OH G-D, A BORDERLINE: CLINICAL DIAGNOSTICS AS FUNDAMENTAL ATTRIBUTION ERROR

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Researchers raise concerns that the diagnostic approach can create stigma and lead to clinical inferences that focus on dispositional characteristics at the expense of situational variables. From social cognitive theory to strict behavioral approaches there is broad agreement that situation is at least as important as disposition. The present study examined the clinical inferences of graduate student clinicians randomly presented a diagnosis (borderline PD) or no diagnosis and either randomly given context information or no context information before watching a videotaped clinical interaction of a fabricated client. Responses to a questionnaire assessing dispositional or situational attributions about the client’s behavior indicated a diagnosis of borderline personality disorder did not significantly increase dispositional attributions and did not significantly moderate the importance of contextual factors. A notable difference between the attributions made by psychodynamic and third wave behavioral respondents was observed. Conceptual and experimental limitations as well as future directions are discussed.
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CHAPTER 1
INTRODUCTION

Once you label me, you negate me

- Søren Kierkegaard

John Watson famously touted that he could make a healthy child into any sort of professional he desired, given that he had exclusive control over the child’s environment. Over the decades, many protested this claim, fearing its deterministic quality. Nevertheless, that child could be shaped into anything and therein lies ultimate freedom; it is only that agency rests not in the child, but in her context. Watson’s claim, an oft cited exemplar of behaviorism’s supposed coldness to humanism, in fact, suggests the near limitlessness of human possibility.

As Kierkegaard’s quote suggests, at least in part, our labeling truly negates the possibilities of humanness; our “this is for that” and “that does this” mentality quickly limits an object its dictionary definition, rather than describing its broad array of properties and functions. For example, a chair is defined as “a seat typically having four legs and a back for one person” (Merriam-Webster online) at the expense of its ability to be used as a device upon which stepping makes items at greater heights more accessible, a source of fuel, or as a weapon. A chair, in and of itself, has no properties which require that it always exist as Webster's definition suggests it should. Rather, like the hypothesized child of Watson's claim, the chair's truer definition is dynamic, its boundaries blurry.

One scientifically founded explanation for how “chair” comes to be rigidly related to as a seat is given by relational frame theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001), but the idea that this process occurs has been a point of consideration for thousands of years. The Taoist sage Chuang Tzu pointed to the human tendency to restrict the value of things to a set of
predetermined ideals as misguided and limiting. A knotty old tree, considered useless by those around him because it could not produce useful timber – the prescribed mark of a useful tree – provided shade for Chuang Tzu (Watson, 1996). The ability to label is of course often useful, and one of our more common uses of the human linguistic tool. Nevertheless, it can also lead us to overlook what actually *is* in the search of what previously conditioned linguistic relations suggest *ought* to be; a chair, constrained to being used as a seat could fail to serve as a protective weapon during a home burglary. How funny it might be to read a newspaper report of a man who simply watched his home burglarized because the chair he sat in ought to be used only for sitting!

Perhaps, in the very same manner, a person described as a “woman” – a term loaded with a myriad of expectations and definitions – might be more likely to behave in concordance with verbally defined prescriptions of womanhood, for better or for worse. In fact, this has been posited to be the case in feminist theory and psychological research supports the idea (Roth & Basow, 2004). The role that gender construction plays easily affects behavior more than actual biological characteristics of men and women (Wachs, 2006). Unfortunately the effects of verbal rules on what black people, white people, Hispanic people, male people, and so on, can do continue to plague lives and hinder opportunities in more subtle, though equally insidious ways. As an example, consider stereotype threat. The mere mention of negative stereotypes about women’s mathematical abilities meaningfully alters women’s actual computational performance (Spencer, Steele, & Quinn, 1999). That is all to say: definitions, labels, and others words, and shape the way that we see the world. We make boxes where there is perhaps only intricate infinity and we often do this for good reasons. Quantifying, calculating, and separating into comprehensible units works in many situations of our everyday lives. It is not a practice that
should necessarily be abandoned, but it is one that should be closely monitored when potentially harmful.

Psychologists follow in the shadow of their medical doctor colleagues by adhering to the *Diagnostic and Statistical Manual (DSM; APA, 2000)*, currently in its 4th edition, which defines the myriad of diagnosable psychiatric conditions. The *DSM-IV-TR* uses a categorical model that separates clusters of behaviors into checklists and boxes. The process of how the *DSM* was conceived and carried out is discussed more fully later in this paper. The diagnoses contained in the *DSM* outline behaviors and characteristics associated with each disorder. Thomas Szasz, a psychiatrist, famously argued that mental illness is a myth of convenience. Not only does mental illness not objectively exist – it is only theory – Szasz argues it is unduly treated as objective truth much as the use of deities and witches were improperly utilized as causal explanations in times past (Szasz, 1960). Diseases of the brain, those with physiological etiology, should be called exactly that and not mental illness, argues Szasz; reducing complex psychosocial behaviors that occur in broad contexts, to simple internal brain illnesses is misleading. In fact, recent research on the efficacy of treating “mental illnesses” like depression with pharmaceutical interventions has recently revealed that antidepressant drugs have little effect beyond placebo (Fournier et al., 2010), suggesting a non-physiological etiology to one of the most *DSM*’s most common diagnoses.

Multiple theoretical approaches indicate that the contexts in which behaviors occur, are at least equally as important as dispositional variables. For example, behavioral genetics posits that the environment plays an integral role by interacting with genetic predispositions to produce behavioral outcomes (Plomin & Rende, 1991). Social cognitive explanations of the role of the environment contend that the interplay of environment and personality traits explains why
sometimes individuals behave similarly across situations and sometimes they do not (Mischel, 1973). This parallels a behavioral explanation that describes interplay between a person’s history of reinforcement and the present environment (Skinner, 1976). Likewise, the notion of reciprocal determinism, proposed by Albert Bandura, implicates the role of both personality and environmental factors in determining behavior and that the interplay between those variables in each moment is reciprocally causal (Bandura, 1986). That is, how past events have shaped personality affect how one responds to the present environment and that interaction then affects future personality development (Bandura, 1986). That the environment in which behavior occurs intimately alters the development and expression of what are often considered dispositional personality factors has not escaped many approaches to the study of psychology. Yet, it is alarming that the diagnostic system fails to fully account for this notion, despite its acknowledgment by many theoretical approaches. As such, this study considers this disparity through the lens of social psychology's idea of the power of situations.

What most psychotherapists are interested in Szasz calls “problems in living” (Szasz, 1960), which are normally-occurring conflicts that result from being a human involved in human dynamics. Szasz takes the stance that the indictment of “mental illness” as cause of these problems is amoral and as problematic as blaming witchcraft and demons for human struggles (Szasz, 1960). The emphasis on internal illness was perhaps a useful convenience at some point but leads us to miss the broader contextual circumstance of being a human being in favor of a myth that life would be satisfying and pleasant should “mental illness” or “psychopathology” be eradicated (Szasz, 1960).

Although developers of the upcoming DSM-V are taking into consideration the idea of dimensional modeling, their focus remains on symptoms, not underlying function (Regier,
Narrow, Kuhl, & Kepfer, 2009). A nomothetic approach underwritten with functional analysis might ease communication and simultaneously provide meaningful direction for treatment (Bissett & Hayes, 1999). Such an emphasis on functional analysis of disordered behavior might exorcise internalized demonic “mental illnesses” as causes for behavior and set clinicians and researchers alike to the task of determining the variables that maintain maladaptive behavior.

One organizing functional class of behaviors, experiential avoidance, has been shown to be meaningfully related to a broad spectrum of disorders and symptoms as catalogued by the DSM system (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Kashdan, Barrios, Forsyth, & Steger, 2006). What’s more, changes in experiential avoidance have been shown to co-occur with, and sometimes precede, changes in therapeutic outcome measures of symptomatology and quality of life (Kashdan et al., 2006; Schmalz & Murrell, in press). Those researchers and clinicians who utilize experiential avoidance as a tool to understanding, researching, and treating maladaptive behaviors recognize that experientially avoidant behaviors are not indicators of “illness,” rather they are the products of socially and naturally mediated reinforcers (Hayes et al., 1996), much like Szasz talked of “problems in living.”

The question that this project proposed to answer was whether merely mentioning diagnostic labels could alter how clinicians view others; centuries ago “she’s a witch!” affected how even the most educated responded. More specifically, this project assessed the following: do diagnoses lead mental health clinicians to ignore the role that context plays in a person’s behavior and attribute the cause of behavior to internalized characteristics of the person? Does a label lead clinicians to fail to see what is there as they search for what ought to be? To fully discuss the possibility of environmental insensitivity due to diagnostic labels, the remainder of this literature review covers: 1) the diagnostic system, including consideration that it may not
fulfill its desired goals, which warrants investigation of how it may be harmful, 2) psychotherapy as an interpersonal process that requires acceptance by the therapist, 3) stigma in mental healthcare, which is related to attribution theory, and 4) social psychology, or more specifically, the power of situations and attribution error.

The Diagnostic System

Sometimes, symptoms might be indication of burgeoning existential growth (May, 1994; Yalom, 1980) or an indication of stressful situational factors that ought to be recognized (Fischer, 1985, 1989). Indeed functional analysis and existential-phenomenological approaches demand that the environment surrounding a cluster of symptoms be considered central to any meaningful psychological assessment (Fischer, 1985, 1989). Yet, the very nature of a diagnostic system renders it likely that clinicians will hone in on symptoms as “things” which are causal and must be done away with (Halling & Goldfarb, 1996). The symptoms identified are likely important; they do suggest that something might be “wrong” after all. Each edition of the DSM brings stronger influence and reliance on its system to the field of psychology (Halling & Goldfarb, 1996).

Although discarding a diagnostic system as a whole is not a viable or likely option in the mental health field (Follette & Houts, 1996), there are a number of problematic issues, both theoretical and pragmatic, about the way that the DSM is structured. Follette and Houts (1996) point out that modern DSMs have been touted as being atheoretical and that this fact has been suggested to be a strength of the system. However, the DSM, in identifying syndrome clusters thought to reflect a common etiology (Frances, First, & Pincus, 1995), assumes that some basic “physiologic problem” (O’Donohue, 1989) – something material – is really present in the person. Claiming a materialist etiology is an ontological assumption, one that implicitly indicta
biological perspective (Follette & Houts, 1996); the *DSM* specifically endorses the medical model and is presented as a means to reintegrating psychiatry into medicine (APA, 2000). There are no grounds to claim that if the *DSM* was theoretically based then it would be inherently flawed. A developed theoretical rationale might lend coherence to the system, though simultaneously making it less palatable to professionals who do not share similar philosophical groundings. In either case, it is clear that there is a materialist medical model at play that implicates an etiological mechanism internal to the diagnosed individual.

Pragmatically, the *DSM* system attempts to address three purposes of diagnostic taxonomy (Millon, 1991): 1) clinical utility, 2) research facilitation, and 3) scientific understanding. Each of these goals is adversely affected by the high rates of comorbidity that result from *DSM* diagnoses. Kendall and Clarkin (1992) describe the issue of comorbidity to be the largest challenge faced by the professional mental health community. In community samples, specific *DSM* disorders yield very high comorbidity rates. Over 90% of individuals diagnosed with panic disorder or schizophrenia had lifetime comorbid disorders (see Clark, Watson & Reynolds, 1995, for a review). That comorbidity is the norm and presentation of a clear single disorder is the exception indicates that the *DSM* system fails to create meaningful diagnostic distinctions that are accurate or of help in clarifying clinical approaches and communication, bolstering research, or increasing scientific understanding of psychopathological behavior.

In fact, the myriad combinations of disorders lead to clinical cases for which practitioners do not feel that empirically supported approaches are well-suited (Ruscio & Holohan, 2006). At the very least, there is warranted uncertainty that the empirical studies of the efficacy of a given treatment for a given disorder are applicable to clients with comorbid conditions. In an effort to increase internal validity, studies used in the determination of empirically supported or validated
status typically screen for the presence of a particular disorder (e.g., major depressive disorder) and exclude participants with common co-occurring diagnoses and circumstances (e.g., prior therapy, suicidal risk; Westen & Morrison, 2001). Although the volume of research has increased as a result of having a unified taxonomy, the very taxonomy has become an “unintended straitjacket,” limiting researchers to particular clear symptom presentations at the expense of the commonality of comorbidity (Clark, Watson, & Reynolds, 1996, p. 123).

Another problem that consistently results from the use of the DSM system is heterogeneity (Clark, Watson, & Reynolds, 1996). Not only do clients often fully meet criteria for multiple disorders (i.e., comorbidity), but their symptom presentations also often overlap across multiple diagnoses in an unclear fashion that makes it hard to clearly differentiate one diagnosis from another (Clark et al., 1996). The problem of heterogeneity is likely the result of a topographical approach that attempts to peg observed symptoms to underlying material etiologies without considering the context in which the symptom occurs and the function it serves in that context (Hayes, et al., 1996).

Research and speculation to date indicates that the DSM system does not succeed in the three domains its creators proposed it would. The problems of comorbidity and heterogeneity are indicators of an inconsistent link between symptoms and physiological etiology that has left psychiatric diagnoses in the realm of syndromal classification and not true disease (Hayes et al., 1996). Clinical work, research, nor scientific understanding seems to be meaningfully moved forward by its presence. It would seem that the DSM has some utility, or the system would have been fully shunned long ago. As suggested at the beginning of this section, a diagnostic system is inevitable, it appeals to the human desire for categories and order. But, if our system does not meet the expectations set for it, something is wrong. If the DSM system is not leading the way
Psychotherapy as Interpersonal Process

The interpersonal process of therapy is central to therapeutic approaches across the board. Excepting perhaps traditional psychoanalysis – wherein the clinician is meant to be a blank slate and does little in the way of providing support or empathy – every school of psychotherapy acknowledges that the enterprise is futile if the interpersonal relationship lies undeveloped. Psychotherapy is a multifaceted and dynamic process. Despite the myriad of different treatment modalities available (e.g., psychodynamic, humanistic, cognitive-behavioral) offering their own blend of specific techniques, forms of intervention, hypothesized etiological explanations, and proposed mechanisms of change, the therapeutic relationship remains a central factor consistently associated with positive outcomes (Martin, Garske, & Davis, 2000). “Common factors” such as therapeutic alliance, warmth, and empathy account for twice as much observed change in therapy as do orientation-specific techniques (Lambert & Barley, 2001).

The dodo bird effect is a phrase used to describe numerous findings that there are no meaningful differences among any psychotherapy variations in techniques (Luborsky, Singer, & Luborsky, 1975; Wampold, et al., 1997). A reference to Alice in Wonderland, the dodo bird effect claims that all therapies must have prizes for their equivalent efficacies. Luborsky and colleagues (1975) assert that the common factors of therapeutic kindness and alliance are the reason for the dodo effect.

Indeed, Zuroff and Blatt (2006) found that across 4 treatment conditions – cognitive behavioral therapy, interpersonal psychotherapy, imipramine-clinical management, and placebo – the therapeutic relationship is a consistent positive predictor of outcome for treatment of depression. Watson and Geller (2005) similarly found the therapeutic relationship to be
predictive of depression, interpersonal problems, self-esteem, and dysfunctional attitudes while no significant differences on these outcomes was observed between cognitive behavioral therapy and process-experiential therapies. A meta-analysis by Martin, Garske, and Davis (2000) found that the therapeutic relationship’s relation to outcome variables is moderate, though consistent, and does not appear to be impacted by moderator variables like type of outcome measure used, type of outcome rater, type of alliance assessment, or type of treatment. This suggests that despite some methodological variability in the meta-analytic process, the therapy relationship is still a robust predictor of success. An earlier meta-analysis (Horvath & Symonds, 1991) also found a consistent, moderate effect of therapeutic relationship with positive therapy outcome with similar robustness with respect to moderating variables.

Some meditational studies have sought to determine more clearly what it is about a good therapeutic relationship that yields positive outcomes. Therapeutic working alliance mediates the relationship between interpersonal problems and depression (Howard, Turner, Olkin, & Mohr, 2006). It appears that the therapeutic relationship likewise mediates the relationship between self-critical perfectionism and sustained client adjustment (Blatt, Zuroff, Hawley, & Auerbach, 2010). Regardless of the specific pathways by which therapeutic alliance is beneficial to therapy, or whether the Dodo bird effect continues to gain support, it is clear that the therapeutic relationship is a fundamental element and robust predictor of positive therapeutic outcome.

Developing therapeutic alliance, in part, requires that the therapist be able and willing to accept the client as they are, where they are, and for all of their behaviors, good and bad (Rogers, 1957). When personal biases or stigmas get in the way of therapeutic alliance development there are, data suggests, likely to be problems with the efficacy of treatment. Motivational interviewing literature specifically emphasizes that clinicians should be careful in their use of
diagnostic terms that are stigmatizing (Miller & Rollnick, 2002). Identifying the extent to which stigmatization occurs from therapist to client is the first step to understanding its overall potentially deleterious effect.

Stigma in Mental Healthcare

It is possible, though presently under-documented, that clinicians who view their clients as broken and without a capacity for change may adversely affect the outcome of treatment. Indeed, Wills (1978) posits that negative perceptions of clients, unrelated to diagnosis, adversely affect the quality of the therapeutic alliance and subsequently the likelihood of positive change resulting from therapy. In society at large there does exist a substantial level of stigma both about seeking mental health services and towards particular diagnoses (Stier & Hinshaw, 2007; Vogel & Wade, 2009). Stigma towards mental illness at the community level can also lead to discrimination and prejudice (Overton & Medina, 2008) and has been found to be insidious to an individual's well-being above and beyond the effects of the “illness” itself (Stier & Hinshaw, 2007). Although it is clear that stigmatization of an individual seeking mental health services is problematic, it is under investigated whether or not clinicians actively, though perhaps unintentionally, stigmatize their clients and as a result adversely affect the outcomes of therapy.

We do know that mental health workers are less stigmatizing of hypothetical clients than are undergraduate students (Ledet, 2010), a feat perhaps lacking profundity. It would seem that as with the general public, education about mental health and disorders does not do away with stigmatizing attitudes by professionals (Vogel & Wade, 2009). In defining stigma in the context of mental healthcare, Stier and Hinshaw (2007) specifically indicate that it centers in part on the disorder label itself. A study involving lay participants found that people are likely to stigmatize individuals labeled mentally ill even when they exhibited no aberrant behavior (Link, 1987).
The scarcity of research on the issue of therapist-to-client stigma may have to do with the stigma of stigmatization among professionals; it is much easier to study those we work with than it is to scrutinize ourselves. Among mental health professionals there does exist a stigma about each others' own problems (Kottsieper, 2009). Many mental health professionals do not feel free to discuss their own psychological struggles or share with their coworkers and superiors that they seek counseling. It would seem that the societal reach of stigma does not stop at the doors of professionals' offices or the walls of the ivory tower. Therefore, more thoroughgoing investigations of what situations and clients are likely to occasion therapist stigma – a matter to be undertaken in this study – and to what extent the presence of stigma does indeed negatively impact therapeutic outcomes is warranted.

Corrigan (2000) specifically calls for research into the effect of labeling in mental illness stigma using an attribution theory approach. Attribution theory broadly indicates that people ascribe the causes of a person’s behavior to the underlying dispositions of that person (Heider, 1958; Jones & Davis, 1966; Kelley & Michela, 1980) with a marked insensitivity towards the control exerted by contextual factors. Furthermore, the extent to which a behavior is thought to be under a person’s own control or influenced by external factors significantly affects whether dispositional or situational attributions, respectively, will be made. Boysen and Vogel (2008) did find partial support for the role of attribution theory in people’s stigmatizing responses towards Schizophrenia versus addiction; people tend to be more stigmatizing of addictions than Schizophrenia because the former is considered more within one’s control than the latter. Disorders that are thought to be caused by a person’s behavior (e.g., AIDS, child abuse) are more highly stigmatized than those that are thought to have biological causes (e.g., Alzheimers, blindness), due to attribution processes (Dijker & Koomen, 2003; Weiner, Perry & Magnusson,
Borderline personality disorder. Personality disorders have a particular stigma about them that is distinct from the stigma associated with other DSM disorders. A particular disorder classified in the DSM, and the one that was used in the present study, is borderline personality disorder (BPD). Like all Axis II (personality) disorders, BPD refers to an “enduring pattern” of maladaptive behavior that is pervasive, causes significant distress, and is not due to a physical illness (APA, 2000, p. 689). People diagnosed with BPD are thought to show a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts” (APA, 2000, p. 706). Related to their “pervasive” and “enduring” natures and to a lifetime of personality development they are thought to be particularly hard disorders to treat. As a result, mental health workers tend to stigmatize these clients to some extent and treat them as though they are hard to deal with (Netwon-Howes, Weaver, and Tyrer, 2008). In particular, BPD is known to receive a heightened level of stigma from the public and mental health professionals and that stigma can negatively impact the course of treatment (Aviram et al., 2006). Interestingly, Burns and Nolen-Hoeksema (1992) found that participants diagnosed with BPD fared worse than other participants with other diagnoses even though levels of one particular component of a strong therapeutic relationship, empathy, were not different. The authors (Burns & Nolen-Hoeksema, 1992) note that clients exhibiting Axis II-type behaviors tend to idealize therapists, even when therapeutic gains are not being made, or for fear of conflict rate therapist empathy higher than their experience might otherwise suggest.

Theoretically, from an attribution theory model, disorders on Axis II inherently cannot be considered to be of biological etiology and are therefore more likely to be seen as a reflection of
an individual’s unwillingness to control their own behavior. There is no published data that this author is aware of, but anecdotally, it is not uncommon to find clinicians who respond with disdain about being assigned to work with clients with Axis II diagnoses and to expect the worst out of them; it is this response which inspired the title of the present project, “Oh G-d, a Borderline.” This negative response by mental health workers is likely due, in part, to the typically chronic and sometimes difficult to treat nature of personality disorders (Bateman & Fonagy, 2000).

Social Psychology: The Power of Situations and Attribution Error

This paper suggests that the presence of these various difficulties found in using DSM taxonomy, which designates internal dispositional problems of the individual at the expense of accounting for behavioral and social psychological assertions that contextual factors weigh heavily on a person’s behavior, do not co-occur without reason. It may be that the taxonomic system indeed, as Szasz argues, is like explaining pathological behavior with witchcraft. Social psychological research has persistently extolled the power of situations to influence a person's behaviors, so much so that this idea has become a central tenet of social psychology.

The following three well-known studies highlight the role of the situation. Solomon Asch, in his conformity studies (1955; 1956), found that a person will go against her own good reason and give apparently false answers when in a group of people who do the same. Milgram’s (1963) renowned obedience study determined that average, healthy people will inflict severe pain, sometimes to the point of apparent death, upon others given the presence of an authority figure telling them to do so. Zimbardo (1971) observed that the social influence of expected roles dramatically influenced people’s behaviors. Specifically, Zimbardo (1971) found that people put into the roles of prisoner and prison guard will begin to act radically different than they would in
ordinary life. Clearly, people’s behaviors are strongly influenced by the environment they find themselves in.

Attribution theory suggests that people interpret observed behavior of another individual as indicative of character or disposition. Attribution theory further assumes that when behavior is explicitly constrained by contextual factors that this attribution process should be less salient. However, the tendency to ascribe dispositional causes even to behavior under constraint has been termed the fundamental attribution error (FAE; Ross, 1977). The FAE was discovered by Jones and Harris (1967) in their well-known study of attributions. Jones and Harris found that regardless of whether an individual chose to write in favor or opposition to Fidel Castro, or if she were made to do so, people perceived the writer’s true feelings towards Castro as consistent with whatever she wrote. This finding countered the previous logic of attribution theory that the extent to which an action was apparently freely chosen would determine how much dispositional attribution was made. The FAE has become a core concept in social psychology, a way of understanding the way that people understand – or misunderstand, as the case may be – one another.

Similar to findings by Jones and Harris (1967), Ross, Amabile, and Steinmetz (1977) found that people favor dispositional explanations in favor of contextual ones even when they are aware of restrictive contextual constraints. In their experiment, Ross, Amabile, and Steinmetz had participants view people in conversation. Some of the individuals had been assigned to create difficult questions for the other to answer. Resultantly, the participants told to create difficult questions appeared more intelligent than their counterpart. Despite being aware that some of the people they were watching had prepared intentionally difficult questions, participants were more likely to rate the ones who had created hard questions more favorably.
The previously discussed studies illuminated the power of the situation, or context that surrounded the surprising observed behaviors. The FAE is also committed in contexts with less salient features than authority figures and group influence. Tal-Or and Papirman (2007) found that the FAE affects people’s perceptions of the actors who play fictional characters; people were most likely to assume that the characters played by actors were expressions of the actor’s personality, even when presented with the actor playing multiple characters. In the case of multiple characters, people attributed character-traits of the last performance seen to the actor. The context within which the Tal-Or and Papirman (2007) study occurred was the only context the participants had to judge the person by. Despite knowing that the person was portraying someone else, participants used their limited exposure to the person to explain the person’s personality traits, rather than recognizing the situation. The element of explanation is an important related aspect to understanding why people so commonly commit the FAE.

Human beings are reinforced for making sense of the world around them. Just as the verbal community asks the individual “why” he behaves in a particular way, so too, the individual asks the same questions of other persons’ behaviors. When it comes to their own behavior, they have an entire lifetime of experience within which to contextualize the power the situation has on their own behavior. There are instances when the answer to “Why did you do that?” is related to specific contingencies in the environment. The child asked, “Why did you not bring back the change from your lunch money?” who responds, “Because the bully took it,” is reinforced for verbal behavior pointing to the role of the situation with understanding by the parent. In contrast, such as when research participants watch short video clips or we see other people behave, we often have little environmental data with which to contextualize why they behave the way they do (Storms, 1973). This tendency is known as the actor-observer bias. The
actor-observer bias is a tendency for people to describe their own behavior (as the actor) in terms of the context which surrounded the behavior, and inversely commit the FAE in identifying the causes of others’ behavior (Jones & Nisbett, 1972). The actor-observer bias is more of an extension of the FAE than a separate concept.

In satisfying the desire to know why people behave the way they do, the FAE is committed as an error of convenience. Indeed, research has found that the more cognitively taxed a person is, the more flagrant and pervasive their engagement of the FAE; identifying behavior and making dispositional attributions comes quite automatically, however, assessing contextual factors and incorporating them into the attribution requires directed, conscious, and thus energy consuming thinking (Gilbert & Patrick, 1995; Gilbert, Pelham & Krull, 1988). After all, it requires greater attention and integrative cognitive work to consider the broader context. Also, some researchers suggest that the FAE comforts us by creating a sense of fairness; other people’s woes are the results of their own poor disposition rather than a harsh environment (Furnham & Gunter, 1984)

The FAE in clinical work. It appears that clinical training models might actually increase the prevalence of FAE commission by master’s level clinicians across their training experience (Gilibert & Banovic, 2009). In part, this is likely related to the FAE’s function as an organization tool for individuals to understand their experience of other people. In clinical work, diagnostics are designed to make for easier communication and orient the clinician by giving her an understanding of the client’s presenting concern (i.e., previously described proposed utilities of the DSM, 1 and 3, respectively). This approach inherently makes dispositional claims about people. Diagnoses in the DSM portray the state of a person, his or her qualities, with no consideration of the power of situations. It is not the author’s intention to place the full blame of
institutionalized dispositional attribution on the shoulders of the DSM. Indeed this is a trend that has been at the heart of psychology since psychoanalysis – with an arguable hiatus at the height of behaviorism.

Assigning a diagnosis to an individual is one clinical equivalent of the FAE, in that it takes away the power of the situation and assigns the person an underlying dispositional pathology that guides their behaviors of clinical interest. Diagnostic work is so fundamental to psychological interventions that its role exists almost as a truism. The assumption that diagnosis (or at least the assessment for possible diagnosis) of disorders is an integral first-step in the therapeutic process remains virtually untested (Rashid & Ostermann, 2009).

The similarities between diagnosis and committing the FAE are quite clear. Snyder (1977) points out that the tendency begins in training programs, which typically orient clinicians to view clients’ problems in terms of their dispositions. Gilibert and Banovic (2009) resound Snyder’s claim and specifically point to this dispositional process as being heuristic in nature. Relatedly, clinicians are indeed more likely to identify their clients’ problems as rooted in the personality factors of the client rather than his or her environment (Batson, O’Quin, & Pych, 1982). Indeed, the FAE has been found to influence the process of therapy such that clinicians focus almost exclusively on attempting to focus the client on himself, without acknowledging the extent to which the environmental factors of the client’s life influence the client’s level of distress (Batson, 1975).

Temerlin (1969) had clinicians listen to an audio recording of an actor portraying a healthy man. If told that the recording was of a man who, according to a “prestige figure,” appeared to be in good psychological health, 100% of participants assigned no diagnosis (5% indicated “mild adjustment problems”). If given no mention regarding psychological health, 43%
of participants assigned a diagnosis. In contrast, those clinicians told that the man in the same recording was “psychotic” gave a diagnosis of some type of psychotic disorder; specifically, 88% of clinical psychology graduate students, 88% of professional clinical psychologists, and 100% of psychiatrists in the sample endorsed a diagnosis of a psychotic disorder. It is apparent that clinicians too are susceptible to the actor-observer bias; one clinician when asked why he had assigned the diagnoses pointed out that he had been told by a mental health authority figure that the man in the tape was psychotic, thus he gave a diagnosis (Temerlin, 1969).

There is evidence that clinicians adhering to some theoretical orientations are more susceptible to the FAE than others. Psychodynamically oriented therapists were more likely than their behaviorally oriented counterparts to engage in attribution bias when a client was referred to as a “patient” rather than a “job applicant” (Langer & Ableson, 1974; Snyder, 1977). Psychodynamically oriented therapies tend to focus heavily on diagnosis, whereas behavioral approaches do not. Though, in fairness, psychodynamically oriented therapies do place an emphasis on historical contextual factors; it is the supposed internalization into personality characteristics of historical events that is particularly questionable when those personality variables begin to take precedence over current contextual variables. Although no similar research design has been applied, cognitive-behavioral therapists may also be at particular risk of making excessive dispositional inferences because the underlying mechanistic philosophy of cognitive-behavioral therapy (CBT) tends to focus more on content of thoughts and less on the contextual function of those thoughts (Ciarrochi & Bailey, 2008).

Hopeful findings suggest that once the FAE is recognized as an ongoing occurrence education about this phenomenon and training techniques oriented towards emphasizing the role of the environment decrease commission of the FAE among both clinicians (Chen, Froehle &
Morran, 1997; Gilibert & Banovic, 2009) and college students (Riggio & Garcia, 2009). Thus, it is important to first determine whether or not, and to what extent the FAE is broadly at play among clinicians and clinicians-in-training so that subsequent interventions can be implemented.

The Present Study

The FAE is a mistake made in everyday interactions when people mistakenly attribute the actions of another to dispositional attributes of that person (Ross, 1977; Jones & Harris, 1967). This mistake ignores the contextual factors that influence why a person behaved in a given way. Interestingly, individuals are generally quite good at recognizing the power of the situation in affecting their own ways of behaving. In stark contrast, research has found that even when given a good understanding of contextual factors which have limited another person’s freedom to choose her behavior, observers will persist in assigning dispositional causes (Ross, Amabile, & Steinmets, 1977).

Despite the fact that many approaches to psychology focus at least equally on both dispositional and contextual factors, applied psychology too has fallen prey to the FAE, conceptualizing and diagnosing client struggles as results of dispositions and personalities. Diagnostic work is the norm in mental health services and regarded as pre-cursor to appropriate treatment, although there is little empirical support showing a link between appropriate diagnosis and positive therapeutic outcome (Rashid & Ostermann, 2009). Furthermore, a key component of clinical training is familiarization with the DSM and the use of assessment measures and techniques to label clients with a myriad of diagnoses. The mere mention of certain diagnostic categories (e.g., Axis II diagnoses) can negatively impact the course of treatment by stigmatizing the mental health worker’s attitude towards the client (Netwon-Howes, Weaver, and Tyrer, 2008). Worse still, pathologizing terminology has been found to alter the decision making of clinicians...
despite a lack of adequate observed behaviors (Temerlin, 1969). It further appears that clinicians of some theoretical orientations (e.g., psychodynamic) are more likely to endorse dispositional attributions than others (Langer & Ableson, 1974; Snyder, 1977).

Temerlin’s (1969) study lays the groundwork for the present study. An important possible difficulty with Temerlin’s study is related to the use of “psychotic” as the independent variable. Given what “psychotic” potentially means, Temerlin’s results could have been confounded by clinicians assuming that what the man on the audio recording said was the product of some overarching delusion. That is, they could have assumed that the man had no insight into his delusions, which within the time of the recording did not touch on any absurdity; not all delusions sound “crazy” (Temerlin, 1969). As a result, the participants may have relied on availability heuristics and conformed to the information provided by an authority figure regarding psychosis. Furthermore, the influence of a “prestige figure” might have also unduly influenced the behavior of participants. Lastly, to the present author’s knowledge, no previous study, including Temerlin’s has investigated the effect of DSM-specific diagnoses.

To address this possibility, the present study used a diagnosis of borderline PD. Clients with borderline PD typically elicit a strong response from clinicians, similar to clients with psychotic phenomena, but without potentially confounding the findings with the often times unclear presentation of psychotic disorders. The goal of the present study was to determine how either being made aware, or not, of contextual factors and the presence of a diagnosis affect the attributions of clinicians. To accomplish this, participants (who were all clinicians in training) were presented with a video recording of a woman expressing anger towards her therapist. In one condition, participants were informed of situational factors that influenced her behavior, while those in the other condition were not. Simultaneously, half of each of these groups was informed
that the woman has been diagnosed with borderline PD, the other half was not. Clinician self-reported theoretical orientation was used as a third independent variable.

Hypotheses

Hypothesis 1. There would be a significant main effect of diagnosis. Those participants who were presented with a diagnosis would make significantly more dispositional attributions.

Hypothesis 2. There would be a significant interaction effect between contextual information and diagnosis. Participants presented with a diagnosis would make greater dispositional attributions regardless of contextual information.

Hypothesis 3. There would be a significant simple main effect of theoretical orientation. Participants endorsing psychodynamic and cognitive-behavioral orientations would exhibit significantly more dispositional attributions than their third wave behavioral, existential, phenomenological, or humanistic colleagues.
CHAPTER 2

METHOD

Participants

The sample was composed of 85 clinicians in training from doctoral and master’s level counseling, clinical, and clinical health psychology programs nationwide. Recruitment was conducted by email disbursement of information through graduate coordinators at potential participants’ respective universities. No external incentive was provided to participants. All participants were presented with a UNT Internal Review Board approved information notice that informed them of potential risks and benefits of completing the study.

Measures

Demographic questionnaire. A demographic questionnaire (Appendix A) was given to all participants that assessed basic demographic variables such as age, sex, ethnicity, and religion/spirituality. The demographic questionnaire also asked questions related to participants’ theoretical orientation, approximate hours of client contact, and type of training (i.e., clinical, counseling, clinical health).

Clinical vignette. There were two stimuli for the experimental portion of this study. Both stimuli were information related to an individual (the Client) who was recruited from UNT undergraduate students and given a $25 gift certificate as an incentive for her participation. A clinical vignette was created including basic demographic information and a truncated background history, similar to a clinical background. All participants received identical vignettes, excepting one element; the experimental group had one line added in their vignette that read: “Ms. X has a diagnosis of borderline personality disorder.” The two versions of the vignette served as the independent variable.
Video-recorded interaction. The Client took part in a video-recording, the second stimulus. The video-recorded interaction was of about 6 minutes in length. This scripted interaction (Appendix B) was presented as a part of a therapy session to participants. The content of the video involved the Client threatening to harm others, the therapist assessing intent, asking for a verbal contract, and the Client subsequently yelling at the therapist and expressing that she feels that the therapist does not care for her. This interaction was loosely based on experiences the therapist has had with clients diagnosed with borderline personality disorder, and to that extent, though it was scripted, the video recorded interaction carried external validity.

Clinical Attribution Scale (CAS; Chen, 1995). The Clinical Attribution Scale is an 18-item scale on a scale from Strongly agree - 1 to Strongly disagree - 5 that assesses levels of dispositional versus situational attributions. It is specifically intended to be used with mental health practitioners to measure the types of attributions they make with regard to a particular client. The CAS showed adequate reliability (α = .87) with a sample of 83 individuals and also evidenced excellent inter-rater reliability (r = .96) during its validation (Chen, 1995). Ten of the 18 items are dispositional in nature and 8 are situational. The 8 situational items are reverse scored. Thus, the higher a total score, the more a person displays a situational attribution and conversely, the lower the score, the more a person shows a dispositional attribution.

Manipulation checks (Appendix C). Four questions were asked to assess whether participants were actually aware of which version of the independent variables with which they were presented. One question assessed whether the participant experienced any technical difficulties associated with the presentation of the video recording.
Procedure

Participants were randomly assigned to one of four groups: diagnosis/context informed, diagnosis/context uninformed, no diagnosis/context informed, and no diagnosis/context uninformed. All participants were provided with a background history of the Client and the diagnosis groups had an added sentence to their vignette indicating that the Client has been diagnosed with borderline personality disorder. After reading the vignette, participants in the context uninformed conditions were given the following description:

You are about to see a video clip of the woman you learned about in the vignette. She is taking part in a weekly therapy session.

Participants in the Context Informed conditions were given the following description:

You are about to see a video clip of the woman you learned about in the vignette. She is taking part in a weekly therapy session. Ms. X reported that just before coming to the session, she was demoted and embarrassed in front of her co-workers. Furthermore, her therapist stated that in the thirty minutes or so just prior to this interaction he was, ‘feeling tired and was worrying about other work’ he needed to complete.

After viewing the interaction, participants responded to the CAS and the manipulation checks questionnaire to ensure the participants were aware of the information presented to them in their respective conditions. Lastly, participants were administered the demographics questionnaire.

Administration in its entirety was conducted online in a single online administration. Access to the survey was restricted to those recruited individuals provided with the link.
CHAPTER 3

RESULTS

Data Preparation and Preliminary Analyses

Eighty-seven individuals submitted their responses to the online administration. The number of those who started but did not complete the experiment was not recorded. One participant did not respond to any questions, but did submit her form, and was excluded from all analyses. Four participants were excluded from analyses because they indicated that they had no therapy contact hours, the only exclusion criteria for the study.

*Missing data and variable recoding.* Four participants had a single missing value on the Clinical Attribution Scale (CAS); given the limited sample size, it was determined that it was better to use imputation than to exclude those cases. There was no observed correlation between individuals with missing values on the CAS and demographic variables, so the missing data was considered random. Following suggestions and procedures outlined by Tabachnik and Fidell (1996), and in consideration of findings suggesting that in the case of missing data on psychometric instruments regression imputations are about as effective as more complicated computer modeling, the former was utilized (Roth, Switzer, & Switzer, 1999). One other respondent had two missing responses to the CAS and the imputation regression was non-significant; that participant’s data was removed from all further analyses. Following all necessary imputations and removals the reliability of the CAS was assessed using Cronbach’s alpha; the measure demonstrated adequate reliability ($\alpha = .83$).

Four demographic variables, theoretical orientation, ethnicity, contact hours, and religion necessitated a small amount of re-coding, outlined below. For the variable theoretical orientation, there were four participants that specified more than one orientation or recorded “integrative” –
these cases were re-coded as “eclectic”. Two participants reported specific combinations of ethnicities and were re-coded as “biracial.” There were four participants who indicated descriptions of their therapy hours (e.g., “multiple hundreds”) that could not be easily transcribed into a numeric value; these values were re-coded as missing and excluded from descriptive statistical analyses of contact hours. For religion, the survey was set up in such a manner that individuals who nominated “Christianity” were asked to provide a specific denomination; during data preparation these nominal categories were all re-coded into the “Christianity” category. Furthermore, two participants responded as “Other” and subsequently specified “Atheist;” these individuals were re-coded into the “None” category.

**Assumption of normality and outliers.** Visual inspection of histograms of total scores on the CAS – for the entire sample as well as by diagnosis and context conditions – did not indicate outliers and suggested normal distribution. Furthermore the CAS total score variable did not exhibit remarkable skewness or kurtosis – as measured by dividing skewness and kurtosis by their standard errors – indicating adequate conformity to the assumption of normal distribution (Tabachnik & Fidell, 1996). Following data preparation suggestions by Tabachnik and Fidell (1996), z-scores were calculated for CAS total scores; no participant had a z-score greater than 3.3, indicating an absence of univariate outliers. The possibility of multivariate outliers was investigated by calculating Mahalanobis distances for the CAS total score variable within the four groups delineated by diagnosis and context. Z-scores of the Mahalanobis distances indicated that no multivariate outliers were present (Tabachnik & Fidell, 1996).

Due to the true randomization of independent variables and the need to drop a few cases, the group sizes for the ANOVA were not equal (Table 3). To evaluate for potential problems in homogeneity of variance, an F-MAX test was conducted on the variances of the four groups
demarcated by the diagnosis and context conditions. Results suggested that equal variances could be assumed.

Descriptive Statistics

After deletion of ineligible respondents, the total usable sample was comprised of 82 graduate students in clinical, counseling, and clinical health psychology programs at the Ph.D., PsyD, and master’s levels of training. Independent samples $t$-tests indicated no significant differences in CAS scores between clinical and counseling students, $t(78) = -.11, p = .91$ or Ph.D. and PsyD students, $t(77) = 1.15, p = .25$; there were not an adequate number of clinical health or master’s student participants to conduct such analyses on those subsets. The sample comprised more females than males (Table 1) and mostly of individuals who identified as White/Caucasian (Table 1). The mean age and contact hours of participants is summarized in Table 2. Theoretical orientation was predominated by individuals identifying as eclectic and cognitive behavioral (see Table 1 for all frequencies).

Inspection of participant responses to the manipulation checks (Table 4) suggested that there were significantly more errors in recalling whether context information had been provided than diagnosis information. Moreover, there were almost twice as many inaccurate recollections of context information provided when the participant was in the diagnosis condition.

Inferential Statistics

Analysis of Hypothesis 1. The hypothesis that there would be a significant main effect of diagnosis was analyzed using a univariate ANOVA with diagnosis and context conditions as fixed factors (Table 3). Levene’s test for homogeneity of variances ($p = .22$) confirmed the indication of the preliminary F-MAX test that homogeneity of variances could be assumed. The results of the ANOVA indicated a non-significant main effect of Diagnosis, $F(1, 81) = 0.04, p =$
.84 on clinical attribution.

**Analysis of Hypothesis 2.** The hypothesis that there would be a significant interaction effect of contextual information on CAS scores by diagnosis was investigated using a univariate ANOVA with diagnosis and context entered into the model as an interaction term. The results of the ANOVA indicated a non-significant interaction effect, $F(2, 81) = 1.43, p = .25$, that graphically (see Figure 1) trends in the hypothesized direction.

**Analysis of Hypothesis 3.** The hypothesis that there would be a significant simple main effect of theoretical orientation at the diagnosis level was investigated using a one-way ANOVA among those presented with a diagnosis. The mean CAS scores by orientation are provided in Table 3; Levene’s test of homogeneity of variances was acceptable, $p = .65$. No significant effect of Orientation was observed at the Diagnosis level, $F(4, 38) = 2.44, p = .06$. 
CHAPTER 4
DISCUSSION

This study examined the potential influence the presence versus non-presence of an often stigmatized diagnosis – borderline personality disorder – could have on the dispositional or situational attributions made by psychology trainees. Furthermore, of interest was whether the interactive effects of contextual information and a diagnosis of BPD on clinical attributions would suggest the commission of the fundamental attribution error (FAE). Lastly, this study intended to determine if the theoretical orientations of psychology trainees may lead to significantly disparate dispositional or situational attributions. The outcomes of these research questions and potential implications of the findings are discussed along with the practical and conceptual limitations of the present research and considerations for future study of attributions and therapeutic outcomes.

Hypothesis 1: Main Effect of Diagnosis

Participants in this study were either presented with a diagnosis of BPD or given no referent to a diagnosis prior to watching the scripted video interaction and subsequently formulating responses regarding situational or dispositional attributions. No statistical, or practical, significance of the presence of a BPD diagnosis was found in the ANOVA with the present sample. Although previous research has suggested a significant effect of diagnostic terminology on attributions (Temerlin, 1969; Langer & Ableson, 1974; Snyder, 1977; Batson, O’Quin, & Pych, 1982), the present findings strongly suggest that a diagnosis of BPD makes no significant difference in attribution conceptualization. If these findings are accurate, it offers a comforting rebuttal to concerns cited in the literature about training models for psychology students that emphasize the consideration of clinical cases by dispositional inferences, rather
than situational ones (Gilibert & Banovic, 2009; Snyder, 1977).

The experimental preparation of this study emphasized external validity in an attempt to better generalize attribution theory to clinical research. As a result the theory was arguably pushed to its extreme. To my knowledge, no previous study of attribution theory has used as extreme of client behavior in the experimental stimuli as this study. As an example, in Temerlin’s (1969) study all participants listened to the same audio recording of a man partaking in an interview that involved no behavior that was clinical in nature. Considering the transcript of the video interaction stimulus (Appendix B), the Client clearly behaves in a very evocative and clinical fashion, exhibiting behavior and statements highly consistent with BPD. Again, this approach was intentional in an attempt to increase external validity; clinicians are likely to experience these behaviors from a client with a diagnosis of BPD. However, the intensity of the Client’s behavior may have had two unintended effects.

First, such extreme behavior in and of itself can be confusing for anyone, and consistent with FAE literature, dispositional assessments are likely to be made in an attempt to understand the extreme behavior presented. Second, because the behavior was so apparently consistent with a BPD diagnosis, it is probable that participants, due to training in diagnostics and in favor of dispositional explanations (Gilibert & Banovic, 2009; Snyder, 1977), were “diagnosing” the Client while watching the video, despite placement in the No Diagnosis condition. After all, participants were told they were participating in a study about “clinical interpretations.”

Hypothesis 2: Interaction of Diagnosis and Context

Context information about the Client’s day was randomly presented to about half of the participants who were informed of a diagnosis of BPD and about half of those who were not. In the present study, ANOVA results indicated no statistically meaningful interaction of diagnosis
and context on clinical attributions. This finding is in contrast to the hypothesis that psychiatric diagnostics lends clinicians vulnerable to committing the FAE. Recall the distinction between attribution theory and the FAE made by Ross (1977) that attribution theory suggests contextual information should decrease dispositional attributions while the FAE occurs when people persist in dispositional attributions in spite of contextual information; a difference in attributions was expected to occur by context when no diagnosis was present that would be moderated by the presentation of a diagnosis. That moderation did not occur, further suggesting that a diagnosis of BPD does not lead to the commission of the FAE. Although the present findings were not statistically significant – and thus the following should not be considered without a great deal of caution – the data trended (Figure 1) towards the hypothesis that the presence of a diagnosis would cause participants in the context condition to make attributions that were significantly more dispositional in nature. Due to recruitment issues and perhaps an overestimation of projected effect size (see Limitations) it is possible that the trend could be meaningful, with more statistical power.

Another intentional difference in the design of the present study as compared to previous research – again in the interest of external validity – was the less salient nature of the context variable. Previous research in this area has presented behavior that was not extreme and/or the situational factors were glaring (Langer & Ableson, 1974; Snyder, 1977; Chen, Froehle & Morran, 1997). In fact, Chen and colleagues (1997) intentionally prepared their five video stimuli “to ensure that the clients’ presenting problems were primarily situational in nature” (p. 76). The present study intentionally did not engage in this preparation; rather, contextual information was implemented as a randomized independent variable. While that decision arguably increased external validity, whether that contextual information was truly interpreted by
participants as such is uncertain (see Limitations).

Assuming that the context manipulation was effective enough to enter into the inference making process of the participants, its lack of statistical profundity may be another indicator of the boundaries of the FAE and attribution theory’s utility in the research of clinical phenomena. That is, if this study did actually better represent real-world clinical situations by modeling contextual information and client behavior after more realistic conditions, then it may be the case that diagnoses do not significantly influence clinicians’ perceptions of the role of contextual factors. On the other hand, it could still be the case that clinicians’ training has so ingrained apathy towards the role of contextual factors that context does not enter into their clinical formulation to even be obstructed by the FAE. Specifically, contextual information does not yield great enough situational attributions to start with, and thus diagnosis does not significantly re-direct clinical attributions towards disposition, because they were dispositional already.

A couple of relevant observations can be made about of the results of the manipulation checks. While there were only six inaccuracies in reporting whether a participant had been given a diagnosis or not, there were 20 inaccurate responses about whether information about the Client’s day (context condition) had been given. Furthermore, that nearly twice as many (Table 4) participants inaccurately recalled whether they had received context information in the diagnosis condition than those in the no diagnosis condition suggests a potential effect of diagnosis that is in concordance with FAE theory. FAE suggests that even prominent contextual controls on behavior are forgotten in the attribution process. The design of this study provided a relatively small amount of information to participants prior to the presentation of the Video stimulus, which suggests that there was not extraneous information presented that would make it difficult for the participant to accurately recall whether they had been provided information about
the Client’s day. If that were to be the case, that nearly twice as many participants in the diagnosis condition provided inaccurate responses could indicate a FAE-like event wherein diagnosis made the recall of contextual information more difficult.

The discrepancy between accurate identification of diagnosis and context conditions could also be attributable to the training that psychology trainees receive. Perhaps in keeping with Snyder’s (1977) assessment, the participants of the present study may have training that makes them keener to give attention to a diagnosis than attend to contextual variables that might affect a client’s behavior.

Hypothesis 3: Theoretical Orientation and Attribution

Theoretical orientation was analyzed as a quasi-experimental independent variable expected to influence clinical attributions. The one-way ANOVA used in the present study indicated no significant effect of cognitive-behavioral, humanistic, or eclectic orientations on attribution, despite some noted theoretical tendencies in cognitive-behavioral therapy that were hypothesized to increase the likelihood of that group making dispositional inferences (Ciarrochi & Bailey, 2008). A large difference between specifically psychodynamic and 3rd wave behavioral clinicians was observed suggesting that psychodynamic clinicians make more dispositional inferences. Therefore a post-hoc t-test comparing just those groups was conducted; the results were significant among those who had received a diagnosis, \( t(13) = -2.28, p = .04 \). The difference yields a large effect size \( (d = 1.3) \) and is concordant with previous research findings (Langer & Ableson, 1974). It is not surprising to see this difference between the two orientations. Psychodynamic therapy is oriented towards personality change on a large scale; third wave behavioral therapies, being behavioral in nature, look specifically to contextual variables that influence and maintain adaptive and maladaptive behaviors.
Implications

The present findings indicate that in the presence of intense client behavior, the roles of contextual information and diagnosis are negligible in the types of attribution inferences that student clinicians make. Observed stigma in relation to diagnoses of BPD and other Axis II disorders is not disproven by the results of this study; participants of this study may still have had greatly stigmatizing reactions towards the Client. Nevertheless, a diagnosis, even a notably stigmatizing one, did not lead clinicians in this sample to make overly dispositional generalizations in the presence of markedly dramatic client behavior.

In the grander context of the present study’s overall finding that there was a lack of meaningful effects due to diagnosis or no diagnosis, the meaningfulness of the differences observed in the attributions of psychodynamic and third wave behavioral clinicians is called into question. After all, both approaches generally have strong empirical support as to their effectiveness. Psychodynamic clinicians do not stigmatize and consequently damage rapport and the outcomes of their clients. The relationship between attribution tendency and therapeutic outcomes is not entirely clear. It could be that there would ultimately be no effect of the former on the latter; it could also be possible that some third variable mediates the relationship between the two, allowing for dispositional conceptualizations to benefit therapeutic outcomes from a psychodynamic orientation.

Limitations

There were a number of limitations to the present study that have been mentioned above, which merit further consideration, as well as a few that have not yet been mentioned. Some of the limitations are of a conceptual nature and some of a practical one.

Practical limitations. The sample size of the present study was hindered by difficulties in
recruitment. Furthermore, the projected sample size was based on a medium effect size that was appropriate to conservative in relation to previous research. Given the changes in the experimental design that lessened the saliency of contextual factors and increased the intensity of the Client’s behavior, the actual effect being sought after might be harder to observe. The use of only one video stimulus is a related limitation. Using multiple videos depicting various levels of intensity in behavior would have allowed for empirical determination of whether the extreme behavior of the video was overly influential. Furthermore, recalling Tal-Or and Papirman (2007) a condition without a video, and instead a copy of the transcript, might have helped to decrease how dispositional the overall attributions made might have been.

That data was collected in an online format, while convenient, means that there was a lack of experimental control over how engaged in the study participants actually were. This too could be an important factor in the observed manipulation checks inaccuracies. Furthermore, the wording of the manipulation check could have been inadequate or misleading: it only assessed whether the participant received information about the Client and did not ask about the information provided about the clinician. That discrepancy could have led to inaccurate responding. Additionally, a simple manipulation check could have been added to assess the internal diagnostic process of participants to better understand whether they were diagnosing the Client despite being in the no diagnosis condition.

Conceptual limitations. The definition of what context is was limited in the present study. As presented to participants, context only referred to occurrences in the Client’s day prior to a session and to small amount of the clinician’s behavior during session. In clinical reality context refers to a great deal more than those details. A clinician generally has access to much more of the historical context that is relevant to a client’s behavior (e.g., familial history, relationship
history, client’s aspirations, etc.) than what was presented to participants of this study. Diagnosis was also, for practical reasons, limited specifically to borderline personality disorder.

Here again, the boundaries of the clinical utility of the FAE may have been pressed too far. The FAE, in particular, looks at how people overlook the power of situations over behavior in the favor of dispositional attributions. In the attribution literature the conceptualization of situational is generally limited to specific observable constraints on behavior that are physically present in the moment. Even had a significant effect been observed it would have been questionable whether context, as provided, was significantly present enough to be truly overlooked by participants.

Considering again the difference observed between psychodynamic and third wave behavioral student clinicians and recalling that these two modalities are empirically sound in terms of client outcomes, the present findings are intriguing, but not necessarily fruitful. Until the conceptual relationships among dispositional inference, stigma, and therapeutic relationship and outcomes are more clearly delineated, we have only found that psychodynamic and third wave behavioral clinicians have different working models for conceptualizing client behavior. One of these models emphasizes internal characteristics and the other contextual ones. In both instances, successful change can be expected.

Future Directions

Future experimental formulations that utilize the attribution theory paradigm to investigate clinical outcomes, including stigma, should consider several factors relevant to independent and dependent variables as well as sample population. To ameliorate questions about the extremity of the Client’s behavior and its impact on the current findings, it would be beneficial to utilize multiple video stimuli with behavior that ranges from mundane to highly
evocative. The implementation of vignette only groups and groups presented with a transcript and not a video could also address concerns about the effects of extreme Client behavior. Context conditions should be re-examined and better defined. The concept of context in psychotherapy is much broader than was captured by the experimental design of this study.

Future research in this area should include additional measures of some key constructs that were not included in the present study. Including direct measures of stigma, both self-report and even physiological ones, could help to clarify the relationship between dispositional attributions and stigma. To take it to the next step, taking this research out of the confines of the laboratory and into the “real world”, where actual therapeutic outcomes – rapport/working alliance and quality of life/symptom reduction – could be assessed alongside development and changes in attributions by a therapist towards a client would be fascinating. Furthermore, considering the relevance of stigma-specific measures in such a clinical outcome design could be illuminating when considered in the context of different theoretical orientations.

Undertaking further inquiry in these directions is necessary to better serve the people that applied psychology intends to serve. The diagnostic system as it is has many reasons to be questioned. So many in fact, that the point has received direct attention from the organizers of the new DSM-V who have taken great lengths to re-organize and re-orient psychiatric diagnostics with some broad changes in conceptualization. Bias has been shown to exist from psychological health providers towards clients and the labels we use can cause problems. When we consider the consequences of allowing choice words to undermine the uniqueness of our clients’ experiences, it should be quite clear that continued pursuit in understanding and undermining stigmatizing responses by clinicians is of the utmost importance.
Table 1

*Characteristics of Student Clinician Sample (N = 82)*

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<td>Clinical Health</td>
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<tr>
<td><strong>Graduate Degree in Progress</strong></td>
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<tr>
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<td>68.3</td>
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<td>28.0</td>
</tr>
<tr>
<td>Master’s</td>
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<td>3.7</td>
</tr>
<tr>
<td><strong>Religious Preference</strong></td>
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<td></td>
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<td>23.2</td>
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<tr>
<td>Buddhist</td>
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<td>1.2</td>
</tr>
<tr>
<td>Christian</td>
<td>28</td>
<td>34.1</td>
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<tr>
<td>Jewish</td>
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<td>4.9</td>
</tr>
<tr>
<td>Other</td>
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<td>6.1</td>
</tr>
<tr>
<td>None</td>
<td>16</td>
<td>19.5</td>
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<tr>
<td><strong>Historical/Current Self Dx</strong></td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>31.7</td>
</tr>
<tr>
<td>No</td>
<td>56</td>
<td>68.3</td>
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*(table continues)*
Table 1 (continued).

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<th>Important Other Dx</th>
<th>Frequency</th>
<th>Percent</th>
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<tr>
<td>Yes</td>
<td>59</td>
<td>72.0</td>
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<tr>
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<td>23</td>
<td>28.0</td>
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</table>

<table>
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<tr>
<th>Self Ever Attended Therapy</th>
<th>Frequency</th>
<th>Percent</th>
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<tr>
<td>Yes</td>
<td>60</td>
<td>73.2</td>
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<td>No</td>
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<td>26.8</td>
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Table 2

**Age and Contact Hours of Sample**

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<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>SD</th>
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<tr>
<td>Age (years)</td>
<td>23</td>
<td>51</td>
<td>27.9</td>
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<tr>
<td>Therapy Contact Hours*</td>
<td>2</td>
<td>2000</td>
<td>427.4</td>
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*n = 78

Table 3

**Group Sizes, Means, and Standard Deviations on Clinical Attribution Scale**

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<th>Condition</th>
<th>Diagnosis</th>
<th>No Diagnosis</th>
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</thead>
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<tr>
<td></td>
<td>n</td>
<td>Mean</td>
</tr>
<tr>
<td>Context</td>
<td>23</td>
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<tr>
<td>No Context</td>
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<td>46.87</td>
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</table>

<table>
<thead>
<tr>
<th>Orientation</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Psychodynamic</td>
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<td>41.40</td>
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<tr>
<td>Cognitive-Behavioral</td>
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<td>49.86</td>
<td>9.45</td>
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<tr>
<td>Humanistic</td>
<td>3</td>
<td>46.00</td>
<td>7.55</td>
</tr>
<tr>
<td>Third Wave</td>
<td>5</td>
<td>54.00</td>
<td>6.89</td>
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<tr>
<td>Behavioral</td>
<td>17</td>
<td>45.46</td>
<td>6.06</td>
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</table>
Table 4

Accuracy of Context Manipulation Check by Diagnosis Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Accurate</th>
<th>Inaccurate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Diagnosis</td>
<td>29</td>
<td>7</td>
<td>36</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>33</td>
<td>13</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>62</td>
<td>20</td>
<td>82</td>
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</table>
Figure 1. Observed relationship of context and diagnosis.

\[ F(2, 81) = 1.43, \ p = .25 \]
APPENDIX A

DEMOGRAPHIC CONSENT
Demographics Form

Age: __________________

Sex:
- Male
- Female

Ethnic/racial background:
- Asian/Pacific Islander
- Black/African American
- Hispanic/Latino
- Middle Eastern/Arab
- Native American
- White/Caucasian
- Biracial, please specify ______________
- Other, please specify ______________

Is English your first language? (1) Yes (2) No (please specify__________)

Current Marital Status:
- Single
- Cohabiting
- Married
- Divorced
- Widowed

Your approximate yearly income:
- <20,000
- 20,000-50,000
- 50,000-100,000
- >100,000

If you are a graduate student, what type of Psychology program are you attending? If you are a professional, what type did you attend?
- Clinical
- Counseling
- Clinical Health

What degree did/will you earn?
- PhD
- PsyD

What is your theoretical orientation?
- Psychodynamic
- Psychoanalytic
- Humanist
- Existential
- Cognitive-Behavioral
- Cognitive
- Third Wave Behavioral
- Gestalt
- Object Relations
- Eclectic
- Other, please specify ____________

Approximately how many client therapy contact hours do you have? ________

Have you been diagnosed with a mental illness, current or historical?
- Yes
- No

Has anyone you consider close to you been diagnosed with a mental illness, current or historical?
- Yes
- No

Have you ever attended mental health counseling/therapy?
- Yes
- No
  If yes, please indicate the type of counselor you saw:
    - educational/guidance counselor
    - social worker
    - couples/marriage counselor
    - clergy member
    - licensed professional counselor
    - psychologist
    - psychiatrist
    - other (please specify ____________)

  If yes, for how long did you attend counseling:
    - 1-3 sessions or <1 month
    - 4-12 sessions or 1-3 months
    - 3-6 months
    - 6 months-1 year
    - 1-2 years
    - 2 years or more

Which category best describes your religious preference?
- Agnostic (1) ☐
- Buddhism (2) ☐
- Christianity (3) ☐ Specify Denomination _____________
- Hinduism (4) ☐
Islam (5) □
Judaism (6) □
Other (7) □ Specify ______________________________
None (8) □

How often do you attend religious services?

More than once per week (1) □
About once per week (2) □
About once per month (3) □
About once or twice per year (4) □
Seldom (less than once per year) (5) □
Never (6) □
APPENDIX B

VIDEO INTERACTION SCRIPT
Video Interaction Script

CLIENT
  I don’t feel like anything matters.
  (PAUSE)

THERAPIST
  That must feel awful.

CLIENT
  (SARCASTICALLY)
  Yeah.
  (PAUSE)
  I’m watching my life get worse and worse, and meanwhile watching everyone’s get better, or at least stay in a state of normalcy. And my mom doesn’t understand that work doesn’t treat me fairly, so she gets really pissed off at me on days like today. And then I go home to my boyfriend who I don’t want to go home to. He’s just not right for me. Yeah, it’s just another one of those relationships like the other relationships, and the one before that.

THERAPIST
  Try to notice, that right now, when you’re this upset, you’re starting to generalize your feelings of disappoint me at work to other areas of your life.

CLIENT
  (ANGRILY)
  Yeah, that’s fucked up too.

THERAPIST
  Okay.

CLIENT
  (AFTER A LONG PAUSE)
  What?!

THERAPIST
  I’m just wanting to give you space to express whatever else might be going on.

CLIENT
  Okay, um. Sometimes I want to-

THERAPIST
  Want to-?

CLIENT
  There’s this guy at work. He sucks. He’s useless, but my boss loves him, he can do no wrong. It’s probably because he’s really pretty. I have this fantasy where I drug him at work. I think it’d be great to watch him get all panicked and not know what was going on.
THERAPIST
  Sounds like you’re feeling pretty desperate right now?
  Hopeless?

CLIENT
  (EXASPERATED AND SARCASTICALLY)
  You think?

THERAPIST
  Is this something you’d actually do?

CLIENT
  Yeah. Totally. I may not have any of the roofies...

THERAPIST
  This guy must make you pretty angry.

CLIENT
  He’s a piece of shit. And, um, he gets away with it. He just
  gets away with everything because my boss is a slut.

THERAPIST
  (PAUSE)
  Sounds unfair. And it sounds like this is all getting
  in the way of some of that stuff that you really value.
  (PAUSE)
  Like having a successful and meaningful career?

CLIENT
  (SHIFTS UNCOMFORTABLY IN HER SEAT)
  Mmm-hmm.

THERAPIST
  It hurts when you’re not getting closer to that.

CLIENT
  It’s awful. I’d kill him. I’d put a gun to his head, I would
  pull the trigger to make him feel as awful as I do. No one
  gets it.

THERAPIST
  I’m really sorry that it’s so hard right now.

CLIENT
  (ANGRILY AND PRESSURED IN SPEECH)
  Are you? I mean you’re here because this is your job. You get
  paid to do this. You get paid to be in this room. And um, I
  don’t know why I even bother really. It’s not like, it’s not
  like you walk out of here thinking about this. I mean you
  think about me probably the morning of when it’s my turn
  during the week to come in. Otherwise you just go home to your
  great house and pretty wife. I don’t even know you.

THERAPIST
  (AFTER A LONG PAUSE)
  I hear that you are really frustrated with this guy at
work and your boss, and that the world feels really hopeless right now; and I can see that you feel like none of them care about you. And you’re right, when I go home today I will go home to a house and to my wife, but that doesn’t mean that you - and the work that we do - don’t matter to me.

CLIENT
(SIGHS HEAVILY)
Sure. Whatever.

THERAPIST
Would you really put a gun to your co-worker’s head?

CLIENT
Probably, I mean I don’t have a gun... yet.

THERAPIST
Again, I get how hard it is right now, and I’ve seen you make progress in here. I need to know that you’re going to be able to come in here next week, without having hurt anyone. (PAUSE) Can you go at least this one week until I see you again without hurting anyone?

CLIENT
(SIGHS HEAVILY)
Sure, I mean that’s what you want to hear right? That way you can tell your supervisor that I said I wouldn’t hurt anybody. I mean it’s about you right? This whole place is about you. I just... you don’t care, like, you don’t give a damn about me. So, yeah, there you go, you got your promise. Can I go now? (CLIENT LEAVES ROOM)
APPENDIX C

MANIPULATION CHECKS
Manipulation Checks

1. Did you receive background information about Ms. X’s life?

2. Did you receive information about Ms. X’s day prior to the therapy session you observed?

3. Were you told a diagnosis for Ms. X?

4. Did you have any technical difficulties with the video?
REFERENCES


Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that 'everyone has won and all must have prizes'? *Archives of General Psychiatry, 32*(8), 995-1008. Retrieved from PsycINFO database.


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