The Influence of Similarity to an Actor on an Observer's Attributions for Negative Behaviors

Gregory Daniel Gudleski

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The Influence of Similarity to an Actor on an Observer's Attributions for Negative Behaviors

A Thesis
Presented to
The Faculty of the Department of Psychology
The College of William and Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree of
Master of Arts

by
Gregory D. Gudleski
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APPROVAL SHEET

This thesis is submitted in partial fulfillment of the requirements for the degree of

Master of Arts

Gregory D. Nolle
Author

Approved, May 1998

Glenn D. Shean, Ph.D.

John B. Nezlek, Ph.D.

W. Larry Ventis, Ph.D.
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ABSTRACT

The present study investigated whether an observer's similarity to an actor would affect the observer's attributions for the actor's negative behaviors. Participants were 37 non-drinking students (NDS), 38 heavy-drinking students (HDS) and 33 clinical subjects (CS) who were active in self-help groups for alcoholics. The participants read scenarios depicting a depressed or alcoholic actor involved in spouse abuse or poor work performance situations. The overall results suggest that the CS group made less dispositional attributions for the alcoholic's negative behaviors that did the NDS and HDS groups. The results lend support for Shaver's (1970) defensive-attribution hypothesis. The results are then discussed in terms of the different processes which may account for the differences found among the groups. The practical applications of this study are also discussed.
The Influence of Similarity to an Actor on an Observer’s Attributions for Negative Behaviors
Introduction

The process by which individuals attempt to infer the causes of observed behavior has been the focus of a considerable amount of research and theory throughout the past several decades. Attribution theory (Jones & Davis, 1965; Kelley, 1967) proposes that such a process involves assessing the effects of dispositional and situational factors. Almost all of these more recent theoretical formulations can be traced back to the work of Heider (1944). Heider's explanation of human behavior relies primarily on the distinction between internal and external factors. Since Heider's work, much evidence has been accumulated to suggest that an actors will make external or situational attributions to explain their behavior and that observers will make dispositional or internal attributions to explain another's behavior. This phenomenon has come to be known as the "actor-observer effect" (Jones & Nisbett, 1971).

Although there have been many studies that demonstrate that the actor-observer effect is both frequent and consistent across many different situations (e.g., Nisbett, Caputo, Legant, & Maracek, 1973), the accumulated research over the past few decades suggests that the effect may be more complex than the simple notion of actors focusing on
external factors and observers focusing on internal factors. For example, it is now generally agreed upon that both actors and observers tend to attribute more causal force to dispositional factors than to situational factors. This tendency is known as the "fundamental attribution error" (Ross, 1977). Also, some studies have shown that the actor-observer effect may be eliminated or reversed by a variety of factors, including salience (e.g., Storms, 1973; Taylor & Fiske; 1975), whether the observer is active or passive (Miller & Norman, 1975), and by the self-serving bias (Miller & Ross, 1975; Russell, McAuley, & Tarico, 1987).

Jones and Nisbett contend that differences in the information available to both the actor and the observer for arriving at causal explanations may be a factor as to why the actor-observer effect occurs. Actors are more aware of their past history and present experience and this may account for an actor's attribution of more situational causes than dispositional. Observers, on the other hand lack information about the actor's past behavior in similar and different situations and this lack of information will lead the observer to believe that a particular behavior is typical of the actor. The observer, with no other evidence to suggest that the actor would behave differently in
Similar situations, makes dispositional attributions for the actor’s behavior. Consequently, one way in which the actor-observer effect may be attenuated is if relevant information about the actor’s past history would be made available to the observer when making attributions about the actor’s current behavior.

One method by which actors are able to divert observers away from making dispositional attributions for the actor’s behaviors is through the use of self-handicapping techniques. Jones and Berglas (1978) coined the term self-handicapping as a strategy used by an individual who “reaches out for impediments, exaggerates handicaps, and embraces any factor reducing personal responsibility for mediocrity and enhancing personal responsibility for success” (p. 202). They proposed that self-handicapping involves the a priori introduction of extraneous causal factors in evaluative situations in order to blur the implications of one’s behavior (Beck, 1990). It is a situation in which the self-handicapper cannot lose: poor performance will be attributed to the handicap, but adequate performance will be attributed to the individual’s abilities.

In their initial studies, Berglas and Jones (1978) demonstrated that participants would ingest a performance-
inhibiting drug prior to a test in order to have an external excuse readily available if they performed poorly and to augment their success if they performed well. Most of the research that has followed has focused primarily on the different kinds of self-handicapping strategies used, such as alcohol consumption (Montgomery, Haemmerlie, & Zoellner, 1996; Tucker, Vuchinich, & Sobell, 1981), obesity (Baumeister, Kahn, & Tice, 1990), choosing unattainable goals (Greenberg, 1985), and test anxiety (Smith, Snyder, & Handelsman, 1982). Other researchers have focused their attention on whether there are gender differences in self-handicapping (Dietrich, 1995; Harris & Snyder, 1986; Shepperd & Arkin, 1989) or on the differences between behavioral or claimed self-handicapping (Hirt, Deppe, & Gordon, 1991). However, there has been much less research focusing on the effectiveness of self-handicapping; that is, does an observer actually attribute the behavior of an actor to external causes when the actor engages in self-handicapping and his behavior has negative consequences?

In one of the few studies that have looked at the effectiveness of self-handicapping, Schouten and Handelsman (1987) explored the question as to whether the use of psychopathology could be used as an effective self-handicapping strategy. They instructed 240 undergraduates
to read one of twelve hypothetical case studies involving either a spousal abuse situation or a poor work performance situation. Within each of the situations, they varied information about the protagonists history. In some conditions, participants were informed that the actor had a long history of depression or only current symptoms of depression. Other participants were not given any information regarding the actor's history of depressive symptoms. The results indicated that participants who received information about the actor's history of depression attributed less blame, cause and responsibility to the actor's behavior than did participants who received no information about the actor's history. Participants who had knowledge of the actor's history also proposed more lenient sanctions for the actors in the work situation. Interestingly, the researchers found no effect for the type of situation (i.e., work or spouse abuse) or in the sanctions that should be imposed in the spouse situation. Nonetheless, Schouten and Handelsman concluded that depression and other symptoms of psychopathology may be used as an effective self-handicapping strategy which could make some negative behaviors seem reasonable and functional to an observer.

In a similar study, Critchlow (1985) investigated
whether an actor's use of alcohol and characterization of the actor as an alcoholic would serve as a useful self-handicapping strategy. Previous studies (Richardson & Campbell, 1982) had shown that drunken people are seen as less responsible for their actions, but few studies have investigated whether an actor's history of alcoholism would cause an observer to place less dispositional attributions on the actor's negative behavior. In Critchlow's study, 80 undergraduates received short scenarios in which an actor engaged in one of eight negative behaviors (e.g., vandalism, beating someone up, forgery, embezzlement). Within each scenario, the actor was presented as either drunk or sober and either a chronic alcoholic or a social drinker. The participant was asked to make causal attributions for the actor's behavior and also suggest a punishment. The results showed that intoxicated actors were attributed less responsibility, blame and causal role than sober actors. However, the characterization of the actor as an alcoholic or a social drinker had very little impact on the participants' rating, and there were no differences in suggested punishments between any of the conditions. These findings are consistent with those of Schouten and Handelsman (1987) in that actors exhibiting clinical symptoms are attributed less responsibility for
their negative actions than actors without any clinical symptoms but the suggested punishment is unaffected.

Although these and other studies (e.g., Baumgardener, Lake, & Arkin, 1985; Smith, Snyder, & Perkins, 1983) have lent support to the notion that psychopathology could be used as a self-handicapping strategy, they failed to take into account distinguishing characteristics of the observers which may influence the observers’ attributions for the actors’ behaviors. In particular, if the observer and the actor shared some salient characteristic, then the observer’s attributions for the actor’s behavior may be affected in some way.

Shaver (1970) conducted a series of experiments in which the severity of an accident and the personal similarity between the actor and an observer was manipulated. Across all of the experiments, it was found that participants who perceived themselves as similar to the actor placed less responsibility and blame on the actor for the accident than those participants who did not perceive themselves as similar to the actor. However, Shaver failed to replicate the findings of Walster (1966) which suggested that as the severity of an accident increases, the amount of responsibility attributed to the actor will also increase. According to Shaver, this
discrepancy occurred because the observers who felt personally similar to the actor wanted to avoid the possibility of being blamed themselves in similar situations which may occur in the future. Since they felt similar to the actor, the possibility existed that the observers might find themselves in a position that was similar to that of the actor. The observers thus sought to avoid blame for their role in a potential future accident (Chaikin & Darley, 1973). On the other hand, consistent with the actor-observer effect (Jones & Nisbett, 1971), if the observers do not see themselves as personally similar to the actor, they will place more blame and responsibility on the actor. This relationship between the perceived similarity of the observer to the actor and the assignment of responsibility to an actor's behaviors has become known as the defensive-attribution hypothesis.

Later studies have found support for the defensive-attribution hypothesis. In a meta-analysis of 22 studies focusing on the defensive-attribution hypothesis, Burger (1981) found that when observers were personally similar to the actor in an accident scenario, they tended to attribute less responsibility to the actor when the severity of the accident increased. When the observer and the actor were personally dissimilar, the opposite effect was found.
Burger concluded that when personal and situational similarity between the observer and the actor are included in research designs, "the defensive-attribution phenomenon appears to be quite robust."

In a more recent study, Wilson and Jonah (1988) investigated the assignment of responsibility and penalties for an actor involved in a drunk-driving incident. These researchers used patrons from drinking establishments and manipulated the personal similarity of participant to actor according to the participants' self-reported incidents of driving while impaired (DWI). The results indicted that the DWI participants assigned less responsibility to the drunk-driving actor and were more lenient in assigning penalties than were non-DWI participants. The researchers speculated that the DWI participants could imagine themselves in a similar situation to that of the actor and, therefore, assigned less responsibility and punishment for the actor because they would also want to avoid blame and harsh penalties if they were in the same situation.

The main purpose of the present study is to investigate whether or nor a shared characteristic (i.e., alcohol abuse) of an observer and an actor will influence the effectiveness of the actor's self-handicapping strategies. As mentioned previously, intoxicated actors
are generally attributed less cause, responsibility and blame for their behaviors which have negative consequences, but an actor's history of alcoholism has been found to have little to no effect on the observers' attributions for the actor. However, if the salient shared characteristic between the observer and the actor is a history of alcoholism, this may have some impact on the attributions the observer makes for the actor's behaviors. In this study, we predict that observers (i.e., participants) with a history of alcohol abuse will identify with an actor with a history of alcohol abuse and that these participants will attribute the negative outcomes of the actor's behavior to external causes. Participants with no history of alcohol abuse will make more dispositional attributions for the actors' negative behaviors. Although previous studies (Critchlow, 1985; Schouten & Handelsman, 1987) have found no differences in suggested punishments for actors who use psychopathology as self-handicapping technique, the author predicted that the participants with a history of alcohol abuse would suggest more lenient punishments for the actor with a history of alcohol abuse than the participants without a history of alcohol abuse. Finally, the author made no predictions as to whether the type of situation (i.e., spouse abuse or poor work performance) would affect
Similarity and Attributions

the participants' attributions.

Method

Participants

Three groups of male participants were used. A non-drinking student (NDS) group and a heavy drinking student (HDS) group were selected from mass-testing questionnaires given to Introductory psychology students. During the mass-testing, students completed an Alcohol Screening Inventory (ASI; see Appendix A) which measured the frequency with which a person drinks alcohol and the amount of alcohol a person drinks at one setting. Scores for the ASI were calculated for each student. Students were selected to be in the NDS group if they indicated that they never had a drink of alcohol during their lifetime. Students were selected to be in the HDS group if their scores on the ASI were in the top 15% of all of the students that completed the ASI. Mean scores for each question on the ASI were calculated for all of the students in the mass-testing session who indicated that they had consumed alcohol during the past month before mass-testing. The score for question 'f' was calculated by giving the student one point for each "yes" response to a question and then adding the number of points. If the student answered "no" to any question he received zero points for that
question. The mean scores for all of the students who indicated that they drank alcohol are reported in Table 1. The mean scores for all of the students selected to be in the HDS group are also reported.

All student participants were contacted by phone and asked to participate in a study entitled “Perceived Responsibility and Blame in Work and Social Situations”. In all, 37 students who fulfilled the criteria for the NDS group agreed to participate in the study, and 38 students who fulfilled the criteria for the HDS group agreed to participate. All students received partial course credit for their participation.

Finally, a group of participants who were active in self-help groups for alcoholism was solicited for the study. The experimenter attended meetings for the self-help group and after the meeting asked male members if they would like to volunteer for a study involving the perception of cause and blame in work and social situations. In all, 33 people agreed to participate. The average age for this clinical symptoms (CS) group was 38.2 years and the average length of their most current period of sobriety was 34.2 months.

Procedure

Participants in the NDS and HDS groups were tested at
different sessions with all of the participants within each group being tested at the same time. Participants were asked to come to a classroom and seated themselves in desks. All of the students who initially agreed to participate in the study came to the testing sessions. When all of the participants arrived for each group, the experimenter welcomed them and read them verbatim instructions on how to complete the testing material (see Appendix B). Participants were basically told to complete all of the questionnaire in the order in which they appear and to just answer the questions as best that they could. They were assured that there were no “right or wrong” answers. Each participant was then given a packet of scenarios, the Beck Depression Inventory (BDI; Beck et al., 1961) the Center for Epidemiological Studies-Depression (CES-D; Radloff, 1977) scale, and the ASI. Each participant was given 2 of 4 scenarios portraying a male protagonist in a poor work or spousal abuse situation. The scenarios were patterned after the scenarios used in Schouten and Handelsman (1987). Within each scenario, information indicating a history and current symptoms of alcohol abuse or depression for the protagonist was varied. So, within each scenario, there were 2 conditions: (1) information about current and past depression with no
reference to alcohol abuse, and (2) information about current and past alcohol abuse with no reference to depression (see Appendix C for complete scenarios and questions).

Each participant received one scenario dealing with each type of situation (i.e., work or spouse abuse). The 2 scenarios that each participant received included a depression condition and an alcohol abuse condition. So, each participant received one of two packets: (1) work situation with depression and spousal situation with alcohol abuse, or (2) work situation with alcohol abuse and spousal situation with depression. The order in which the scenarios were presented in each packet was counterbalanced.

After reading each scenario, all respondents answered several questions on 7-point scales. The first 3 tapped attributions of causality, responsibility and blame for the actor in the scenario. In addition, questions dealing with sanctions for the actor were included in each questionnaire. The participants then completed the BDI and the CES-D. These questionnaires were given to account for any variability due to the participants' levels of depression. Namely, we wanted to control for the possibility that a depressed participant will identify with
the depressed actor in the scenarios. Also, research (Rodman & Burger, 1985) has shown that a person’s level of depression may influence his attributions for a given situation. Finally, the participants again completed the ASI to assure that their drinking patterns had not changed since mass testing. The session ended when all participants had completed all of the questionnaires and after the experimenter had fully debriefed the participants (see Appendix D for debriefing).

The procedure for the CS group was basically the same as those for the NDS and HDS groups except for a few minor exceptions. Instead of the instructions and debriefing being read to the CS group, they were included with the testing materials. Everything else that was presented to the NDS and HDS groups was also presented to the CS group except the ASI. This questionnaire was not given to the CS group because it was assumed that people in a self-help group for alcoholism actually had problems with their use of alcohol.

Results

The ASI mean scores for the HDS group in the testing session are listed in Table 1. Comparison of the mass-testing scores and the testing sessions scores suggest that their patterns of drinking did not change significantly.
All of the participants in the NDS group continued to abstain from drinking throughout both sessions.

The mean BDI and CES-D scores for each group are listed in Table 2. A MANOVA revealed significant differences between the groups for both the BDI, $F(2, 105) = 3.71, p < .05$ and the CES-D, $F(2, 105) = 17.80, p < .001$. Subsequent Newman-Keuls tests indicated that the CS group differed from both the NDS and HDS groups on both the BDI and CES-D, $p$'s < .05. The NDS and HDS groups did not differ from one another on either the BDI or the CES-D. Because of these findings, the BDI and the CES-D were used as covariates throughout the analyses since the NDS and the HDS groups may tend to identify with the actor in the depression condition more than the CS group may tend to identify with him. This study focused on the perceived similarities between participants and an alcoholic actor. The author wanted to control for the possibility that some participants in any group may also identify with the depressed actor.

Each participant received only 2 of the possible 4 scenarios, producing a 3 (group) X 2 (situation; work vs. spouse) X 2 (psychopathology; alcohol vs. depression) incomplete factorial design. Subsequent analyses focused primarily on type of situation or type of psychopathology.
Similarity and Attributions

**Spouse Abuse Situation**

A 3 (attribution) X 3 (group) X 2 (psychopathology) mixed model ANOVA with attribution (cause, responsibility, and blame) as the within-subject factors and group and psychopathology as the between-subject factors was performed for the spouse abuse situation. The BDI and the CES-D were used as covariates in this and all subsequent analyses. The estimated marginal means for this analysis are shown in Table 3.

Tests of between-subjects effects yielded a significant psychopathology main effect, $F(1, 100) = 9.73$, $p < .05$, with the participants attributing less cause, responsibility and blame for the actor in the depressed condition ($M = 5.30$) than the actor in the alcohol condition ($M = 5.79$).

A significant group main effect, $F(2, 100) = 13.03$, $p < .001$ was also found. Subsequent Newman-Keuls tests revealed that participants in the CS group ($M = 4.85$) made greater situational attributions for the actor than participants in the NDS ($M = 6.03$) and HDS ($M = 5.75$) groups, $p$’s $< .05$. There was no significant difference between the NDS and HDS groups. So, while the participants overall attributed less cause, responsibility and blame to the actor who was depressed, participants in the CS group
made more situational attributions for the actor in both conditions than did the participants in the NDS and HDS groups.

Tests of within-subjects effects revealed a significant attribution X psychopathology interaction, F(2, 200) = 7.78, p < .001. Inspections of the means suggest that although participants made less causal attributions for the actor in the depressed condition (M = 4.47) than in the alcohol condition (M = 5.45) the amount of responsibility and blame in each condition was about the same.

A significant attribution X group interaction, F(4, 200) = 2.95, p < .05 was also found. Although participants in the CS group ascribed less responsibility and blame to the actor than participants in the NDS and HDS groups, the largest difference occurred in the causal attribution. So, whereas the CS group did not see the actors as being the cause of their negative behaviors, they still saw the actors as potentially responsible for the outcome of their behaviors.

As for sanctions against the actor in the spouse situation, recommendations for the actor to go to jail was coded as 1 and a recommendations for therapy was coded as 0. Therefore, the lower the number represents a more
lenient disposition. A 2 (group) X 2 (psychopathology) ANOVA yielded no significant interactions or main effects, however the main effect for group approached significance, F(2, 100) = 3.01, p = .054. Table 4 depicts the estimated marginal means of this analysis. Although there were no statistically significant differences, the NDS group tended to prescribe a harsher punishment for the actor in the alcohol condition (M = 0.68) than in the depressed condition (M = 0.39), whereas participants in the HDS and CS groups both preferred treatment for the actor in both conditions.

Work Situation

A 3 (attribution) X 3 (group) X 2 (psychopathology) mixed model ANOVA was performed for the poor work situation. Again, attribution was the within-subject factor, group and psychopathology were the between-subject factors. The estimated marginal means for this analysis are shown in Table 5.

Tests of between-subject effects yielded a significant group X psychopathology interaction, F(2, 100) = 17.92, p < .001. Participants in the NDS group ascribed less dispositional attributions to the actor in the depressed condition (M = 3.8) than in the alcohol condition (M = 6.1), as did participants in the HDS group (M = 4.2
and M = 5.8, respectively). However, participants in the CS group made approximately the same attributions for both the alcohol (M = 4.5) and the depressed (M = 4.8) conditions. So, the student groups attributed the actor in the alcohol condition more cause, responsibility and blame for his poor work performance than the actor in the depression condition. As for the CS group, the type of condition did not matter. They attributed an equal amount of cause, responsibility and blame to the actors in both conditions.

There was also a main effect for condition, F(1, 100) = 43.39, p < .001, with participants making more dispositional attributions for the actor in the alcohol condition (M = 5.46) than the actor in the depressed condition (M = 4.27). There was no main effect for group, F (2, 100) = 1.47.

There were no significant interactions for the within-subject effects, however there was a significant main effect for attribution, F(2, 200) = 25.87, p < .001. Overall, participants made less causal attributions (M = 4.30) than responsibility or blame attributions (M = 5.14 and M = 5.14). Again, the participants did not see the actor as being the cause of his behaviors, but they did see him as being responsible for his actions.
As for sanctions against the actor in the work situation, recommendations to be fired were coded as 1 and recommendations against firing were coded as 0. Again, the lower number represents a more lenient disposition (see Table 6 for estimated marginal means). A 3 (group) X 2 (psychopathology) ANOVA yielded a significant group x psychopathology interaction, F(2, 100) = 6.23, p < .05. Participants in the NDS group were very lenient with the actor in the depressed condition (M = 0.10) and harsh with the actor in the alcohol condition (M = 0.78). Participants in the HDS group offered a somewhat harsher punishment for the actor in the depressed condition (M = .45) than the NDS group and a somewhat more lenient punishment for the actor in the alcohol condition (M = .67). Participants in the CS group were lenient in the depression condition (M = .38) and even more lenient in the alcohol condition (M = .29). Post hoc tests revealed that the difference between conditions was greater for the NDS group (.68) than for the HDS (.22) and CS (-0.09) groups, p < .05. There was no difference between the HDS and the CS groups.

The questionnaires for the job scenarios included an additional item that assessed expectations of subsequent performances (see Table 7 for estimated marginal means).
3 (group) X 2 (psychopathology) MANOVA on the whether the duties and performance standards should be lowered for the actor revealed a significant group X psychopathology interaction for standards, $F(2, 102) = 5.37, p < .05$, but no interaction for duties, $F(2, 102) < 1$. Inspection of the means suggest that in the depression condition, as the level of similarity between the actor and the participant increases, the standards for the actor should be increased ($M = 3.47$, NDS; $M = 4.05$, HDS; and $M = 4.56$, CS). As for the alcohol condition, both the NDS ($M = 5.33$) and the CS ($M = 5.12$) groups believed that the standards should be kept relatively high when compared with the HDS group ($M = 4.56$). There was a main effect for psychopathology for duties, $F(1, 102) = 7.30, p < .05$, with participants agreeing that the number of duties performed should be lowered more for the actor in the depression condition ($M = 4.79$) than in the alcohol condition ($M = 5.27$).

**Alcohol Condition**

A 3 (attribution) X 3 (group) X 2 (situation: work vs. spouse) mixed model ANOVA was also performed on the alcohol condition (see Table 8 for estimated marginal means). Tests of between-subjects effects only revealed a significant main effect for group, $F(2, 100) = 16.73, p < .001$. Post hoc tests revealed that participants in the
NDS (M = 6.20) and the HDS (M = 5.85) groups made more dispositional attributions for the actors' behaviors in both situations than did the participants in the CS group (M = 4.86), p < .05. There was no difference between the NDS and the HDS groups.

Tests of within-subject effects revealed a significant attribution by situation interaction, F(2, 200) = 4.01, p < .05. Participants made less causal attributions (M = 5.19) than responsibility (M = 5.83) or blame (M = 5.98) attributions. However, the differences between situations was greatest in the causal (M = 5.45, spouse and M = 4.92, work) and blame (M = 6.19, spouse and M = 5.77, work) attributions where there was no difference in the responsibility attribution (M's = 5.83). Again, overall the participants saw the actors in both situations as being less of the cause of their behavior, but still responsible for the outcomes.

Also a significant attribution by group interaction, F(4, 200) = 3.63, p < .05, was found. Although the CS group placed less cause (M = 3.9), responsibility (M = 5.2) and blame (M = 5.2) on the actors than the NDS (M = 5.9, M = 6.3, M = 6.4, respectively) or HDS (M = 5.6, M = 5.9, M = 6.1, respectively) groups, the difference was the greatest in the causal attributions.
Depression Condition

Finally, a 3 (attribution) X 3 (group) X 2 (situation) mixed model ANOVA was performed for the depression condition (see Table 8 for estimated marginal means). Tests of between-subjects effects revealed a significant group X situation interaction, F(2, 100) = 13.742, p < .001. Participants in the NDS (M = 3.81) and HDS (M = 4.18) groups placed less dispositional attributions on the actor in the work situation than did the participants in the CS group (M = 4.50). However, participants in the NDS (M = 5.82) and HDS (M = 5.45) groups placed more dispositional attributions on the actor in the spouse abuse situation than did participants in the CS group (M = 4.47). So, the NDS and HDS groups placed less cause, blame and responsibility on the actor in the work situation and more cause, blame and responsibility on the actor in the spouse situation. The CS group, on the other hand, placed an equal amount of cause, responsibility and blame to the actors in both situations.

There was also a significant main effect for situation, F(1, 100) = 27.395, p < .05, with participants ascribing more dispositional attributions for the actor in the spouse abuse situation (M = 5.25) than in the poor work situation (M = 4.16).
Tests of within-subject effects revealed only a significant attribution x situation interaction, $F(2, 200) = 3.08, p < .05$. Although participants made less responsibility and blame attributions for the actor in the work situation compared to the actor in the spouse situation, the greatest difference occurred in the causal attributions. The CS group saw the actor as being less of the cause for his behavior than the other 2 groups. The amount of responsibility and blame for the actor increased within the CS group as compared to cause, but was still less than that of the NDS and the HDS groups.

Discussion

These results suggest that the use of psychopathology as a self-handicapping technique is more effective when the observer shares some salient characteristic of the actor which may influence the behavior of that actor. The CS group, which shared the characteristic of a history of alcohol abuse with the alcoholic actor, made significantly less dispositional attributions for the actor’s behavior which had negative outcomes.

The results of this study provide support for Shaver’s (1970) defensive-attribution hypothesis. The recovering-alcoholic participants may have been familiar with, or perhaps could see themselves in similar situations in the
future as that of the alcoholic actor. This may have led those participants to place less cause, responsibility and blame on the actor. Since they would want to avoid blame for their own potential actions, they could not place blame on an actor who had already engaged in behaviors which had negative consequences.

On the other hand, the participants who did not drink at all made more dispositional than situational attributions for the alcoholic actor. Since they could probably not imagine themselves in a similar situation as the actor, they made more dispositional attributions, which the actor-observer hypothesis would have predicted.

It is of interest to note that although the CS group ascribed less dispositional attributions to the alcoholic actor overall, they consistently made more situational causal attributions than blame or responsibility attributions. This may be the result of what alcoholics learn in self-help groups: they are not the cause of their behaviors because they have a disease, but they are accountable for any of their actions when they are under the influence of alcohol. This may also account for the fact that there were no significant differences in the sanctions imposed in the spouse situation.

Although the defensive-attribute hypothesis has been
supported in many studies, some researchers claim that the effect is either very small or even nonexistent. Fincham and Hewstone (1982) postulated that the defensive-attribution hypothesis "is one of the more elusive findings in social psychology" (p. 54). Although studies have failed to replicate Shaver's findings, this failure may be due to methodological flaws. For example, in Fincham and Miles' study, personal similarity was manipulated by telling the participants that the actor in a story liked similar paintings as the participants. The actor in the story was involved in an accident in which she scratched her leg or broke her leg. The failure to replicate Shaver's findings in this study may be due to the fact that a similar liking for paintings has nothing to do with having an accident. If, on the other hand, the similarity manipulation involved clumsiness or low attention span, then the similarity may have been relevant to the situation. How relevant a perceived similarity between the actor and the observer may be a crucial determinant of the defensive-attribution hypothesis.

Walster (1966) also claimed that as the severity of the outcome increased, so will the responsibility ascribed to the person potentially responsible for the outcome. This effect is harder to demonstrate in this study because
of its design. It could be argued that the spouse abuse situation had more severe outcomes than the work situation. The actor in the spouse situation was facing a possible jail sentence whereas the actor in the work situation was on the brink of losing his job. If jail could be considered a more severe outcome than job loss, then Walster’s hypothesis held for the alcoholic participants when ascribing responsibility and blame to the alcoholic actor. However, both the heavy-drinking students and the non-drinking students ascribed approximately equal responsibility and blame for the alcoholic actor in both the spouse and work situations.

What complicates the matter even more is that Walster’s hypothesis held for the non-drinking and heavy drinking students who were to attribute responsibility and blame to the actors in the depression condition: they attributed more responsibility and blame to the actor in the spouse condition than in the work condition. However, the recovering alcoholics ascribed almost equal blame and responsibility to the actors in both situations. Clearly, more research with better designs are needed to clarify the inconsistencies in this area.

The overall results are generally consistent with those found in previous studies (Critchlow, 1985; Schouten
Similarity and Attributions 30

& Handelsman, 1987) dealing with psychopathology as a self-handicapping strategy. However, in this study, the strategy was most effective when the observer shared some salient characteristic with the actor. Jones and Nesbitt (1971) argued that the actor-observer effect is mediated not only by different information available to both the actor and the observer, but by the different ways in which the actor and the observer process that information. The actor's history of psychopathology was made known to the observers through the actor's use of self-handicapping. Then, participants in the CS group were able to process the information in the scenario as the actor would because they were able to identify with the actor since they shared similar histories. This allowed the observers to make more situational attributions than the other two groups because they were only observing the actor's behavior from an "observer's" point of view. Previous researchers (e.g., Galper, 1976; Storms, 1973) have shown that when observers are told to empathize with an actor, they will make more situational attributions for an actor's behavior which has negative outcomes. Although no measures of empathy were taken in this study, it could be argued that the recovering alcoholics empathized with the alcoholic actor which led them to make more situational than dispositional
attributions. Future researchers may want to incorporate this empathy effect into their studies of attribution processing.

One of the practical implications regarding the results of this study may be the process of jury selection. If a lawyer has a client who has a history of some kind of psychopathology, then he may be well inclined to search for jurors who suffer from the same kind of psychopathology but is in remission. Furthermore, the jurors may not have to have the exact same psychopathology, but any kind of disorder may do. Even if the jury member has a family member who suffers from some kind of disorder, that jury member may begin to empathize with the defendant without even being asked to do so and may make more situational attributions for the defendant’s behavior than dispositional ones. Research findings on aggression (Driscoll, 1985) supports this contention, with persons having a history of aggressive acts attributing less blame to an aggressive actor than persons with no history of aggression.

Although this study has some interesting findings, there are some limitations to the study. First of all, the design was an incomplete factorial design which did not allow us to look at all of the interactions. Future
researchers may want to opt for a fully between-subjects design or give all of the scenarios to the participants so they will have a complete factorial design.

Second of all, there were no control conditions to which we could compare the results. A condition should be added with no mention of psychopathology so the effects of self-handicapping and empathy could be better understood. Along those same lines, although it was possible to determine when observers were making more situational attributions, there were no actor ratings to which we could compare the observers' ratings.

It also could be argued that the differences in attributions among the groups were not due to whether the observers had a history of alcohol abuse, but due to simple age differences among the groups. The recovering alcoholics were nearly 20 years older than the student drinkers and non-drinkers. Also, most of the results showed no difference between the student groups. In order to clarify this potential confound, future researchers may want to include a sample of non-drinking adults who are the same age as the recovering alcoholics.

Finally, some researchers have argued that the use of clinical symptoms is not a true self-handicapping strategy. Berglas (1986) has been particularly critical of the
inclusion of clinical symptoms under the category of self-handicapping. He argues that while the functional use of symptoms may appear similar to previous studies involving self-handicapping, it is actually quite distinct and deserves closer inspection in order to clarify the precise nature of self-handicapping behavior. Also, most researchers who have looked at self-handicapping, including this study, have only looked at the advantage of an a priori excuse for negative behaviors (e.g., DeGree & Snyder, 1985; Smith, Snyder & Perkins, 1983.) The use of psychopathology to enhance personal responsibility for success has not yet been systematically studied. In addition, the scenarios used in this study, especially in the alcohol conditions, maybe somewhat different than pure self-handicapping. It could be argued that although the actors engaged in a impression management strategy, they may not have self-handicapped. Future researchers may want to modify the scenarios in order to make the protagonists' self-handicapping clear.
References


Nebraska Press.


accident. Cognitive Therapy and Research, 9, 651-657.


Table 1

Mean Scores for Each Question on the Alcohol Screening Inventory

<table>
<thead>
<tr>
<th>Question</th>
<th>Mass-testing scores of all drinking students</th>
<th>Mass-testing scores HDS group</th>
<th>Testing session scores of HDS group</th>
</tr>
</thead>
<tbody>
<tr>
<td># times 5 drinks or more at one sitting during past month</td>
<td>3.17</td>
<td>6.06</td>
<td>5.66</td>
</tr>
<tr>
<td>average # of drinks/week</td>
<td>7.22</td>
<td>16.71</td>
<td>16.07</td>
</tr>
<tr>
<td># days during week at least one drink</td>
<td>1.90</td>
<td>2.89</td>
<td>2.88</td>
</tr>
<tr>
<td>frequency with which you get drunk</td>
<td>2.95</td>
<td>4.81</td>
<td>5.00</td>
</tr>
<tr>
<td>average # of “yes” responses to hangover, blackout, vomiting, missing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>class and time recovering due to drinking in the last month</td>
<td>1.17</td>
<td>2.26</td>
<td>2.37</td>
</tr>
</tbody>
</table>
Table 2

**Mean BDI and CES-D Scores**

<table>
<thead>
<tr>
<th>Group</th>
<th>NDS</th>
<th>HDS</th>
<th>CS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>5.73</td>
<td>6.05</td>
<td>3.21</td>
</tr>
<tr>
<td>CES-D</td>
<td>11.14</td>
<td>12.79</td>
<td>2.91</td>
</tr>
</tbody>
</table>

Note: NDS = Non-Drinking Students; HDS = Heavy Drinking Students; CS = Clinical Subjects
Table 3

Mean Scores of Cause, Responsibility, and Blame in the Spouse Abuse Situation

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th></th>
<th></th>
<th>Depression</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NDS</td>
<td>HDS</td>
<td>CS</td>
<td>NDS</td>
<td>HDS</td>
<td>CS</td>
</tr>
<tr>
<td>Cause</td>
<td>6.05</td>
<td>5.60</td>
<td>4.56</td>
<td>5.22</td>
<td>4.94</td>
<td>3.18</td>
</tr>
<tr>
<td></td>
<td>6.21</td>
<td>5.90</td>
<td>5.31</td>
<td>6.05</td>
<td>5.72</td>
<td>5.00</td>
</tr>
<tr>
<td>Blame</td>
<td>6.53</td>
<td>6.23</td>
<td>5.75</td>
<td>6.17</td>
<td>5.72</td>
<td>5.29</td>
</tr>
</tbody>
</table>

Note: NDS = Non-Drinking Students; HDS = Heavy Drinking Students; CS = Clinical Subjects
Table 4

Mean Recommendations for Jail or Therapy in the Spouse Abuse Situation

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDS</td>
<td>0.684</td>
<td>0.389</td>
</tr>
<tr>
<td>HDS</td>
<td>0.400</td>
<td>0.333</td>
</tr>
<tr>
<td>CS</td>
<td>0.188</td>
<td>0.177</td>
</tr>
</tbody>
</table>

Note: The lower the number means a greater suggestion for therapy. The higher the number means a greater suggestion for jail time. NDS = Non-Drinking Students; HDS = Heavy Drinking Students; CS = Clinical Subjects.
Table 5

Mean Scores of Cause, Responsibility, and Blame in the Poor Work Situation

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th></th>
<th>Depression</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NDS</td>
<td>HDS</td>
<td>CS</td>
<td>NDS</td>
</tr>
<tr>
<td>Cause</td>
<td>5.78</td>
<td>5.61</td>
<td>3.29</td>
<td>3.42</td>
</tr>
<tr>
<td>Responsibility</td>
<td>6.44</td>
<td>5.94</td>
<td>5.06</td>
<td>4.05</td>
</tr>
<tr>
<td>Blame</td>
<td>6.17</td>
<td>5.94</td>
<td>5.18</td>
<td>3.94</td>
</tr>
</tbody>
</table>

Note: NDS = Non-Drinking Students; HDS = Heavy drinking Students; CS = Clinical Subjects
Table 6

Mean Recommendations for Firing
in the Poor Work Situation

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDS</td>
<td>0.778</td>
<td>0.105</td>
</tr>
<tr>
<td>HDS</td>
<td>0.667</td>
<td>0.450</td>
</tr>
<tr>
<td>CS</td>
<td>0.294</td>
<td>0.375</td>
</tr>
</tbody>
</table>

Note: The higher the number means a greater suggestion for firing. NDS = Non-Drinking Students; HDS = Heavy Drinking Students; CS = Clinical Subjects.
Table 7

**Mean Expectations of Subsequent Duties and Work Performance Standards**

<table>
<thead>
<tr>
<th>Duties</th>
<th>Alcohol</th>
<th>Depression</th>
<th>Alcohol</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDS</td>
<td>5.50</td>
<td>4.74</td>
<td>5.33</td>
<td>3.47</td>
</tr>
<tr>
<td>HDS</td>
<td>5.28</td>
<td>4.95</td>
<td>4.55</td>
<td>4.05</td>
</tr>
<tr>
<td>CS</td>
<td>5.06</td>
<td>4.69</td>
<td>5.11</td>
<td>4.56</td>
</tr>
</tbody>
</table>

Note: The higher the number indicates that all duties have to be performed and that standards of performance should not be lowered. NDS = Non-Drinking Students; HDS = Heavy Drinking Students; CS = Clinical Subjects
Table 8

**Mean Scores of Cause, Responsibility, and Blame in the Alcohol Condition**

<table>
<thead>
<tr>
<th></th>
<th>Work</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NDS</td>
<td>HDS</td>
</tr>
<tr>
<td>Cause</td>
<td>5.78</td>
<td>5.61</td>
</tr>
<tr>
<td></td>
<td>6.44</td>
<td>5.94</td>
</tr>
<tr>
<td></td>
<td>6.17</td>
<td>5.94</td>
</tr>
</tbody>
</table>

Note: NDS = Non-Drinking Students; HDS = Heavy Drinking Students; CS = Clinical Subjects
Table 9

Mean Scores of Cause, Responsibility, and Blame in the Depression Condition

<table>
<thead>
<tr>
<th></th>
<th>Work</th>
<th></th>
<th></th>
<th></th>
<th>Spouse</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NDS</td>
<td>HDS</td>
<td>CS</td>
<td></td>
<td>NDS</td>
<td>HDS</td>
<td>CS</td>
<td></td>
</tr>
<tr>
<td>Cause</td>
<td>3.42</td>
<td>3.75</td>
<td>4.06</td>
<td></td>
<td>5.22</td>
<td>4.94</td>
<td>3.18</td>
<td></td>
</tr>
<tr>
<td>Resp.</td>
<td>4.05</td>
<td>4.40</td>
<td>5.06</td>
<td></td>
<td>6.05</td>
<td>5.72</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>Blame</td>
<td>3.94</td>
<td>4.40</td>
<td>5.38</td>
<td></td>
<td>6.17</td>
<td>5.72</td>
<td>5.29</td>
<td></td>
</tr>
</tbody>
</table>

Note: NDS = Non-Drinking Students; HDS = Heavy Drinking Students; CS = Clinical Subjects
Appendix A

Alcohol Screening Inventory

Instructions: Please answer the following questions about you alcohol use with the understanding that, similar to all the other information you have provided as part of this packet, your responses will not be revealed to anyone (other than members of the research team who will enter your data into a computer), under any circumstances. (When answering these questions a ‘drink’ refers to a bottle or can of beer, a glass of wine, a wine cooler, a shot of liquor, or a mixed drink).

Circle the response that best represents your answer.

a. During the past month how many times did you have five or more drinks at a sitting?

   0  1  2  3  4  5  6  7  8+

b. What is the average number of drinks you consume in a week? ____

c. On average, how many days during the week do you have at least one drink? ____

d. At what age did you first drink alcohol (more than a few sips)? ____

e. What is the frequency with which you get drunk?

   0.Don’t know   1.Never   2.Rarely
f. during the last month did you:

have a hangover: no yes (About how many?____)

have a blackout due to drinking: no yes (About how many?__)

vomit because you drank too much: no yes (How many times?____)

miss class due to drinking: no yes (How many times?____)

spend time recovering from drinking: no yes (About how many hours?____)
Appendix B

Instructions on How to Complete Test Material

Hello and thank you for participating in this study. My name is Greg Gudleski and I’m conducting a study on the perception of cause and blame in social and work-related situations. In this study you will be asked to read two scenarios and to answer a series of questions after each scenario. After reading the scenarios and answering the questions, there will be two more mood questionnaires and an alcohol questionnaire that you will have to complete. It probably will not take you very long to complete this assignment (probably around 20 minutes), so I ask you to read the scenarios very carefully and to just answer the questions to the best of your abilities. There are no “right or wrong” answers. Also, please answer the questionnaires in the order in which they are presented.

On the cover sheet of the packet of scenarios and questions, you will find a consent form. Please read this form and sign and date it on the spaces provided if you wish to participate in this study. I want you to know that all of your responses will be kept confidential (I will have the only access to them), and that you may terminate your participation in the study at any time.

After you complete the questionnaires, I will collect
them and tell you what the study was all about and exactly what we were looking for. Thank you again for your participation.
Appendix C

Scenarios for Alcohol and Work Situations

Scenario 1

George was called into the supervisor’s office yesterday. The supervisor confronted George on the fact that he has failed to meet assigned deadlines, costing the company a considerable amount of money on more than one occasion, that he has been coming in late at least twice a week, and that he has missed more days than the company’s sick leave policy allows for. George was advised that he will have to be let go unless he can come up with a good explanation. The supervisor had noticed that George had trouble concentrating and trouble making routine decisions, as though preoccupied with something else. George was known to talk about himself in a self-depreciating way, and about having a lot of stress and health problems. George often seemed sad and discouraged about something, but his co-workers never seemed to be able to cheer him up.

In response to the supervisor’s request for an explanation George said, “I’m sorry. I’ve just been really tired lately. Things just have been getting away from me. I just don’t know what to do with myself anymore.”

George has a history of depression, has been
previously diagnosed as a chronic depressive, and has been hospitalized before. George has been seeing a psychiatrist and had been taking anti-depressant medications as of approximately three weeks prior to being called in by the supervisor.

This is an opinion survey. There are no right or wrong answers.

**Directions**: Circle the number which best describes your opinion about the situation.

1. To what extent is George himself the **cause** of his behavior?
   
   1 2 3 4 5 6 7
   
   Not at all Somewhat Totally

2. In your opinion, how **responsible** is George for what happened as described above (as compared to other things such as situational variables or chance)?
   
   1 2 3 4 5 6 7
   
   Not at all Somewhat Totally

3. In your opinion, to what extent should George be held accountable and to blame for his performance on the job? (For example, should George be punished?)
   
   1 2 3 4 5 6 7
   
   Not at all Somewhat Totally

4. In your judgement, should George be fired? (Check one)
5. Assume that George is not fired. Under the circumstances described above, please give your rating (on a scale of 1 to 6) as to what kind of performance should be expected from George?

(A)  

lowered performance standards  

(B)  

perform less duties
Scenario 2

George was called into the supervisor’s office yesterday. The supervisor confronted Bill on the fact that he has failed to meet assigned deadlines, costing the company a considerable amount of money on more than one occasion, that he has been coming in late at least twice a week, and that he has missed more days than the company’s sick leave policy allows for. George was advised that he will have to be let go unless he can come up with a good explanation. The supervisor had noticed that George had trouble concentrating and trouble making routine decisions, as though preoccupied with something else. George was known to drink quite heavily after work and on weekends, and was recently talking about a lot of stress and health problems. George often seemed very irritated about something and his co-workers had trouble talking with him about his problems.

In response to the supervisor’s request for an explanation George said, “I’m sorry. I’ve just been really tired lately. Things just have been getting away from me. I just don’t know what to do with myself anymore.”

George has a history of alcohol abuse and has spent some time in an alcohol rehabilitation clinic. Along with
his stay at the clinic, George has tried AA meetings in order to control his drinking, but nothing seems to work. This is an opinion survey. There are no right or wrong answers.

**Directions:** Circle the number which best describes your opinion about the situation.

1. To what extent is George himself the cause of his behavior?
   
   1 2 3 4 5 6 7
   
   Not at all Somewhat Totally

2. In your opinion, how responsible is George for what happened as described above (as compared to other things such as situational variables or chance)?
   
   1 2 3 4 5 6 7
   
   Not at all Somewhat Totally

3. In your opinion, to what extent should George be held accountable and to blame for his performance on the job? (For example, should George be punished?)
   
   1 2 3 4 5 6 7
   
   Not at all Somewhat Totally

4. In your judgement, should George be fired? (Check one)
   
   Yes ______  No ______

5. Assume that George is not fired. Under the circumstances described above, please give your rating (on
a scale of 1 to 6) as to what kind of performance should be expected from George?

(A) 1 2 3 4 5 6
lowered performance standards same standard

(B) 1 2 3 4 5 6
perform less duties perform same duties
Scenario 3

Joe and his wife were planning to give a bridge party at their new home. They disagreed on the plan for dinner. At one point during the disagreement Joe said that he would rather cancel the party because his wife was "obviously unwilling" to make a dinner that was "appropriate to the event." His wife responded by telling Joe that he didn't make enough money to pay for the kind of dinner that he wanted.

The disagreement turned into an argument, escalating to the point of cursing and name-calling. Joe than hit his wife several times, leaving her with several visible bruises around her neck and on her arms, along with contusions above her left eye. Joe's wife left the house and has not returned since. She is filing for a divorce. Joe is also currently facing charges of assault and battery also being filed by his wife.

About a week before the fight, when talking with some friends about getting together for the evening, Joe had seemed emotionally distant and removed, as though preoccupied with something else. Joe had talked about himself in a self-deprecating way, and about having a lot of stress and health problems. Joe often seemed sad and discouraged about something but his friends never seemed to
be able to cheer him up. When one of his friends asked him what was going on with him, he said, "I’m sorry. I’ve been real depressed and tired lately. Things have been getting away from me. I feel so pointless and hopeless I don’t know what to do with myself anymore."

Joe has a history of depression, has been previously diagnosed as a chronic depressive, and has been hospitalized before. Joe has been seeing a psychiatrist and had been taking anti-depressant medications as of approximately three weeks prior to the fight.

**Directions:** Circle the number which best describes your opinion about the situation. This is an opinion survey. There are no right or wrong answers.

1. To what extent is Joe himself the **cause** of his behavior?

   1  2  3  4  5  6  7
   Not at all  Somewhat  Totally

2. In your opinion, how **responsible** is Joe for what happened as described above (as compared to other things such as situational variables or chance)?

   1  2  3  4  5  6  7
   Not at all  Somewhat  Totally

3. In your opinion, to what extent should Joe be held accountable and to blame for his actions? (For example, should Joe be punished for his actions?)
4. In your judgement, as a result of court action on this matter, what would be the best decision? (Circle one)

Joe should:

(A) Be given a jail sentence appropriate to assault and battery.

(B) Be referred for psychiatric treatment or hospitalization.
Scenario 4

Joe and his wife were planning to give a bridge party at their new home. They disagreed on the plan for dinner. At one point during the disagreement Joe said that he would rather cancel the party because his wife was "obviously unwilling" to make a dinner that was "appropriate to the event." His wife responded by telling Joe that he didn't make enough money to pay for the kind of dinner that he wanted.

The disagreement turned into an argument, escalating to the point of cursing and name-calling. Joe than hit his wife several times, leaving her with several visible bruises around her neck and on her arms, along with contusions above her left eye. Joe's wife left the house and has not returned since. She is filing for a divorce. Joe is also currently facing charges of assault and battery also being filed by his wife.

About a week before the fight, Joe's friends noticed that he had started drinking heavily again and was talking about a lot of stress and health problems. Joe seemed very irritated about something and his friends had trouble talking with him about his problems. When one of his friends asked him what was going on with him, he said, "I'm sorry. I've just been really tired lately. Things
just have been getting away from me. I just don't know what to do with myself anymore.”

Joe has a history of alcohol abuse and has spent some time in an alcohol rehabilitation clinic. Along with his stay at the clinic, Joe has tried AA meetings in order to control his drinking, but nothing seems to work.

**Directions**: Circle the number which best describes your opinion about the situation. This is an opinion survey. There are no right or wrong answers.

1. To what extent is Joe himself the **cause** of his behavior
   
   1 2 3 4 5 6 7

   Not at all Somewhat Totally

2. In your opinion, how **responsible** is Joe for what happened as described above (as compared to other things such as situational variables or chance)?

   1 2 3 4 5 6 7

   Not at all Somewhat Totally

3. In your opinion, to what extent should Joe be held accountable and to blame for his actions? (For example, should Joe be punished for his actions?)

   1 2 3 4 5 6 7

   Not at all Somewhat Totally

4. In your judgement, as a result of court action on this matter, what would be the best decision? (Circle one)
Joe should:

(A) Be given a jail sentence appropriate to assault and battery.

(B) Be referred for psychiatric treatment or hospitalization.
Appendix D

Debriefing

In this study, we were interested in whether shared characteristics between an observer and an actor will influence how the observer will view the actor’s behavior. We administered these questionnaires to three groups of people: 1) undergraduate students who do not drink at all; 2) undergraduate students who drink frequently and to excess; and 3) people who are in a recovery program for alcohol abuse/addiction. In the scenarios that you just read, the actor either was known to use alcohol quite frequently or there was no mention of any kind of alcohol use but some information about a history of depression. His behavior in both of work and social scenarios had negative outcomes—he was being fired from a job or he was losing his wife and had charges brought against him. We hypothesized that Groups 2 and 3 may identify with the actor in the scenario that involved alcohol use and place less blame and responsibility for his actions on him (internal attributions) and more on his involvement with alcohol (external attributions). For Group 1, we hypothesized that they would tend to ignore the actor’s alcohol use and place more blame and responsibility on him. Basically, we were interested in how shared characteristics
would influence a person’s internal and external attributions for an actor’s negative behaviors. We also hypothesized that Groups 2 and 3 would be more lenient in suggested punishments than Group 1.

You also received a scenario in which the actor showed signs of depression and also had a history of depression. We included these conditions in order to rule out the possibility that people will attribute blame and causality to external sources for an actor with any kind of psychopathological disorder, in this case, depression. The last two questionnaires that you filled out will give us a general level of your depression and we will use these scores to factor out any variability that was due to your own depression. In other words, if you score high on depression, you might have a tendency to identify with the depressed actor, and we just wanted to control for that possibility.

Well, that’s basically what our study was about. If you have any questions or would like to know how the study turned out, you may contact me by phone, mail, or e-mail. All of that information is listed below.

Once again, thank you very much for your participation.
Gregory Gudleski
102 Willow Drive
Williamsburg VA 23185
757-258-3098; e-mail: ggudleski@aol.com
VITA

Gregory Daniel Gudleski

Born in Mount Carmel, PA, on March 13, 1967.
Graduated from Mount Carmel Area High School in June, 1985.
In May, 1996, he received his B.A. in Psychology from Bloomsburg University in Bloomsburg, PA. He entered the Master of Arts program in Psychology at the College of Williams and Mary in August, 1996.