variation in behavioral social rejection. A possible lack of sensitivity of the social distance measure, though the measure has been used repeatedly in past studies, would also account for the absence of any independent variable effects for social rejection.

Social rejection was found to be significantly correlated with the degree of subjects' identification with the client's problem. As one might expect, greater problem identification led to less social rejection. Interestingly, no corresponding correlation occurred between social rejection and role identification. Thus, being able to identify with the role of being a client does not alter one's feelings about the client; rather, one's rejection of the client is lessened only when one can identify with the specific area of difficulty or behavior of the client.

Summary

The major purpose of this investigation was to explore the impact of three social factors on observers' maladjustment perceptions and social rejection, exploring the role of causal attributions in these reactions. As expected, the decision by an expert as to whether or not the client needs treatment was an important communicator of maladjustment information. The social factors of professional label of help source (psychiatrist versus social worker) and the help seeking similarity or dissimilarity of the observer to the client proved to be non-influential on observers' causal attributions, perceptions of maladjustment, and social rejection of the client.

Subjects who have seriously considered seeking help themselves were found to identify to a greater extent both with the client and the nature of the problem. Discriminant analysis suggested, however, that this reflected a greater interest in, or focussing of attention on the client rather than an empathic response. A significant, though small correlation was found between situational attributions and role identification, and the relationship was seen as confirming the attributional aspect of empathy.

Surprisingly, perceptions of maladjustment and social rejection were not found to involve a causal attribution component. The absence in the current study of a causal attribution - perceived maladjustment relationship was

discussed in terms of the use of structured versus unstructured measures and professional versus non-professional populations. The expected correlation between perceived maladjustment and social rejection was observed, but this was also surprisingly low. The professional label of the help source was also not found to influence any of the dependent variables in the present study, including social rejection. Possibly, the importance and strength of stigmatizing effects have been overestimated by previous studies.

It was suggested that future research might fruitfully look at the impact of a stronger manipulation of treatment decisions. This would include an investigation of the impact of different modalities of treatment on causal attributions (cf. Batson, 1975) and perception of maladjustment. A comparison of biological and verbal treatment modalities was specifically recommended. Further research is required as well as to the nature of attributional language in clinical situations. Not only would such research be interesting in its own right, but it would possibly clarify some of the reasons for the structured versus unstructured measure discrepancy in the attributional literature.

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Appendix A

Academic History Questionnaire

ACADEMIC HISTORY

The following information would be most useful to the researchers in analyzing the results of this study:

1. I attended regular winter day classes at the University of Manitoba last year (1978-79)

YES NO

2. I am _____% sure I will be attending regular winter day classes at the University of Manitoba this coming year (1979-80)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Appendix B

Preliminary Instructions to Subjects

INTERVIEW JUDGMENT STUDY

We are conducting research on how accurately people are able to make judgments about others who are seeking help for certain problems they have. Before beginning the study, it is necessary that you fill out a questionnaire giving us some important information about yourself. All information you give us will be confidential, and you may remain entirely anonymous. Please turn to the next page and fill out the questionnaire. Don't rush. Please think carefully about your answers. When you finish the questionnaire, stop and wait for the others to catch up.

Appendix C

Personal Information Questionnaire

PERSONAL INFORMATION QUESTIONNAIRE

1) Age _____ 2) Sex: M F

3) Marital Status: Single ____
Engaged ____
Married ____
Separated ____
Divorced ____

4) Family Background:

A) As a teenager, my family resided in a community with a population of

100 or less ____
100 - 1000 ____
1000 - 10,000 ____
10,000 - 100,000 ____
100,000 and over ____

B) Number of brothers and sisters _____

C) In order of birth, I am the _____ oldest of the children in my family.

5) University Background:

A) Faculty _____

B) Current or expected college major _____

C) Year _____

6) Often we find we cannot solve all our problems ourselves. How seriously in the past have you considered seeking help from someone else (such as a counselor, priest, teacher, psychiatrist, etc.)?

1	2	3	4	5	6	7
not seriously at all						very seriously

Appendix D

Expanded Instruction to Subjects for Psychiatrist Condition

INSTRUCTIONS

We are interested in finding out how accurately people are able to make certain judgments based on the information occurring during the first five minutes of an interview between a person seeking help and a Psychiatrist. You will initially be given the same information as was available to the Psychiatrist before the interview began, followed by a brief summary of the interview. You will then listen to a tape recording of the first five minutes of this interview. Please concentrate fully so you are able to use accurately the information presented to you. Your task is, on the basis of the available information, to derive as accurate a perception of the person as possible, in particular considering the <u>likely cause</u> of the person's problems.

Appendix E

Expanded Instruction to Subjects for Social Work Condition

INSTRUCTIONS

We are interested in finding out how accurately people are able to make certain judgments based on the information occurring during the first five minutes of an interview between a person seeking help and a Social Worker. You will initially be given the same information as was available to the Social Worker before the interview began, followed by a brief summary of the interview. You will then listen to a tape recording of the first five minutes of this interview. Please concentrate fully so you are able to use accurately the information presented to you. Your task is, on the basis of the available information, to derive as accurate a perception of the person as possible, in particular considering the <u>likely cause</u> of the person's problems.

Appendix F

Information Sheet for Psychiatrist/Psychotherapy Condition

INFORMATION SHEET

Name: Ms. H.

Sex: Female

Age: 20

Occupation: College Student.

Summary of interview:

Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Psychiatrist who makes a decision that Ms. H. requires treatment in the form of psychotherapy.

Appendix G

Information Sheet for Psychiatrist/Counseling Condition

INFORMATION SHEET

Name: Ms. H.

Sex: Female

Age: 20

Occupation: College Student.

Summary of interview:

Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Psychiatrist who makes a decision that Ms. H. requires treatment in the form of counseling.

Appendix H

Information Sheet for Psychiatrist/No Decision Condition

INFORMATION SHEET

Name: Ms. H.

Sex: Female

Age: 20

Occupation: College Student.

Summary of interview:

Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Psychiatrist who does not make a decision regarding treatment for Ms. H.

Appendix I

Information Sheet for Psychiatrist/No Treatment Condition

INFORMATION SHEET

Name: Ms. H.

Sex: Female

Age: 20

Occupation: College Student.

Summary of interview:

Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Psychiatrist who makes a decision that Ms. H. does not require any treatment.

Appendix J

Information Sheet for Social Work/Psychotherapy Condition

INFORMATION SHEET

Name: Ms. H.

Sex: Female

Age: 20

Occupation: College Student

Summary of interview:

Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Social Worker who makes a decision that Ms. H. requires treatment in the form of psychotherapy.

Appendix K

Information Sheet for Social Work/Counseling Condition

INFORMATION SHEET

Name: Ms. H.

Sex: Female

Age: 20

Occupation: College Student

Summary of interview:

Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Social Worker who makes a decision that Ms. H. requires treatment in the form of counseling.

Appendix L

Information Sheet for Social Work/No Decision Condition

INFORMATION SHEET

Name: Ms. H.

Sex: Female

Age: 20

Occupation: College Student.

Summary of interview:

Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Social Worker who does not make a decision regarding treatment for Ms. H.

Appendix M

Information Sheet for Social Work/No Treatment Condition

INFORMATION SHEET

Name: Ms. H.

Sex: Female

Age: 20

Occupation: College Student.

Summary of interview:

Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Social Worker who makes a decision that Ms. H. does not require any treatment.

Appendix N

Client Interview Tape Rating Forms

NAME _____ TAPE _____

The following is a role play of the first five minutes of an initial interview conducted by a psychiatrist. Listen carefully to the recording and answer the following questions:

1. To what extent does the tape adequately portray a clinical interview?

1	2	3	4	5	6	7	8	9
not at all		somewhat		moderately		good		excellent

2. Regardless of your personal opinion, to what extent do you feel the client attributes her problems to the situational versus personal factors as defined below?

   A. Situational Factors: Such factors as her environment, the behavior of other people, events taking place around her, and external pressures.

   B. Personal Factors: Such factors as personality, traits, character, personal style, attitudes, mood, and internal pressures.

1	2	3	4	5	6	7	8	9
totally situational				equally situational and personal				totally personal

3. Indicate how disturbed and maladjusted you would rate the client portrayed in this tape to be.

1	2	3	4	5	6	7	8	9
well adjusted				moderately disturbed and maladjusted				very disturbed and maladjusted

NAME _____ TAPE _____

The following is a role play of the first five minutes of an initial interview conducted by a social worker. Listen carefully to the recording and answer the following questions:

1. To what extent does the tape adequately portray a clinical interview?

1	2	3	4	5	6	7	8	9
not at all		somewhat		moderately		good		excellent

2. Regardless of your personal opinion, to what extent do you feel the client attributes her problems to the situational versus personal factors as defined below?

   A. Situational Factors: Such factors as her environment, the behavior of other people, events taking place around her, and external pressures.

   B. Personal Factors: Such factors as personality, traits, character, personal style, attitudes, mood, and internal pressures.

1	2	3	4	5	6	7	8	9
totally situational				equally situational and personal				totally personal

3. Indicate how disturbed and maladjusted you would rate the client portrayed in this tape to be.

1	2	3	4	5	6	7	8	9
well adjusted				moderately disturbed and maladjusted				very disturbed and maladjusted

Appendix O

Graduate Student Ratings of Client Interview Tapes

Graduate Student Ratings of Client Interview Tapes

Subject	Test Tape: tape 1	tape 2	tape 3	tape 4
Adequacy Rating				
Social Work Condition				
Subject 1	4	7	5	7
Subject 2 (male)	5	3	7	7
Subject 3 (female)	5	4	6	8
Subject 4 (male)	6	7	5	6
Psychiatry Condition				
Subject 1 (female)	5	5	5	5
Subject 2 (male)	7	6	7	6
Subject 3 (female)	7	7	7	7
Subject 4 (male)	8	7	8	7
Subject 5 (male)	5	5	7	7
Situation - Personal Attribution				
Social Work Condition				
Subject 1 (female)	7	6	5	4
Subject 2 (male)	4	4	4	6
Subject 3 (female)	2	2	5	6
Subject 4 (male)	7	4	2	2
Psychiatry Condition				
Subject 1 (female)	7	8	4	6
Subject 2 (male)	8	5	2	2
Subject 3 (female)	7	4	7	5
Subject 4 (male)	8	6	6	5
Subject 5 (male)	7	7	6	4
MALADJUSTMENT RATING				
Social Work Condition				
Subject 1 (female)	3	4	5	5
Subject 2 (male)	3	3	5	3
Subject 3 (female)	6	5	6	5
Subject 4 (male)	6	7	6	5
Psychiatry Condition				
Subject 1 (female)	5	6	5	5
Subject 2 (male)	4	4	4	5
Subject 3 (female)	6	6	6	7
Subject 4 (male)	5	4	4	3
Subject 5 (male)	5	6	7	6

Appendix P

Attribution Questionnaire

On the following pages, you will be asked several questions about the person whose interview you have just heard. Take your time, and make your decision carefully.

* * *

Based on the information you have been given, and using the scale provided, describe the extent that you judge Ms. H's problems to be due to situational versus personal factors as defined below:

A. Situational Factors: Such factors as Ms. H's social environment, the behavior of other people, events taking place around her, and external pressures.

B. Personal Factors: Such factors as personality, traits, character, personal style, attitudes, mood, and internal pressures.

1	2	3	4	5	6	7	8	9
totally situational				equally situational and personal				totally personal

Appendix Q

Perceived Maladjustment Questionnaire

Based on the information you have been given, indicate how disturbed and maladjusted you believe this person to be.

1	2	3	4	5	6	7	8	9
well adjusted				moderately disturbed and maladjusted				very disturbed and maladjusted

Appendix R

Social Rejection Questionnaire

We are also interested in your personal reaction to this individual based on the information you have been given. There are probably some people with whom you would be willing to be very good friends, and others you would just as soon not even be around. We would like you to tell us how close a relationship you would be willing to have with this person. Check the space below each of the following statements which most closely corresponds to <u>your feelings</u> about the person. Guess if you aren't really sure.

I would like to live next door to this person.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to sit next to this person in class.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to have this person as a roommate.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to have this person care for my children in my absence.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to have this person as a close personal friend.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to invite this person home to dinner.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to go to a party to which this person was invited.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to eat lunch with this person in school.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to have this person as a member of my social group or club.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to have this person as one of my speaking acquaintances.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to work on a two-person project with this person.

strongly agree	agree	no opinion	disagree	strongly disagree

I would like to have this person marry a close member of my family.

strongly agree	agree	no opinion	disagree	strongly disagree

Appendix S

Factor Analysis of Social Rejection Scale

The Social Rejection Questionnaire was a 12 item scale covering relationships involving school, friendship, acceptance into family, etc. A factor analysis was performed to assess whether or not the different areas included resulted in differential responding (i.e., separable social rejection factors). A principle component analysis with varimax rotation indicated that only one factor had an eigenvalue greater than one (4.69) and accounted for 85.8% of the variance. Thus the scale proved to be a unidimensional measure of social rejection.

Appendix T

Additional Dependent Measure Questionnaire

1. With whom were you identifying while making your evaluation?

1	2	3	4	5	6	7	8	9
totally with interviewee				equally with interviewee and interviewer				totally with interviewer

2. To what extent were you able to identify with the interviewee's problems?

1	2	3	4	5	6	7	8	9
not at all				moderately				entirely

3. To what extent do you feel that the interview you heard is typical of helping interviews in general?

1	2	3	4	5	6	7	8	9
not typical at all				moderately typical				entirely typical

Appendix U

Feedback to Subjects

FEEDBACK

We would like to give you some feedback on the specific purpose of the study, which is, as we said at the beginning, to look at people's judgments about someone seeking professional help for a problem.

The process of judging someone to be maladjustive, disturbed, mentally ill is a complex one, and one which even trained professionals have great difficulty with and are inconsistant in making.

One factor which is thought to play a role in people making estimates of maladjustment is the nature of the perceived cause of the problem. For the same problem, it is often the case that seeing the cause as a personal one, lying within the person, is likely to result in a greater estimate of maladjustment than if the cause is seen as situational. Such a tendency is neither right or wrong, but we are interested in seeing how consistantly such a tendency occurs.

Please don't discuss this experiment with other classmates until next week, when the study is over, as you might influence their reactions to it.

Appendix V

Univariate Analyses of Variance for Help Seeking

Univariate Analyses of Variance for Help Seeking

Source	df	MS	F	p
Treatment Decision (Treat)	3	0.992	1.06	.370
Professional Label (Label)	1	0.023	0.02	.877
Help Seeking Similarity (Simil)	1	484.454	514.92	.000
Treat x Label	3	0.215	0.28	.838
Treat x Simil	3	0.121	0.13	.943
Label x Simil	1	0.818	0.87	.352
Treat x Label x Simil	3	0.061	0.06	.979
Subjects Within Groups	160	0.991		

Appendix W

Observed Cell Means

Observed Cell Means

Label x Treatment x Similarity	Dependent Variable					
	Attribution	Maladjustment	Social Rejection	Role Identification	Problem Identification	Typicalness
1,1,1	5,72727	5,00000	32,54545	2,54545	6,72727	5,90909
1,1,2	5,00000	5,36364	36,36364	3,18182	4,90909	6,27273
1,2,1	5,18182	5,54545	37,27273	3,81818	5,90909	5,90909
1,2,2	4,72727	5,45455	35,27273	4,54545	6,27273	5,45455
1,3,1	4,81818	5,27273	37,00000	3,00000	6,18182	5,63636
1,3,2	4,72727	6,18182	34,45455	3,18182	5,63636	5,09091
1,4,1	5,09091	4,45455	38,54545	3,00000	5,54545	5,36364
1,4,2	5,27273	4,00000	35,72727	2,54545	5,63636	5,90909
2,1,1	4,81818	6,00000	36,36364	2,36364	6,90909	6,00000
2,1,1	4,81818	4,63636	34,45455	4,00000	5,18182	5,90909
2,2,1	5,18182	5,18182	37,36364	2,54545	7,00000	6,00000
2,2,2	4,81818	5,18182	40,36364	4,27273	5,63636	6,00000
2,3,1	5,27273	5,54545	37,18182	2,90909	6,00000	5,63636
2,3,2	5,36364	6,45455	37,81818	4,90909	6,00000	5,72727
2,4,1	5,36364	4,81818	36,00000	2,36364	7,18182	6,72727
2,4,2	5,27273	3,72727	35,90909	2,45455	7,00000	5,09091

Label: 1 = Social Worker; 2 = Psychiatrist

Treatment: 1 = Psychotherapy; 2 = Counseling;

3 = No decision; 4 = No Treatment

Similarity: 1 = Similar; 2 = Dissimilar

Appendix X

Grand Means and Standard Deviations

Grand Means and Standard Deviations

Dependent Variable	Mean	Standard Deviation
Attribution	5.0909	1.5722
Perceived Maladjustment	5.1761	1.7461
Social Rejection	36.4148	7.1084
Role Identification	3.2273	1.9316
Problem Identification	6.1080	1.9316
Typicalness of Interview	5.7898	1.5986

Appendix Y

Questionnaire for Assessing Stimulus Value of No Decision Condition

The following is a summary statement of an interview between a person seeking help for certain problems she has and a Psychiatrist. Read it and answer the question below.

> Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Psychiatrist who does not make a decision regarding treatment for Ms. H.

What thoughts immediately come to your mind upon reading that the Psychiatrist <u>does not make a decision regarding treatment for Ms. H.</u>? (Give as complete an answer as possible.)

Appendix Z

Questionnaire for Assessing Stimulus Value of No Treatment Condition

The following is a summary statement of an interview between a person seeking help for certain problems she has and a Psychiatrist. Read it and answer the question below.

> Ms. H. reports during the interview that she has been experiencing several problems and difficulties, and as a result is feeling upset. She discusses these problems with the Psychiatrist who makes a decision that Ms. H. does not require any treatment.

What thoughts immediately come to your mind upon reading that the Psychiatrist <u>makes a decision that Ms. H. does not require any treatment</u>? (Give as complete an answer as possible.)

Appendix AA

Responses to No Decision Condition

1. Either he wants her to learn to work it out for herself or he does not know what she should do. One other possibility is that there is no further treatment or advice he could give her that would help her any further.

2. If this person is a trained Psychiatrist maybe he/she feels that a decision should not be made by himself. Ms. H. maybe felt that she should have to help solve these problems by coming up with a possible decision regarding treatment. I believe that the Psychiatrist was just in doing this.

3. The psychiatrist doesn't help Ms. H. to solve the problem. He is not a good psychiatrist.

4. The immediate thoughts which came to my mind are that the psychiatrist doesn't seem to be adequately trained or capable enough to help this person and should refer her to another psychiatrist who maybe could help her. I felt sorry for the patient because, if the doctor couldn't even help her with he problem, then this would really make her feel worse. This could be all true unless, the psychiatrist feels that the woman's only need was to tell someone else about her problem. Therefore, she would already have been helped. Otherwise, she should not waste her time with him any further.

5. The psychiatrist is trying to frustrate Ms. H. so that she could think for herself, her real problem. She could get a chance to analyze herself, too.

6. The Psychiatrist wants to talk with Ms. H. again and learn more about her. He probably wants to see if Ms. H. changes and is no longer depressed. By not prescribing anything for Ms. H., she is able to deal with her problem by herself. If she had drugs, she would possibly relate problem solving with drugs which is wrong.

7. Her troubles are not really serious and she probably can solve them by herself and doesn't need any treatment at all. Or the psychiatrist doesn't know what to do or could find a solution for her. Maybe he needs more time to judge the problems.

8. I feel that the Psychiatrist either does not feel that the problems are out of the ordinary and therefore do not need extra special attention to "treating" them, or the Psychiatrist may feel that more sessions will be necessary to understand the basis of the problems, in which case proper treatment will then be prescribed to Ms. H.

In either case, I feel that the Psychiatrist is not competent, in that he cannot come to any conclusions, regarding further treatment for Ms. H.

9. The thought immediately coming to my mind is why Ms. H. is going to the psychiatrist if he or she can't make a decision on treatment needed. The psychiatrist has been no help and she will remain upset or have to sort it out for herself. She is right at the beginning of her problem again.

10. The psychiatrist probably is undecided about what to do and perhaps will, in the future, decide upon a treatment for her.

11. The Psychiatrist perhaps feels himself in no position to make this decision. He may feel that his opinion could be unjustly biased and therefore does not suggest treatment. He may also admit unto himself that the above case has never come up before, and, being thus totally unique, cannot be the object of treatment.

12. I think that probably the psychiatrist feels that he would not be justified in making a decision regarding treatment because he feels he doesn't know her well, all her symptoms are not very specific, we all have problems and are upset. I think in order for the doctor to prescribe treatment Ms. H. would have to be more specific. The doctor needs more time with her, to try and figure out exactly what is bothering her. In my point of view if in fact Ms. H. does have a psychological problem she could try and help herself.

The doctor however is within his right not to propose treatment. I would certainly hope that he would try a little more to get to the problem which Ms. H. seems to have.

13. That perhaps he wants to go deeper to find out the real cause of the problem. Perhaps he feels that the problem Ms. H. has discussed with him is not the real depth or the root of the problem causing her to feel upset. Or maybe he doesn't really understand it himself to give Ms. H. a treatment right away, but he intends to go more deeper into the problem.

14. The thoughts that come to my mind are that the psychiatrist does not know what kind of treament to offer, or the psychiatrist doesn't know enough about the patient's background or what caused the problems. The psychiatrist might think the problem is minor.

15. Psychiatrist perhaps wants to discuss Ms. H's problems and let her decide what treatment or help she needs. Also before reaching any decision regarding treatment it is first necessary to discover the cause of the problems.

16. Probably the psychiatrist doesn't think she has a major problem and that she will get over it without needing any specific help - the only help the psychiatrist can offer is just to let her talk it out.

17. Ms. H. is obviously looking for some type of outside assistance that will enable her to solve her problems. Because the Psychiatrist does not make a decision regarding treatment for Ms. H., this does not necessarily indicate that he is uninvolved or uncaring, but perhaps shows that he feels that only she can answer her problems. A Psychiatrist, by no means has answers to all of our questions, and solutions to all of our problems but instead is there to possibly help us formulate answers and solutions of our own accord. Ms. H. will solve her difficulties, with the help of the Psychiatrist, but she must also help herself.

Appendix AB

Responses to No Treatment Condition

1. The psychiatrist has obviously not listened openly to the patient's complaints. If she believes she is experiencing difficulties then there must be a reason why she is having difficulties. What a dumb question!!

2. I feel that the Psychiatrist is not doing his job because he refuses to give Ms. H. help. He must feel that her complaints are superficial and do not need treatment, however, if they are superficial he should help her realize this. If there is some kind of validity whether it be internal or external he should help her cope with her problems and difficulties.

3. The psychiatrist shouldn't be authoritated to say whether Ms. H. is well or sick. He shouldn't have the responsibility to make this kind of decision. There obviously is a problem if the woman feels that she requires professional help, and the psychiatrist should respect her decision. It is quite possible, too, that Ms. H. is simply neurotic, and feels sorry for herself. But if problems and difficulties can upset her, she may have a personality problem, or she may be immature for her age, in which case she still needs help.

4. Her problems and difficulties are due to external environment rather than her own internal conflicts or anxiety or psychological unbalanced. So, psychological treatment can't be any help and it will only bring about bad effect such as confusion of herself and lack of self-confidence.

5. The thought that immediately comes to my mind is that the psychiatrist may be wrong in his decision. As a result, Mrs. H. will not receive any help and she will probably continue to be upset. It may happen that Mrs. H. will come to the stage where she can't cope with her problems any more, and consequently, she may commit suicide. The psychiatrist's decision was too hasty. He should have used more than one interview to make his decision.

6. From the above statement I feel that Ms. H. must have a very trivial problem or that she may have some nerve disorder which cannot be treated by a psychiatrist. These problems and difficulties may be the type in which she alone can only cure. From this I also gather that Ms. H. is a very independant person and one who is unwilling to do as others may advise to her and as a consequence the psychiatrist feels that her problem cannot be saved by his knowledge of her problem.

7. The thoughts that come to mind are that the woman's problems must be very insignificant and not really what the problem is for the psychiatrist to not prescribe treatment.

8. Ms. H. should be able to handle her problems without help by herself or with her family. Ms. H. may be experiencing problems that many people have in general at one time or another and are not so "serious" as to require professional help. Ms. H. is capable enough to deal with the problems without assistance. Maybe the problems are problems that can only be solved by Ms. H. herself. The problems are probably fairly common or the behaviour is not what the majority of people would call "abnormal." The psychologist upon talking to Ms. H. feels she is a competent enough person to "help herself."

9. I think the psychiatrist is nuts. In the first place, she must "think" she has problems, because she did go and see a psychiatrist. Secondly, if a person is upset enough to go and have to talk out their problems with someone professional, they really do have a problem. We shouldn't need psychiatrist in normal, "everyday" situations, but some people can't take the pressures of even "normal" situations, so they do need advice. She (Ms. H.) went for help, expecting someone to guide her through her problems, and the psychiatrist denied her that guidance!

10. This statement makes me think that the psychiatrist has underestimated the severity of Ms. H's problems and is kind or just brushing her aside without really considering how upset she may be. If Ms. H. felt upset enough to come to a psychiatrist, she deserves treatment to help her solve her problems and feel less upset.

11. The psychiatrist makes such a statement because the woman has just discussed her problems. Talking about her problems has already helped the patient. Also, whether this is relevant, Ms. H. represents a liberated woman. Possibly her liberation has been upsetting her, and Ms. H. just neded to talk to someone.

12. Mr. Psychiatrist probably doesn't know what he is doing. I wonder whether Ms. H. checked to see if he had a diploma on his wall. Could be however that he got it at Woolworths on $1.49 day. The guy is definitely only after getting the money off her. Probably charged her $50. to tell her she doesn't need treatment. I'm sick of paying out money to psychiatrists who just tell me to go home without any pills.

13. The problem is not a major issue in Ms. H. life so she doesn't need treatment from him.

14. I think nothing of it. Either the psychiatrist has realized that Ms. H. doesn't require treatment, or perhaps he is merely incompetent. There is not enough info. to decide which it is, though. Therefore, I don't really think anything of his decision.

15. It seems that there really isn't a problem. It is all in Ms. H's head.

16. I figure that he is not a psychatrist that is that concerned with the person. He shouldn't tell her there is nothing wrong, he should ask her more about the problems and try to find one cause. He could possibly tell her to continue on and if more problems arise then come for treatment.

17. Ms. H. probably does not require any treatment because she probably is just confused as the psychiatrist sees it. She does not need any treatment because she is not mentally ill. She probably just needed someone to talk to. Ms. H. is probably just like most people who are very emotional about various things because the article mentions that she was upset. The doctor probably feels that she had let out all her frustrations and therefore does not need further help.

18. 1) Ms. H. is making her problems out to be much more serious and troublesome than they actually are.
2) The psychiatrist himself may be making a snap judgment, made without enough information on Ms. H.