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Cause and Perceived Seriousness of Deviant Behavior and Attribution of Responsibility

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CAUSE AND PERCEIVED SERIOUSNESS OF DEVIANT BEHAVIOR AND ATTRIBUTION OF RESPONSIBILITY

by

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Cause and Perceived Seriousness of Deviant Behavior
and Attribution of Responsibility
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The purpose of this study was to investigate the relationship between differing stated causes of deviant behavior which is commonly labelled mental illness, and the perceived seriousness of these behaviors in determining judgments of the degree of responsibility attributed to described deviant individuals. This was accomplished by having subjects rate four different vignettes as to degree of perceived seriousness and degree of responsibility for behavior.

The subjects were 76 undergraduate students enrolled in either introductory psychology and/or introductory anthropology. The subjects were divided into four groups. Each group of 19 subjects received the same four vignettes. Each vignette gave a behavioral description which was characteristic of one of four categories of mental illness: paranoid schizophrenic, simple schizophrenic, depressed neurotic, and phobic compulsive. Each group received a different stated cause for the described behavior. These causes were biological, social learning, unknown, and both biological and social learning. The subjects were asked to rate the individual described in each vignette as to how

serious they perceived the individual's behavior to be on a scale of 1-4. Subjects were also asked to rate how responsible the described individual was, in their judgment, for his behavior on a scale of 1-5.

The specific questions addressed by this study were: (1) Does the degree of responsibility for deviant behavior attributed by normal individuals to various types of described deviant behavior vary as a function of the stated cause of behavior? (2) Does the degree of responsibility for deviant behavior attributed by normal individuals to various types of described deviant behavior vary as a function of the perceived seriousness of the behavior? and (3) Do stated cause and perceived seriousness of behavior interact in determining the degree of responsibility normal individuals attribute to deviant individuals.

The results of this study indicated that there is a significant relationship between the perceived seriousness and degree of responsibility attributed to deviant individuals. More specifically, the paranoid schizophrenic individual, rated as the most serious, was seen as significantly less responsible than the less serious depressed neurotic or phobic compulsive individual. No significant main effect was found for the stated cause of behavior and no significant interaction, cause by perceived seriousness, was found.

These results provide support for the notion that perceived seriousness contributes more to the determination of attribution of responsibility than does the stated cause of behavior. The implications of these findings as they relate to psychiatric rehabilitation were discussed as were the limitations of this study which included concerns regarding instrumentation and statistical analysis.

(78 pages)

CHAPTER I

STATEMENT OF THE PROBLEM

Introduction

Throughout recorded history, in most societies, there have been a small percentage of the population who have behaved in bizarre and socially unacceptable ways, as defined by other members of the society. These individuals have often been given perjorative labels such as "crazy," "insane," or "mentally ill." For as long as the behavior of these individuals has been a subject of interest and social significance, attempts have been made to ascertain possible causes of these apparent mental disorders in the hope of developing new understanding, possible treatment strategies, and more effective means of social control.

According to historical accounts (cf. Foucalt, 1965; Scull, 1979; Szasz, 1974), prior to the 16th century, during what Szasz calls the Age of Faith, madmen were seen as heretics and were ostracized by society. With the advent of the scientific Age of Reason, new means of dealing with this form of deviance slowly evolved. According to Scull (1979), until the mid 19th century most deviants lived out their lives at home and were categorized among the degenerate and indigent. Scull (1979) also documents the mid 19th century, in England, as the time during which madmen were confined in hospitals, or otherwise segregated, and defined as a "problem population". This new form of social control of

the mad, hospitalization, is terms by Scull as the "medicalization" of deviance.

Reform in the treatment of the mentally ill began by treating deviant individuals "as if" they were sick and in need of medical care. Attempts were made to diagnose the causes of deviant behavior and to treat it as a medical problem. This reform in the treatment of mental disorders posited a new interpretation regarding its cause. A shift toward an orientation which assigned a medical cause to deviant behavior provided a supposedly more humanitarian approach to mental disorders. Out of this new humanitarian approach, new and more effective treatment strategies were not immediately forthcoming, however, a new form of social control had been found.

Over the years, the medical model of mental illness gained increasing popularity. Individuals who exhibited deviant behavior were viewed as being sick and were treated in the medical domain.

In current professional thinking, the medical model is still prevalent. Within this model, deviant behavior is viewed as a result of an underlying disease entity or process. Individuals who exhibit deviant behaviors are perceived as "sick" or "ill", and it is held that they should be treated in a manner analagous to treating a person with medical problems, i.e., rest, medication, hospitalization (Bord, 1970-71). It has been suggested by Parsons that "being sick" is a societal role and that there are expectations relative to this role. These include: (1) exemption from normal social responsibilities, i.e., family support, employment; (2) exemption from personal responsibility for the sickness; (3) a patient should want to try to get well; and (4)

a patient is obliged to seek professional help, usually medical (Mechanic, 1969). The first two of these expectations could be considered privileges of "being sick". The second two more closely resemble the obligation of "being sick". According to Sarbin and Mancuso (1980) diagnosis serves primarily to confer the social role of "sick person", which role exonerates one from responsibilities; in other words, grants privileges to "sick" persons.

Proponents of the medical model contend that acceptance of their model is beneficial in that it reduces stigmatization of those members of society who are labelled mentally ill by not holding them accountable for normal social responsibilities or for their own sickness. This model contains the assumption that "sick" persons are less stigmatized and rejected than are "immoral" or "bad" person who exhibit identical deviant behaviors. However, according to Sarbin (1967) persons who are labelled mentally ill are not regarded as merely sick. They are regarded as non-persons deserving of degradation and fear, and the use of an illness paradigm or medical model is not sufficient to overcome the moral censure by the public of these labelled mentally ill.

Although the medical model has remained a popular approach to understanding and treating mental disorders, other approaches have rejected this biological orientation. One approach which has rejected this orientation is the social learning model. According to Akers (1973) the basic premise of social learning theory is that all behavior, both conforming and deviant, is learned. Deviant behavior, in this model, is not a result of heredity or intrapsychic trauma, but a result of the way an individual has learned to respond to his environment. The

appropriateness or inappropriateness of an individual's behavior is defined by social norms, both formal and informal. Within this framework, treatment consists of relearning and re-education with a focus on consequences, particularly interpersonal consequences, for behavior. Clients are not treated as "sick" nor do they assume a patient role. Unlike the medical model, the social learning model does not recognize the concept of "sick role" which appears to exonerate individuals from normal social responsibilities.

Responsibility has become a watch-word for many current therapies and self improvement strategies. Increasing personal responsibility for behavior is thought, by many authors on theory and treatment, to be a necessary condition for change (cf. Perls, 1969). It would appear that the degree to which a deviant individual is seen as responsible for his behavior, both by himself and by others, has important implications for therapeutic change.

The medical and social learning models represent two current ways of looking at causes of deviant behavior. Both have found their way into the general public consciousness and may serve to affect how the general public views deviant behavior. In light of the current controversy regarding the nature of the causes of deviant behavior, it would appear that the most common situation in which the general public finds itself is one of ambiguity, either with no information regarding cause or with conflicting information.

An important part of how a deviant individual is viewed by others may be their ideas about why he or she behaves as they do. According to Wortman (1976) and Snyder (1976) assigning causes to events or behavior

aids people in structuring and organizing their perceptions of the world in ways which make it meaningful. The perceived causes of events, including behavior, often has direct implication for how these events and/or behaviors are viewed and responded to. An individual whose belief system explains events as having a cause related to fate, or being otherwise externally determined, may feel that people have little individual ability to change themselves or the course of events, and may feel that people are powerless. Under this assumption, a deviant individual may be viewed by others as not having control over his or her behavior and may be seen as a victim deserving of empathy, understanding, and sympathy. This person may be viewed as being forced, by internal disease entities, to behave in socially disapproved of ways, and be absolved of all responsibility for his or her behavior. The medical model of mental illness appears to take this point of view. At the other end of the continuum, an individual whose belief system values the role of the individual's ability to make things happen, may feel that people are more in control of the day to day events of life, and do have at least some control over their behavior. Under this assumption, deviant behavior are seen as within the person's control. He or she may not be seen by others as a victim, but as the author or perpetrator of the situation, and may receive little sympathy. Indeed, this person may be considered worthy of punishment, and is often judged as morally and personally responsible for his or her behavior. Thus it appears that one factor which may effect individual's perceptions of those exhibiting deviant behavior is perceived cause of behavior. The social learning model of mental illness appears to take this point of view.

In addition to cause, another fact which may be important in determining an individual's perception about deviant behavior is the perceived seriousness of the behavior. Behaviors associated with mental disorders range from the withdrawn and very non-threatening to very violent other or self destructive behaviors.

The more visible and serious a deviant behavior appears, the more likely it may be that individuals need to assign cause to it and interpret it. As noted earlier Wortman (1976) and Snyder (1976) have posited that assigning causes to events or behavior aids people in structuring and organizing their perceptions of the world. Perhaps most individuals have no need to deal with non-serious deviant behaviors, but do need to assign cause to and interpret serious deviant behaviors. Thus a second factor that may effect individuals' perceptions about deviant behavior is the perceived seriousness of the behavior.

Statement of Problem

At the present time the literature is unclear regarding how cause and perceived seriousness of deviant behavior effects the degree of responsibility assigned to a deviant individual for his behavior. The present study proposes to investigate the relationship between cause, and perceived seriousness in determining judgments of the degree of responsibility deviant individuals are seen to have for their behavior.

Purpose and Objectives

The purpose of this study is to empirically test whether different stated causes of deviant behavior will result in differences in the

degree of responsibility assigned to a described deviant individual. The study will also examine the effects of differing stated causes on assignment of responsibility as perceived seriousness of deviant behavior varies. Should the findings reveal that different causal interpretations do not significantly effect the degree of responsibility assigned to a deviant individual, this would call into question one of the primary differences between the models in question. That is, the difference between the two models with regard to issues of personal responsibility for behavior. If seriousness of behavior proves to result in significant differences in assignment of responsibility, these findings would also tend to suggest that seriousness is a relevant variable to be considered when assignment of responsibility judgments are made. Results which demonstrate an interaction effect between perceived seriousness and stated cause in the assignment of responsibility may indicate that any particular type of deviant behavior may be a special case when responsibility is assigned and not governerd by the rules applied to other instances of deviant behavior. Information regarding the relationship among these variables, i.e., cause, seriousness, and assignment of responsibility, is lacking in the literature.

This study will attempt to answer the following specific questions:

1. Does the degree of responsibility for deviant behavior attributed by normal individuals to various types of described deviant behavior vary as a function of the stated cause of the behavior?

2. Does the degree of responsibility for deviant behavior attributed by normal individual to various types of described deviant behavior vary as a function of the perceived seriousness of the behavior?

3. Do stated cause and perceived seriousness of behavior interact in determining the degree of responsibility normal individuals attribute to deviant individuals?

CHAPTER II

REVIEW OF LITERATURE

This review of literature is divided into four basic areas: (1) public attitudes toward mental illness; (2) effects of attributing different causes for deviant behavior; (3) public perception of seriousness of deviant behavior; and (4) attribution of responsibility for behavior.

Public Attitudes Toward Mental Illness

Numerous attempts have been made to determine how the public responds to mental illness through the assessment of public attitudes. The majority of this research uses survey research techniques.

Ramsey and Seipp (1948) represent one early attempt to determine the public's ideas regarding the etiology and treatment of mental illness. A stratified sample of 345 adults in Trenton, New Jersey, was asked a series of questions regarding their beliefs about the etiology and treatment of mental illness. The results indicated that subjects in higher education and occupational levels were less likely to see mental illness as punishment for sins and were more optimistic about changes for recovery. This early attempt to systematically investigate public attitudes lacked the breadth and sophistication, both conceptually and statistically, of later research, however, great care was taken in the sampling procedure which set a standard for later research.

Star (1957) using six case abstracts asked a sample of 3.500 respondants whether or not they thought the individuals described in the abstracts were mentally ill. The six abstracts of deviant behavior used by Star corresponded with the clinical categories of paranoid schizophrenic, simple schizophrenic, depressed neurotic, phobic compulsive, alcoholic, and juvenile delinquent. Star found that only the most extremely disturbed abstract, i.e., paranoid schizophrenic, was identified by lay persons as describing mental illness. She concluded that the general public was resistant to labeling deviant behavior as mental illness unless the behavior was extreme and serious.

Cumming and Cumming (1957), in another early study, measured the attitudes toward mental illness of people in a small rural agricultural Canadian town. Subjects were assessed before and after a six-month educational campaign designed to promote more accepting attitudes toward mental illness. They found that a wider range of deviant behavior is considered normal by the non-professional public than was once believed. They also found that subjects vehemently rejected the possibility that normal and abnormal behavior fall on a continuum and are not qualitatively different.

In an investigation of the social consequences of psychiatric hospitalization, Whatley (1958-59) demonstrated that people tend to distance themselves from people who have had psychiatric hospitalization. He suggested that this distancing creates a type of social isolation for former mental patients which makes social readjustment more difficult.

Nunnally (1961) conducted a six-year study of a nationally representative sample of 400 respondants to determine what the public knew and felt about mental illness and its treatment. Public knowledge was assessed by asking subjects to respond to 180 opinion statements on a seven-point scale of agree-disagree. Attitudes were assessed through the use of semantic differential scales, free association tests, and paired comparison items. Nunnally concluded that persons who were labelled as mentally ill were regarded with fear, distrust, and dislike by the general public. He also concluded that the public suffered from a great lack of information regarding mental illness.

The findings of these early studies of public attitudes toward mental illness conducted in the 1940's and 50's suggested that the general public was uninformed about mental illness and more tolerant of deviant behavior than once suspected, provided it was not labelled as mental illness. They appeared reluctant to label individuals as mentally ill except when a described individual's behavior was very severe. They appeared to be mistrusting, afraid, and rejecting of the mentally ill and tended to distance individuals labelled as mentally ill.

During the 1960's these early results of studies of public attitudes toward mental illness were questioned by other investigators. Crocetti and Lemkau (1963, 1965, 1972), in several survey studies, reported greater tolerance toward the mentally ill than had been previously reported. They ascribed these changes to the efforts of mental health professionals to "re-educate" the public by means of public educational campaigns and political efforts at the local, state,

and national levels. A question left unaddressed was whether these purported changes were statistically significant or culturally and clinically significant.

The 1960's also brought pessimism on the part of some researchers and theoreticians regarding the efficacy of the findings and attempts at re-education efforts. The results of Tringo (1970) suggested that the "mentally ill" are still heavily stigmatized and that educational programs have had only minor effect on public ignorance and have done little to mitigate rejecting attitudes toward those labelled mentally ill (Sarbin & Mancuso, 1972). They also began to question the utility of treating deviant behavior as an illness. These pessimists advocated the use of conceptual models which reject the labelling of deviant behavior as mental illness and which endorse a view of personal responsibility for such behavior (Szasz, 1961, 1974; Scheff, 1966; Sarbin & Mancuso, 1970, 1972). These authors seriously question the propagandizing of a model (the medical model) that has the potential for leading the public to make unwarranted conclusions regarding a possible cause of certain deviant behaviors.

It can be concluded that researchers do not agree on the state of public attitudes toward mental illness. Rabkin (1974) suggested that these discrepancies in survey research may be related to differences in the ideologies and methodologies among researchers. Current researchers such as Szasz suggest that issues of personal responsibility need to be addressed more than adherence to any particular model of cause of deviant behavior.

It would appear that educational efforts have had, at best, debatable effects on public attitudes toward mental illness. Research appears to be lacking which attempts to identify factors which affect public perception of mental illness. More specifically, the public attitude literature lacks studies which attempt to determine how the general public assigns responsibility to deviant individuals and possible factors which effect these judgments of personal responsibility for behavior. Whether or not deviant individuals are judged to be responsible for their behavior or not is a facet of public attitudes toward the mentally ill which has not been widely addressed.

Effects of Attributing Different Causes for Deviant Behaviors

Attribution theory deals with the processes by which people are presumed to infer the causes for certain events (Monson & Snyder, 1977). Researchers in the field of attribution of cause have traditionally relied on a dispositional/situational dichotomy to conceptualize cause (Monson & Snyder, 1977). Dispositional causes have to do with corresponding inner states, dispositions, ability, and attitudes. Situational causes tend to reflect the current social and environmental pressures on an individual. An analagous dichotomy in psychology is exemplified by analytical vs. behavioral orientations of the nature of human behavior. The analytic orientation assumes that behavior originates as a result of the interaction of inner states and forces within the individual. The behavioral orientation assumes that behavior is caused by the individual's environment and his or her reaction to those environmental stimuli.

Rotter (1954) has proposed that people can be characterized as having either an internal or external locus of control based on their proclivity to interpret events as in the control of external forces (external locus of control) or of interpreting events as determined by the individual him or herself (internal locus of control). With respect to how causes are generally grouped, it would appear that causes can be grouped into two general categories; those that come from within the individual and are under his or her control and those which are a product of factors external to the individual.

A similar dichotomy can be posited with respect to causes of deviant behavior. The medical model appears to look at causal factors which are similar to disease processes and are not under the control of the individual. Social learning on the other hand, suggests that deviant behavior is controlled in part by external events which the individual has some chance of effecting.

The effects of attributing differing causes for deviant behavior have been heatedly argued, but until recently have not been the focus of experimental research. Farina, Fisher, and Getter (1978) studied the effects of assigning two different causes for mental illness on the degree of stigma attributed to those labelled "metally ill". In this study, 119 college undergraduate student subjects were taught either a biological or social learning model. The authors found that subjects reported themselves to support the model about which they were instructed, but that there was little reported difference in terms of degree of stigma attached to the mentally ill individual, regardless of the differences in the stated causes of this type of behavior.

Farina et al. (1978) using a sample of 38 undergraduate students, further investigated the consequences of teaching either of these two models, and found that subjects given the biological model saw the mentally ill more as victims who were less likely to be able to solve their problems than did the subjects taught a social learning model. These results suggest that individuals to whom a biological cause for deviant behavior is assigned, will not be seen as active agents able to change their behavior or solve their problems.

Morrison and Teta (1977) found, with a sample of 37 community residents, that by teaching a social learning model, the subjects' number of positive self-attribution as measured by a semantic differential scale, was significantly increased. They suggested that this type of orientation assists individuals in seeing themselves as able to cope and solve their own problems. Morrison (1977) found that be teaching a social learning orientation to mental patients, that their negative statements describing other mental patients were significantly decreased.

It would appear from the results of these studies that varying the stated cause of the behavior of persons labelled mentally ill has little effect on stigmatization, as found by Farina et al. (1978). Varying the stated cause of behavior did, however, appear to modify the subject's self-concept and the mentally ill subject's negative statements about other mentally ill persons as demonstrated in the studies by Morrison. Also varying the stated cause of deviant behavior appears to affect how deviant individuals are perceived in terms of being active agents able to change their behavior. Questions left to be addressed by this body

of research include what other variable effect the assigning of responsibility for deviant behavior and how do the determining variables interact.

Public Perception of Seriousness of Deviant Behavior

Seriousness of deviant behavior labelled mental illness, is a variable which has been addressed, though minimally, in the literature. Phillips (1964) demonstrated, using social distance measures, that the rejection of the paranoid schizophrenic, as portrayed in the Star vignettes, was greater than that of other psychiatric types. Phillips suggested that this finding was a product of how visibly the behavior deviated from socially prescribed norms. He also implied that potential disruptiveness corresponds with degree of visibility. Bord (1970-71) took issue with this interpretation of the findings. His research involved having a sample of 350 college undergraduate students enrolled in introductory sociology evaluate the same Star vignettes on the basis of their perceived seriousness. The hypothesis that subjects would judge the degree of seriousness in a parallel fashion to that dictated by psychiatric norms was supported. The vignettes were ordered from most to least serious as follows: paranoid schizophrenic, simple schizophrenic, depressed neurotic, phobic compulsive, and normal. However, when rejection of each of the individuals portrayed was measured, subjects were more rejecting in the following order: paranoid schizophrenic, depressed neurotic, simple schizophrenic, phobic compulsive, normal. Bord suggested that this is support of the contention that awareness of psychiatric descriptions does not imply

decreased rejection of the mentally ill. Results of this study indicate that subjects' judgments of clinical seriousness are similar to those of professionals, however, social seriousness, inferred from increased rejection, is a different matter. Bord suggested that perceived social seriousness is a product of perceived unpredictability and threat.

It would appear that the lay public, as represented by Bord's sample, can clearly distinguish varying degrees of seriousness from reading vignettes describing non-labelled behaviors which fall into traditional clinical categories. Bord suggested that the stated cause of the deviant behavior may not be as salient a type of information upon which to make decisions, judgments, or take actions, as might by the seriousness of the behavior itself.

It can be concluded that the lay public is able to distinguish psychiatric types in terms of perceived seriousness in a manner similar to professional mental health personnel. A question left to be addressed is whether or not the degree of perceived seriousness affects the degree to which deviant individuals are seen as responsible for their behavior. In response to Bord's suggestions, another question unanswered at this time is which factor, cause or seriousness, is a more salient factor when making a judgment regarding degree of responsibility and how do they interact.

Attribution of Responsibility

Responsibility is defined by Webster's Dictionary (Gore, 1972) as moral, legal, or mental accountability. By its definition, responsibility implies a moral evaluation of a person's behavior. Attribution of

responsibility is the degree to which an individual holds another individual responsible or accountable for something, e.g., an outcome, circumstance, or behavior.

Phares and Wilson (1972) suggested that the degree to which one person holds another as responsible for the latter's acts is a prime determinant of much of interpersonal behavior. That is, responses that are accepting vs. rejecting, punishing vs. rehabilitating, may be mediated by the degree of responsibility attributed to an individual for his or her behavior.

Typically, research in the area of attribution of responsibility has used an accident paradigm. In this paradigm, a scenario of an automobile accident is constructed for the subjects wherein various factors are manipulated, e.g., severity of outcome, ambiguity regarding who is to blame. Subjects are asked to make a judgment as to how responsible a particular individual is for the described accident and its outcome.

Walster (1966) and Shaw and Sulzer (1964) reported that an increasing amount of responsibility is assigned to the potentially guilty person as the seriousness of the accident increases. Attempts by Walster (1967) to replicate her previous result failed. Shaver, (1970) reported that the relationship between seriousness and degree of responsibility assigned was not reliable.

Phares & Wilson (1972) in an attempt to resolve these inconsistencies in the literature, used an accident paradigm and examined the role of outcome severity, situational ambiguity, and inter-external locus of control in the assignment of responsibility.

Eighty subjects were given eight brief case descriptions and asked to rate the described individual's degree of responsibility and recommend a punishment for the acts. Their results demonstrated that greater responsibility, as measured by a simple rating scale, was attributed when descriptions were clear than when ambiguous. Assignment of greater responsibility was also associated with severe outcomes as compared with non-severe outcomes. However, when the issues of responsibility was least ambiguous, attribution of responsibility significantly increased with severity of outcome. The authors suggest that this type of paradigm may not generalize well to other instances of responsibility attribution and that care should be exercised in making generalization when different measures of responsibility are used.

The variable of accountability was also investigated by See (1968). It was concluded that if an individual is regarded as accountable for his or her behavior and behaves in a deviant fashion, he or she is typically regarded as immoral or bad. If the behaviors are not seen as under the individual's control, the person is seen as sick. These results suggest that if a person's behavior is attributed to biological causes (illness) over which he or she does not have control, he or she will be seen as not responsible for his or her behavior. Conversely, if this same behavior is seen as a failure on the part of the individual to make correct decision or failure to learn appropriate interpersonal skills and ways of coping, he or she will be assigned a greater degree of responsibility.

Phares & Wilson (1973) in a study where female subjects rated wives who had encountered problems resulting from pregnancy or children on

attribution of responsibility, found that differences in attribution of responsibility were significant for problem source and type. Wives who were said to be experiencing psychological as opposed to other types of problems such as financial or vocational were rated as less responsible. Wives were rated as more responsible for their problems when the problem was presented as the wife's fault than when it was presented as the husband's fault or ambiguously. They suggested that the relationship between assignment of responsibility, kind of problem situation, and presumed source of problems (psychological and/or physical) was in need of further investigation. According to attributional rules, generally a person cannot be held responsible for an act unless he or she intended to cause the act. Intent typically is an integral part of personal responsibility and, therefore, attribution of responsibility usually implies that the person intended to produce the outcome (Maselli & Altrocchi, 1969). However, Beckman (1979) in a study of beliefs about the causes of alcohol-related problems, noted that attribution of responsibility in the case of severe negative consequences does not always follow such logical rules with regard to intent. In other words, when acts have severe negative consequences, individuals are likely to be blamed or held accountable even when intention is absent.

Based on the reviewed literature, it would appear that the traditional accident paradigm may not generalize well to other instances of attribution of responsibility. Any result regarding severity of outcome, cause, or ambiguity found in studies using this paradigm would not necessarily follow when measuring attribution of responsibility as a response to mental disorders. It has, however, been suggested by Phares

and Wilson (1973), that attribution of responsibility varies with problem situation and problem source. Less responsibility was attributed when the problem type was psychological and greater responsibility was attributed when the individual was seen as the source of his or her problems. According to Beckman (1979) and Phares and Wilson (1972) severity of outcome, or severity of behavior, would appear to be a factor in the determination of degree of responsibility.

From this review of literature it can be concluded that early studies indicated that the mentally ill are feared, mistrusted, and that the general public is resistant to labelling individuals as mentally ill. It was also demonstrated that the public is generally uninformed regarding mental illness. The impact of educational efforts to improve the public's response to the mentally ill has been heatedly debated. It is known that varying the reported cause of deviant behavior affects whether or not the mentally ill are seen as able to solve their own problems, however, it does not appear to have had any effect on degree of stigmatization. It has also been demonstrated that perceived seriousness of deviant behavior by lay persons corresponds with judgments of perceived seriousness made by professionals. From the attribution of responsibility literature it has been demonstrated that severity, ambiguity, and intent play a role in the assignment of responsibility. In summary, questions which have been left unanswered relate to the identification of possible factors, e.g., cause, seriousness, and their possible interaction which may play a part in determining the degree of responsibility assigned for deviant behavior.

CHAPTER III

METHODOLOGY

This study sought to examine the relationships between the way in which people perceive the seriousness of deviant behavior and the degree to which they attribute responsibility for these behaviors when they are told that the behaviors are caused by different factors. The procedure utilized to accomplish this study will be outlined in this chapter.

Sample

The population used for this study was made up of students who were enrolled for Summer Quarter, 1980, at Utah State University, Logan, Utah. Data was collected from 82 undergraduates who were enrolled in Introductory Psychology and/or Introductory Anthropology. In order to make it possible to divide the sample into four equal groups, six subjects were eliminated at random, by use of a table of random numbers. This resulted in a final sample of seventy-six subjects with nineteen subjects in each comparison group.

Procedure

Materials

A packet was prepared for each subject. Each packet contained: (1) Informed Consent Agreement Form; (2) Background Information and Instruction Sheet; and (3) four of the Star vignettes. The four vignettes were an unlabelled behavioral description which described, in

non-technical language, behavior associated with each of the following psychiatric categories: paranoid schizophrenic, simple schizophrenic, depressed neurotic, and phobic compulsive. These vignettes and their adaptations have been used extensively as a stimulus for assessing various facets of attitudes such as social desirability and judgments regarding the presence or absence of mental illness. These vignettes have been established as an acceptable and valuable stimulus for investigation of attitudes.

The behavioral description of the paranoid schizophrenic read as follows:

> Here is a description of a man. Imagine that he is living in your neighborhood. He is very suspicious. He doesn't trust anybody, and he is sure that everyone is against him. Sometimes he thinks that people he sees on the street are talking about him or following him. A couple of times he has picked fights with men who didn't even know him, because he thought they were spying on him and plotting against him. The other night he began to curse his wife terribly, because he said she was working against him too--just like everybody else.

The behavioral description of the simple schizophrenic read as follows:

> Here is a description of a man. Imagine that he is living in your neighborhood. He has never had a job and doesn't seem to want to go out and look for one. He is very quiet; he doesn't talk much to anyone--even in his own family. He acts like he is afraid of people, especially young women his own age. He won't go out with anyone, and whenever someone comes to visit his family, he stays in his own room until they leave. He just stays by himself and daydreams all the time, and shows no interest in anything or anybody.

The behavioral description of the depressed neurotic read as follows:

> Here is a description of a man. Imagine that he is living in your neighborhood. He has a good job and he is doing fairly well at it. Most of the time he gets along all right with people, but he is always very touchy and loses his

> temper quickly if things aren't going his way, or if people find fault with him. He worries a lot about little things, and seems to be moody and unhappy all the time. He can't sleep nights, brooding about the past and worrying about things that might go wrong.

The behavioral description of the phobic compulsive read as follows:

> Here is a description of a man. Imagine that he is living in your neighborhood. He seems happy and has a good job, but he just can't leave his house without going back in to see if he left the gas stove on or not. Then he always goes back again to make sure all the doors and windows are locked. One more thing, he just won't go anyplace where he will have to ride in an elevator, he's so afraid of them.

Within the packets the order of the vignettes was randomized to control for ordering effects. To each vignette was added a final statement indicating the cause of the behavior. All four vignettes contained within one packet had the same assigned cause. There were four versions of the causal interpretation which was appended to the vignettes: Biological, Social-Learning, Unknown, Both (biological and social-learning).

The Biological assigned cause read as follows:

> This kind of behavior is generally thought to result from an illness or inherited condition which affects the person's brain.

The Social-Learning assigned cause read as follows:

> This kind of behavior is generally thought to result from an individual failing to learn how to get along with others and cope with the day-to-day anxieties of life.

The Unknown assigned cause read as follows:

> The cause of this kind of behavior is generally not known.

The Both assigned cause read as follows:

> This kind of behavior may be the result of an illness or inherited condition which affects the person's brain, or it may be the result of an individual's failure to learn how to get along with others and cope with the day-to-day anxieties of life.

Following each vignette were two Likert Scale questions. The first question asked the subject to rate, on a scale of one to five, the degree of accountability for his behavior of the individual described in the vignette. Only three points were labelled on the five-point scale. They were labelled as follows: 1 - not at all; 3 - partly; 5 - completely. The second question asked the subject to rate, on a scale of one to four, the seriousness of the behavior of the person described in the vignette. Points on the scale were labelled as follows: 1 - not at all; 2 - a little; 3 - quite; 4 - very.

This procedure yielded 19 packets for each causal group. See Appendices A, B, C, and D for a sample packet from each group.

Administration of Materials

The instructor of the introductory classes introduced the researcher near the end of a regular class period. The instructor requested the subjects' participation in a study which was introduced by the researcher as follows:

> I am conducting a study regarding whether you think that certain people are accountable for their behavior or not. You will be asked to respond to a question about accountability and a question about seriousness for each description. This should only take approximately 15 minutes of your time. This is voluntary and you are requested, but not obligated, to participate. For those of you who decide to participate, you will be given an informed consent form to sign. These forms will be detached from your booklet before I leave the room in order to guarantee your anonymity. The instructions are on the second sheet. Please be sure to circle the number which corresponds with your answer.

Following the introduction, the researcher passed out the packets individually to the subjects.

After completing the packet at their own pace, the subjects returned them to the researcher who supervised their work. In response to questions, the researcher reiterated appropriate information from the researcher's introduction. The informed consent agreement was removed from the packets in the presence of the researcher and placed separately from the packets in order to verify to the subject that his/her anonymity would be maintained.

Statistical Analysis

The Freidman test, a non-parametric test which uses a X^2 distribution, was used to test the notion that each behavioral description represented distinctly different populations in terms of perceived seriousness.

The data were analyzed utilizing a split-plot analysis of variance. The following sources of variance were entered into the analysis: (1) degree of seriousness (paranoid schizophrenic, simple schizophrenic, depressed neurotic, phobic compulsive); (2) causality (Biological, Social Learning, Unknown, Both (biological and social-learning); and (3) degree of seriousness by cause. For significant main effects, differences between means were tested for statistical significance by the Tukey test.

CHAPTER IV

RESULTS

This chapter will report the results of the present study. The results of the Freidman test will be presented first. Thereafter, the results of the analysis of variance will be discussed in terms of the following three specific questions:

1. Does the degree of responsibility for deviant behavior attributed by normal individuals to various types of described deviant behavior vary as a function of stated cause of the behavior?

2. Does the degree of responsibility for deviant behavior attributed by normal individuals to various types of described deviant behavior vary as a function of the perceived seriousness of the behavior?

3. Do stated cause and perceived seriousness of behavior interact in determining the degree of responsibility normal individuals attribute to deviant individuals?

Friedman Test

In order to determine whether the behavioral descriptions represented four distinct types in terms of degree of perceived seriousness, a Freidman test was performed. In the Freidman test, each rating is given a rank value. A mean rank is then computed for each type, and the mean ranks are compared using X^2 for testing their significant difference from each other.

The results of the Friedman test indicated that the behavioral descriptions were ranked from most to least serious as follows: paranoid schizophrenic, simple schizophrenic, depressed neurotic, and phobic compulsive. See Table 1 for the absolute frequencies of the perceived seriousness ratings by behavioral description. See Table 2 for the frequency percentages of the perceived seriousness ratings by behavioral description.

Table 1

Absolute Frequencies of Degree of Seriousness Ratings

	Seriousness				
	1	2	3	4	
Paranoid Schizophrenic	1	2	33	40	76
Simple Schizophrenic	2	10	34	30	76
Depressed Neurotic	2	32	37	5	76
Phobic Compulsive	8	35	25	8	76

See Table 3 for the results of the mean rankings of the ratings of perceived seriousness by behavioral description.

The results of the analysis of the mean rankings of the ratings indicated that there was a significant difference in degree of perceived seriousness among the different behavioral descriptions. However, when paired comparisons between the behavioral descriptions were made (See Table 4 for results), it was found that there was no significant

Table 2

Percentage Frequencies for Degree of Seriousness Ratings

	Seriousness			
	1	2	3	4
Paranoid Schizophrenic	1.3	2.6	43.4	52.6
Simple Schizophrenic	2.6	13.2	44.7	39.5
Depressed Neurotic	2.6	42.1	48.7	6.6
Phobic Compulsive	10.5	46.1	32.9	10.5

Table 3

Freidman Test Results

Perceived Seriousness	Mean Ranks of Ratings
Paranoid Schzophrenic	3.26
Simple Schizophrenic	2.96
Depressed Neurotic	1.99
Phobic Compulsive	1.79

$p < .001$

Table 4

Paired Comparisons of Perceived Seriousness

Source	d.f.	X^2
PS - SS	1	3.803
PS - DN	1	34.224*
SS - DN	1	21.053*
SS - PC	1	23.211*
DN - PC	1	1.592

*$p < .001$

difference in the degree of perceived seriousness between the paranoid schizophrenic and the simple schizophrenic type. There was also no significant difference in the degree of perceived seriousness between the depressed neurotic and the phobic compulsive. There was, however, a significant difference in degree of perceived seriousness between the simple schizophrenic and the depressed neurotic. These results would indicate that for purposes of examination of the results of this study that the paranoid schizophrenic and the simple schizophrenic type are not statistically different, and that the depressed neurotic and the phobic compulsive type are not statistically different.

Analysis of Variance

Cause

The first question considered in this study was whether the differing stated cause accompanying each vignette would result in significant differences in attribution of responsibility. In order to determine whether this was the case, an analysis of variance was

performed. The results of the analysis of variance for degree of perceived seriousness, causality, and perceived seriousness by causality are shown in Table 5. As can be seen from this table, there is a non-significant main effect (F = 2.61, N.S.) for cause, that is, the particular stated cause does not significantly affect the degree of responsibility attributed to deviant individuals. The mean values for the degree of responsibility attributed to the deviant individuals described in the vignettes by cause are shown in Table 6.

Table 5

Results of Analysis of Variance

Source of variation	df	Sum of Squares	Mean Square	F
Cause	3	13.03	4.34	2.61
Main Plot	72	120.00	1.67	
Perceived Seriousness	3	13.24	4.41	6.60*
Cause x Perceived Seriousness	9	6.95	.77	1.16
Error	216	144.32	.67	

*$p < .05$

Seriousness

The second question considered was whether the degree of which subjects perceive the behavior in a vignette to be serious will be significantly related to the degree to which they attribute responsibility for the behavior. As shown in Table 5, there is a significant main effect (F = 6.60, p. < .05) for perceived seriousness. In other words, perceived seriousness does affect, in a significant way, the degree of responsibility attributed to deviant individuals.

Table 6

Mean Attribution of Responsibility Scores

	Biological	Unknown	Social Learning	Both	
Paranoid Schizophrenic	3.05	3.21	3.47	3.53	x = 3.20
Simple Schizophrenic	3.26	3.47	3.53	3.63	x = 3.55
Depressed Neurotic	3.37	4.05	4.05	4.11	x = 3.70
Phobic Compulsive	2.90	3.63	3.68	3.74	x = 3.71
	x = 3.32	x = 3.47	x = 3.49	x = 3.88	

In closer examination of these results, a Tukey test for differences between the means was performed. The results of this test indicated the following. The mean responsibility value for the paranoid schizophrenic was significantly lower (less responsibility) than the mean responsibility value for the depressed neurotic. The mean responsibility value for the paranoid schizophrenic was also significantly lower (less responsibility) than that of the phobic compulsive. There was no significant difference in the mean responsibility value for the phobic compulsive and the depressed neurotic. There was also no significant difference in the mean responsibility values between the simple schizophrenic and the other three types.

Interaction of Cause and Perceived Seriousness

The third question considered was whether there is an interaction

effect between perceived seriousness and causal interpretation when subject attribute a degree of responsibility for deviant behavior. This interaction, as shown by Table 5, was non-significant ($F = 1.16$, N.S.). In other words, these two factors, cause and seriousness, do not work in combination in such a way that significant differences in attribution of responsibility are a result.

CHAPTER V

DISCUSSION AND CONCLUSIONS

This chapter contains a discussion of the data presented in this study and conclusions drawn from these data.

Discussion

The analysis of these data indicate first of all that this particular sample of subjects did not rate each behavioral description, in terms of perceived seriousness, as significantly different from each of the others. Previous research by Bord (1970-71) demonstrated that subjects in that study were able to distinguish the four behavioral descriptions; paranoid schizophrenic, simple schizophrenic, depressed neurotic, and phobic compulsive, in terms of perceived seriousness. The data from the present study would indicate that subjects did not rate the paranoid schizophrenic and the simple schizophrenic differently in terms of perceived seriousness. Neither did they distinguish between the depressed neurotic and the phobic compulsive. What is demonstrated, however, is that the behavior of both the paranoid schizophrenic and the simple schizophrenic is perceived as significantly more serious than that of the depressed neurotic and phobic compulsive. It would appear that naive subjects do, in fact, as Bord suggested, perceive the seriousness of deviant behaviors in a manner similar to that of mental health professionals.

With respect to the degree of responsibility attributed to deviant individuals, the analysis of these data indicated that subjects did not attribute differing degrees of responsibility depending upon what they were told had caused the behavior. In view of the literature that has suggested that assignment of a biological causal would result in decreased attribution of responsibility, the results of the present study are puzzling. These present results would suggest that there is no significant difference in attribution of responsibility regardless of the cause provided. Likewise, the degree of ambiguity created by the causal interpretations, specifically the Unknown and Both conditions, did not affect the degree of responsibility attributed to the deviant individual described.

On closer examination of the actual mean values of the degree of responsibility attributed, it can be seen that the range of scores is restricted (2.9 - 4.1), and is confined to the mid to upper portions of the scale. These results would suggest that regardless of causal interpretation or perceived seriousness, every individual described was seen as being at least partly responsible for his behavior. This may indicate that the 5-point Likert scale measure is not adequately sensitive, or that mental disorders, even those biologically caused, do not allow for total absolution of responsibility in the way that individuals with other illnesses can be absolved of responsibility. It may be that the behaviors described need not be labelled as "mental illness" for the stigma associated with mental illness to be attached to them. It may be impossible to eliminate elements of stigma from the attribution of responsibility for these types of behaviors.

Another possible explanation for the non-significant results regarding causal interpretation may be related to the use of the split-plot design. In this study cause was not a repeated measure. According to Kirk (1968) the test of significance on the non-repeated measure is less powerful than the test of significance on the repeated measure (perceived seriousness) and the interaction effect. In other words, significant differences in attribution of responsibility which result from different causal interpretations are more difficult to obtain due to the fact that this dimension was not repeated.

Another possible explanation may be found in the demand characteristics of the materials presentation. Each subject received the same causal interpretation for each of the four vignettes. It is possible that stated cause of deviant behavior was not as influential on determining subjects' responses as was the manipulated variable for each subject, that is, degree of perceived seriousness.

Phares & Wilson (1972), using a traditional accident paradigm, suggested that as ambiguity increased regarding who or what was to blame for a certain behavior, attribution of responsibility decreased. The present study does not provide support for this notion; however, it does support their suggestion that their results do not generalize well to other instances of attribution of responsibility.

The author had previously speculated that the attribution of responsibility for certain types of deviant behaviors might vary as a function of being combined with different stated causes for deviant behavior. This notion was not supported as evidenced by a non-significant interaction effect.

There was a significant main effect for degree of perceived seriousness. From a test of the differences of the means, this main effect was determined to be due to significantly less attribution of responsibility for the paranoid schizophrenic as compared to the depressed neurotic, and significantly less attribution of responsibility for the paranoid schizophrenic as compared to the phobic compulsive.

These results indicate that the behavior with the highest degree of perceived seriousness were most likely to be granted exemption from personal responsibility. The present study demonstrated that behaviors do not have to be labelled "mental illness" as in Jackson, Smith, and Liao (1978) in order for these differences to occur. Even though subjects were consistently able to identify each category as more or less serious than the other, the attribution of responsibility mean values were not significantly different for each category, i.e., the paranoid schizophrenic was statistically equivalent to the simple schizophrenic; the simple schizophrenic was statistically equivalent to the depressed neurotic and phobic compulsive; the depressed neurotic and phobic compulsive were statistically equivalent.

Beckman (1979) suggested that as the severity of the negative consequences of a behavior increased, attribution of responsibility increased regardless of mitigating factors such as cause. The present study finds little support for this latter notion. In fact, the paranoid schizophrenic individual is attributed the least responsibility for his/her behavior and the severity of the negative aspects of his behavior are clearly demonstrated in the paranoid

schizophrenic vignette. This discrepancy in results between previous studies which indicate that as negative consequences increase, attribution of responsibility increases may arise from differences between stated negative consequences and implied negative consequences. The vignette which received the lowest attribution of responsibility was that of the paranoid schizophrenic. The behavior described in this vignette is clearly threatening and unpredictable, however any negative consequences are not clearly stated. Bord (1970-71) would contend that it is the threat and unpredictability which influences the subject's response more than causal interpretations. Bord, however, measured rejection and found the paranoid schizophrenic the most rejected. Granted measures of rejection and measures of attribution of responsibility are both moral judgments, however, the result that attribution of responsibility was significantly lower for the paranoid schizophrenic in this study remains to be explained.

The phenomenon of defensive attribution (Walster, 1966) would predict that the more responsibility or blame that could be placed on another individual, while the observer at the same time seeing him or herself as different from that individual, the observer protects him or herself from similar circumstances.

Lerner's (1965) theory of "belief in a just world" accounts for increased attribution of responsibility when there are severe negative consequences, by suggesting that this is necessary for the observer to maintain his or her belief that the world is just.

Neither of these posited explanations appear to be supported by the results of the present study. Subjects, in this study, attributed

significantly more responsibility to those individuals who were more likely to be similar to themselves, i.e., depressed neurotic and phobic compulsive. A plausible explanation for these results may be that subjects view those most likely to be similar to themselves as being responsible for and in control of their behavior because they view themselves as being responsible and in control of those behaviors themselves. Due to the unpredictability and threat perceived in individuals most dissimilar, the paranoid schizophrenic, this individual can be more easily viewed as not responsible and not in control of his behavior.

The results of this study indicate that no significant distinctions were made between the various stated causes of deviant behavior in the attribution of responsibility for deviant behavior. This would suggest that educating individuals as to causal interpretations for deviant behavior, commonly labelled mental illness, does not change how accountable for his/her behavior an individual is perceived to be. The results suggest that any specific causal orientation is not as important in the attribution of responsibility as is the degree of perceived seriousness.

Lagos, Perlmutter, and Saexinger (1977) suggest that regardless of educational campaigns to convince the public that the mentally ill are not to be feared, this may not, in fact, be the case. They provide empirical support for the common man's fear of those labelled mentally ill. The results of their study indicated that 36 percent of 321 psychiatric admissions were preceded by some form of violent, fear-inspiring behavior. They suggest that educational efforts should focus

not on causal interpretations or telling the public mental illness is not to be feared, but a more accurate education as to the extent and under what circumstances these individuals ought to be feared.

It may be that the lay person can have any number of differing cognitive orientations regarding the source of mental illness, but the often inherent threat and unpredictability of another individual's behavior and/or affect may be more important in determining the lay person's response than is cognitive understanding. It would appear difficult for the lay person to ignore these deviant behavioral and affective components which are anxiety-producing and threatening to his or her own sense of control in making judgments about another person.

Conclusions

The purpose of this study was to empirically test the assumption that differing stated causes of deviant behavior as well as differing degrees of seriousness of deviant behavior would be related to differences in degree of responsibility attributed to individuals described in the Star vignettes. It was found that seriousness of deviant behavior is related to significant differences in attribution of responsibility between the paranoid schizophrenic and the depressed neurotic, and the paranoid schizophrenic and the phobic compulsive. No significant main effect was found for causal interpretation and no significant interaction, causal interpretation by seriousness, was found.

The results of this study suggest that the degree of perceived seriousness does relate to differences in attribution of responsibility. More specifically, paranoid schizophrenic individuals are seen as less

responsible for their behavior than depressed neurotic or phobic compulsive individuals. However, providing differing stated causes does not result in significant differences in attribution of responsibility.

These results provide support for Bord (1970-71) who suggests that perceived seriousness is the more salient variable used by subjects to make judgments. These results provide partial support for the suggestion of Phares & Wilson (1973) that problem type and source of difficulty are important variables to consider and that their relationship to attribution of responsibility would lead to different results than have been obtained in the traditional attribution of responsibility paradigms previously used.

Implications

One of the implications of this study is that individuals who are perceived as seriously deviant will be most likely to be exempted from personal responsibility for their behavior, and be most likely to be granted "sick role" privileges. The medical model would suggest that being granted these exemptions is beneficial to the individual in that stigmatization and rejection would be reduced. However, when individuals are granted these privileges, it would seem that their ability to change their behaviors might be significantly decreased.

Rabkin (1974) concludes the psychiatric rehabilitation is facilitated when mental health professionals recognize the social realities that their patients encounter in the day to day activities of life. One of these social realities is how the person who exhibits the type of deviant behavior, commonly labelled mental illness, is viewed by

significant others, and other people in the community. It would seem that the more the individual is perceived as unpredictable, the less the deviant individual is held accountable or responsible for his behavior--the less consequences there will be for deviant behavior--the less change in behavior will result. Szasz (1974) suggests that regardless of the actual or posited cause of deviant behavior, this does not change the fact that individuals are in need of being held accountable for their behavior and not treated as "sick".

Whether or not individuals are seen as responsible for their behavior not only impacts individual members of the public on a day to day basis, but more broad social implications are present. More specifically, the legal system is increasingly called on to make judgments as to whether individuals who commit crimes are responsible for their behavior. The results of the present study would not necessarily generalize to those in the legal system responsible for making decisions as to an individual's responsibility for his or her behavior. However it could be suggested that with very severe or serious deviant behaviors, the individual might be more likely to be seen as less responsible regardless of stated cause of behavior, hospitalized, and consequently treated "as if" he or she were sick.

Perceived seriousness does appear to play a role in the attribution of responsibility for deviant behavior labelled or not labelled mental illness. Research has demonstrated that changes in causal interpretations can be accomplished through educational efforts. However, with respect to attribution of responsibility, it would appear that the differing causal interpretations do not affect such judgments

in a systematic way. This may be do to the inherent unpredictability and degree of perceived seriousness of deviant behavior.

Limitations

Several limitations of this study will be discussed in this section.

1. The results of this study lack generalizability to any other population than students at Utah State University. Though religious orientation was not taken into account, the sample is drawn from a population which tends to be homogeneous in terms of religious orientation, i.e., LDS. One of the values of this particular religious culture is that of personal responsibility for behavior.

2. It appears that the five-point Likert scale used may not be a sensitive enough measure when attempting to measure attribution of responsibility. Attribution of responsibility studies have commonly used Likert scaling, and one of its strongest features is that it allows direct access to information by simply asking the subject to rate his or her response. However, one of the drawbacks of Likert scaling is the subjects' possible desire to give socially approved of responses. This type of responding may have biased the results of this study. The small range of mean scores (2.9 - 4.11) could indicate that subjects may have misunderstood what was being asked, are not of the belief that anyone is ever totally non-responsible, or as discussed earlier, assigning no responsibility may appear to be a socially unacceptable response.

3. As discussed previously, the fact that causal interpretation was a non-repeated measure in the split-plot design may have been a

factor in the non-significant results of the causal interpretation variable.

Recommendations for Further Research

In further study of the relationship between causal interpretation, perceived seriousness, and attribution of responsibility, the following recommendations are made:

1. Increase generalizability through enlarging and redefining the population and increasing the sample size;

2. Investigate the relationship between stigmatization/rejection and attribution of responsibility; and

3. Increase the senstivity of the measurement device.

4. Design and statistical analysis should use repeated measures on both variables, causal interpretation and perceived seriousness.

5. Further manipulation of the variable of unpredictability and threat, and incorporation of various explicit negative consequences should be pursued.

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APPENDICES

Appendix A

Packet for the Biological Causal Interpretation Group

INFORMED CONSENT AGREEMENT

Utah State University

I hereby give my consent to participate in the project involving human subjects. I understand the procedure to be followed in the study. I will receive answers to any inquiries regarding the project and agree to withdraw my consent and discontinue participation in the project at any time. I also understand that all information I give will be kept confidential and no person participating in the study will be identified by name in release of the findings of the study.

_____

Participant's Signature Date

_____

Researcher's Signature Date

Sex: male _____ female _____

Age: _____

Year in college: Fr. ____ Soph. ____ Jr. ____ Sr. ____ Grad. ____

In this study you will be asked to read a description of a man and decide how accountable you think that he is for his behavior. You will also be asked to decide how serious you think that his behavior is.

Please circle the number which corresponds with your response.

Here is a description of a man. Imagine that he is living in your neighborhood. He is very suspicious. He doesn't trust anybody, and he is sure that everyone is against him. Sometimes he thinks that people he sees on the street are talking about him or following him. A couple of times he has picked fights with men who didn't even know him, because he thought they were spying on him and plotting against him. The other night he began to curse his wife terribly, because he said she was working against him too--just like everybody else.

This kind of behavior is generally thought to result from an illness or inherited condition which affects the person's brain.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He has a good job and he is doing fairly well at it. Most of the time he gets along all right with people, but he is always very touchy and loses his temper quickly if things aren't going his way, or if people find fault with him. He worries a lot about little things, and seems to be moody and unhappy all the time. He can't sleep nights, brooding about the past and worrying about things that might go wrong.

This kind of behavior is generally thought to result from an illness or inherited condition which affects the person's brain.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He has never had a job and doesn't seem to want to go out and look for one. He is very quiet; he doesn't talk much to anyone--even in his own family. He acts like he is afraid of people, especially young women his own age. He won't go out with anyone, and whenever someone comes to visit his family, he stays in his own room until they leave. He just stays by himself and daydreams all the time, and shows no interest in anything or anybody.

This kind of behavior is generally thought to result from an illness or inherited condition which affects the person's brain.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He seems happy and has a good job, but he just can't leave his house without going back in to see if he left the gas stove on or not. Then he always goes back again to make sure all the doors and windows are locked. One more thing, he just won't go anyplace where he will have to ride in an elevator, he's so afraid of them.

This kind of behavior is generally thought to result from an illness or inherited condition which affects the person's brain.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Appendix B

Packet for the Social Learning Causal Interpretation Group

INFORMED CONSENT AGREEMENT

Utah State University

I hereby give my consent to participate in the project involving human subjects. I understand the procedure to be followed in the study. I will receive answers to any inquiries regarding the project and agree to withdraw my consent and discontinue participation in the project at any time. I also understand that all information I give will be kept confidential and no person participating in the study will be identified by name in release of the findings of the study.

_____

Participant's Signature Date

_____

Researcher's Signature Date

Sex: male _____ female _____

Age: _____

Year in college: Fr. ____ Soph. ____ Jr. ____ Sr. ____ Grad. ____

In this study you will be asked to read a description of a man and decide how accountable you think that he is for his behavior. You will also be asked to decide how serious you think that his behavior is.

Please circle the number which corresponds with your response.

Here is a description of a man. Imagine that he is living in your neighborhood. He has a good job and he is doing fairly well at it. Most of the time he gets along all right with people, but he is always very touchy and loses his temper quickly if things aren't going his way, or if people find fault with him. He worries a lot about little things, and seems to be moody and unhappy all the time. He can't sleep nights, brooding about the past and worrying about things that might go wrong.

This kind of behavior is generally thought to result from an individual failing to learn how to get along with others and cope with day-to-day anxieties of life.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He has never had a job and doesn't seem to want to go out and look for one. He is very quiet; he doesn't talk much to anyone--even in his own family. He acts like he is afraid of people, especially young women his own age. He won't go out with anyone, and whenever someone comes to visit his family, he stays in his own room until they leave. He just stays by himself and daydreams all the time, and shows no interest in anything or anybody.

This kind of behavior is generally thought to result from an individual failing to learn how to get along with others and cope with day-to-day anxieties of life.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He seems happy and has a good job, but he just can't leave his house without going back in to see if he left the gas stove on or not. Then he always goes back again to make sure all the doors and windows are locked. One more thing, he just won't go anyplace where he will have to ride in an elevator, he's so afraid of them.

This kind of behavior is generally thought to result from an individual failing to learn how to get along with others and cope with day-to-day anxieties of life.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He is very suspicious. He doesn't trust anybody, and he is sure that everyone is against him. Sometimes he thinks that people he sees on the street are talking about him or following him. A couple of times he has picked fights with men who didn't even know him, because he thought they were spying on him and plotting against him. The other night he began to curse his wife terribly, because he said she was working against him too--just like everybody else.

This kind of behavior is generally thought to result from an individual failing to learn how to get along with others and cope with day-to-day anxieties of life.

How accountable is this man for his behavior?

not at all	. . . . .	partly	. . . . .	completely
1		2	3	4	5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all	. . . .	a little	. . . .	quite	. . . .	very
1		2		3		4

(Please circle the number which corresponds with your response.)

Appendix C

Packet for the Unknown Causal Interpretation Group

INFORMED CONSENT AGREEMENT

Utah State University

I hereby give my consent to participate in the project involving human subjects. I understand the procedure to be followed in the study. I will receive answers to any inquiries regarding the project and agree to withdraw my consent and discontinue participation in the project at any time. I also understand that all information I give will be kept confidential and no person participating in the study will be identified by name in release of the findings of the study.

_____

Participant's Signature Date

_____

Researcher's Signature Date

Sex: male _____ female _____

Age: _____

Year in college: Fr. ____ Soph. ____ Jr. ____ Sr. ____ Grad. ____

In this study you will be asked to read a description of a man and decide how accountable you think that he is for his behavior. You will also be asked to decide how serious you think that his behavior is.

Please circle the number which corresponds with your response.

Here is a description of a man. Imagine that he is living in your neighborhood. He has a good job and he is doing fairly well at it. Most of the time he gets along all right with people, but he is always very touchy and loses his temper quickly if things aren't going his way, or if people find fault with him. He worries a lot about little things, and seems to be moody and unhappy all the time. He can't sleep nights, brooding about the past and worrying about things that might go wrong.

This kind of behavior is generally not known.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He has never had a job and doesn't seem to want to go out and look for one. He is very quiet; he doesn't talk much to anyone--even in his own family. He acts like he is afraid of people, especially young women his own age. He won't go out with anyone, and whenever someone comes to visit his family, he stays in his own room until they leave. He just stays by himself and daydreams all the time, and shows no interest in anything or anybody.

This kind of behavior is generally not known.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He seems happy and has a good job, but he just can't leave his house without going back in to see if he left the gas stove on or not. Then he always goes back again to make sure all the doors and windows are locked. One more thing, he just won't go anyplace where he will have to ride in an elevator, he's so afraid of them.

This kind of behavior is generally not known.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He is very suspicious. He doesn't trust anybody, and he is sure that everyone is against him. Sometimes he thinks that people he sees on the street are talking about him or following him. A couple of times he has picked fights with men who didn't even know him, because he thought they were spying on him and plotting against him. The other night he began to curse his wife terribly, because he said she was working against him too--just like everybody else.

This kind of behavior is generally not known.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Appendix D

Packet for the Both (Biological and Social Learning) Causal Interpretation Group

INFORMED CONSENT AGREEMENT

Utah State University

I hereby give my consent to participate in the project involving human subjects. I understand the procedure to be followed in the study. I will receive answers to any inquiries regarding the project and agree to withdraw my consent and discontinue participation in the project at any time. I also understand that all information I give will be kept confidential and no person participating in the study will be identified by name in release of the findings of the study.

Participant's Signature Date

Researcher's Signature Date

Sex: male _____ female _____

Age: _____

Year in college: Fr. ____ Soph. ____ Jr. ____ Sr. ____ Grad. ____

In this study you will be asked to read a description of a man and decide how accountable you think that he is for his behavior. You will also be asked to decide how serious you think that his behavior is.

Please circle the number which corresponds with your response.

Here is a description of a man. Imagine that he is living in your neighborhood. He seems happy and has a good job, but he just can't leave his house without going back in to see if he left the gas stove on or not. Then he always goes back again to make sure all the doors and windows are locked. One more thing, he just won't go anyplace where he will have to ride in an elevator, he's so afraid of them.

This kind of behavior may be the result of an illness or inherited condition which affects the person's brain, or it may be the result of an individual's failure to learn how to get along with others and cope with the day-to-day anxieties of life.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He is very suspicious. He doesn't trust anybody, and he is sure that everyone is against him. Sometimes he thinks that people he sees on the street are talking about him or following him. A couple of times he has picked fights with men who didn't even know him, because he thought they were spying on him and plotting against him. The other night he began to curse his wife terribly, because he said she was working against him too--just like everybody else.

This kind of behavior may be the result of an illness or inherited condition which affects the person's brain, or it may be the result of an individual's failure to learn how to get along with others and cope with the day-to-day anxieties of life.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He has a good job and he is doing fairly well at it. Most of the time he gets along all right with people, but he is always very touchy and loses his temper quickly if things aren't going his way, or if people find fault with him. He worries a lot about little things, and seems to be moody and unhappy all the time. He can't sleep nights, brooding about the past and worrying about things that might go wrong.

This kind of behavior may be the result of an illness or inherited condition which affects the person's brain, or it may be the result of an individual's failure to learn how to get along with others and cope with the day-to-day anxieties of life.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)

Here is a description of a man. Imagine that he is living in your neighborhood. He has never had a job and doesn't seem to want to go out and look for one. He is very quiet; he doesn't talk much to anyone--even in his own family. He acts like he is afraid of people, especially young women his own age. He won't go out with anyone, and whenever someone comes to visit his family, he stays in his own room until they leave. He just stays by himself and daydreams all the time, and shows no interest in anything or anybody.

This kind of behavior may be the result of an illness or inherited condition which affects the person's brain, or it may be the result of an individual's failure to learn how to get along with others and cope with the day-to-day anxieties of life.

How accountable is this man for his behavior?

not at all . . . . . partly . . . . . completely
1 2 3 4 5

(Please circle the number which corresponds with your response.)

How serious is this man's behavior?

not at all . . . . a little . . . . quite . . . . very
1 2 3 4

(Please circle the number which corresponds with your response.)