



1978

The Effect of Diagnostic Labeling on Social Perception

Lorraine D. Wukitsch D'Asta
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_theses



Part of the [Psychology Commons](#)

Recommended Citation

D'Asta, Lorraine D. Wukitsch, "The Effect of Diagnostic Labeling on Social Perception" (1978). *Master's Theses*. 3002.

https://ecommons.luc.edu/luc_theses/3002

This Thesis is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Master's Theses by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License](#).
Copyright © 1978 Lorraine D. Wukitsch D'Asta

201

THE EFFECT OF DIAGNOSTIC LABELING ON
SOCIAL PERCEPTION

by

Lorraine D. D'Asta

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
Master of Arts

May

1978

ACKNOWLEDGMENTS

The author wishes to thank James Johnson, Ph.D., and John Shack, Ph.D. who encouraged this study and offered guidance and support whenever it was needed. Thanks are also given to Frank Slaymaker, Ph.D. and George Hartwein, who consulted on the data analysis in this study.

Appreciation is also extended to my family and friends and especially my husband, who tolerated much inconvenience and anxiety for the sake of this thesis.

VITA

The author, Lorraine D. (Wukitsch) D'Asta was born July 11, 1954, in Chicago, Illinois, the youngest of four children of Frank and Dorothy (Schlessler) Wukitsch. Lorraine's natural mother died in 1958, and her father married Grace LaBanco later that year. Lorraine's father died in 1965. In August, 1975, Lorraine married Nicholas A. D'Asta, a public accountant.

Lorraine attended St. Augustine grade school and high school (Chicago), and was valedictorian of her graduating class in 1972. While in high school she attended classes part-time at Chicago City Colleges.

In September, 1972, she entered Loyola University of Chicago. In June, 1975, she received the degree of Bachelor of Sciences, Summa Cum Laude, with a major in psychology. During her undergraduate years, she did work with retarded and emotionally disturbed children.

She entered the clinical psychology doctoral program of Loyola University of Chicago in September, 1975. At the same time, she began her clinical training at the Loyola Guidance Center and Day School. As of March, 1978, she has completed in excess of 3500 hours of clinical training at that facility. In September, 1978, she will begin an internship in pediatric psychology at Rush-Presbyterian-St. Luke's Medical Center in Chicago.

TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	ii
VITA	iii
LIST OF TABLES	iv
Chapter	
I. INTRODUCTION	1
II. REVIEW OF RELATED LITERATURE	3
Nature and Functions of Diagnosis	3
Effects of Labels on the Perceptions of "Experts"	6
Effects of Labels on the Perceptions of Clients	12
Effects of Labels on the Perceptions of the Public	14
Methodological Issues	23
Hypotheses	27
III. METHOD	29
Subjects	29
Recruitment of Subjects	30
Materials	31
Semantic Differential	34
Peterson Problem Checklist	35
Procedure	36
IV. RESULTS	39
V. DISCUSSION	45
Perceived Pathology: A Function of Imposed and Actual Diagnosis	45
Perceived Pathology: A Function of Experience and Interest	48
Methodological Issues	51
Future Research	54

TABLE OF CONTENTS (continued)

	Page
REFERENCES	57
REFERENCE NOTES	62
APPENDICES	
A. Volunteer Recruitment Questionnaire	64
B. Semantic Differential with Key	66
C. Peterson Problem Checklist	70
D. Cover Sheets for Test Booklets	73

LIST OF TABLES

Table	Page
1. Mean Scores on Two Measures Showing Labels X Visual Interaction	41
2. Mean Scores on Two Measures Showing Main Effects of Groups	43

CHAPTER I

INTRODUCTION

Psychiatric diagnostic labels are commonly assigned to both inpatient and outpatient clients seen by psychotherapists or consultants. This labeling practice is supported by government agencies and private foundations who subsidize clinics, hospitals, etc., and other third party payees (e.g., insurance companies), who require that clients have some identifiable, classifiable problem. Most mental health professionals comply with these requests for formal diagnoses, and few have addressed the issue of the effects of such labeling procedures.

Some professionals in the mental health field have supported the usefulness of conventional psychiatric diagnoses in clinical practice (e.g., Caveny, Wittson, Hunt, & Herman, 1955; Gough, 1971; Klopfer, 1962; Zubin, 1967). However, such diagnoses have been found to be statistically unreliable (e.g., Rosenhan, 1973; Temerlin, 1968; Yates, 1970). Clinicians were found to diagnose the same person with very different labels (Temerlin, 1968), and the perception and interpretation of behaviors are strongly influenced by psychodiagnostic labels (Rosenhan, 1973).

Neutral or normal behavior can, indeed, be misperceived or misinterpreted when a psychiatric diagnosis has been imposed; and the diagnostic labels are rarely removed, once affixed (Rosenhan, 1973). Therefore, the person who seeks psychological treatment may be "branded" with an unreliable label and later judged negatively on the basis of that label (Jones, Hester, Farina, & Davis, 1959; Phillips, 1963).

The present study is a replication of research done by Saper (notes 1, 2) who investigated the effects of psychodiagnostic labels on perception, rating, and interpretation of the behavior of children. Saper also looked at observer characteristics, including professional training (in the mental health fields), therapeutic orientation, and experience. In evaluating his own work, Saper noted that his format of presenting stimulus subjects limited important cues by using silent films of children labeled either normal or emotionally disturbed. The present study used these same films but attempted to deal with this criticism by adding an audio dimension. The present research focused on the effects of interest in working with such children and of volunteer experience with such children on the labeling phenomena.

CHAPTER II

REVIEW OF RELATED LITERATURE

Nature and Functions of Diagnosis

Psychiatric diagnosis is a much-discussed (and often hotly debated) issue. Zubin (1967) in world-wide survey found fifty classification systems for behavior disorders. The American Psychiatric Association revised its diagnostic system in 1968, and it is currently in the process of revising the revision. It seems to be very difficult to design a classification system which will satisfy all concerned. In fact, in recent years the very idea of diagnosis has come under attack by some groups. The question seems to lie in the nature, functions, and effects of diagnosis.

Caveny, Wittson, Hunt, and Herrman (1955) have stated that:

Diagnoses are carriers of information and they should be viewed as such. They should be evaluated in terms of the economy with which they transmit information, the extent and accuracy of the information transmitted, and the functional importance or relevance of this information in the particular diagnostic situation (p. 368).

Meehl (1956) suggested that the human element (i.e., the clinician) be eliminated in the process of gleaning

personality descriptions from test data, and that an empirically-based cookbook method would provide more accurate descriptive and predictive data.

The purpose of psychodiagnosis, according to Gough (1971) is "to identify the problem the patient has presented in such a way that no appropriate restorative treatment may be carried out" (p. 160). He suggests three levels of diagnosis and lists their treatment implications: 1) clustering of symptoms, implying relief of symptoms; 2) recognition of specific pathology, implying relief of underlying factors; and 3) identification of etiology, implying prevention.

Critics say that psychodiagnosis has not and is not fulfilling these functions. There are those who would argue that the labeling of mental illness most often does more harm than good. This is the viewpoint of Szasz (1967), who says that there is no such "thing" as mental illness--that mental illness cannot be used to explain away the problems of the world and mankind. He sees the concept of mental illness as a "social tranquilizer", a "myth", which obscures the fact that "life for most people is a continuous struggle. . .for a 'place in the sun'. . .or some other human value." (p. 253) Belief in this myth allows people to avoid the problem of making good and safe choices: the absence of mental illness is supposed to insure such

proper choices, and life would be harmonious and satisfying if it were not for mental illnesses. Instead, Szasz states that what people have is problems in living and conflicts in relations and values and that they should not blame a concept or a group of labeled individuals for their own concerns and fears.

Scheff (1966) too, proposes that the popular stereotypes of mental illness are primary determinants of symptomatology. In particular, once the individual is labeled, the popular conceptions of mental illness influence the expectations of the "rule-breaker" and those around him, forcing his behavior closer to the stereotyped role of one carrying such a diagnosis. Scheff's general position is that members of a society or social group are aware of what they perceive a mentally ill person to be like and how he should behave, and that a person becomes mentally ill when he sees himself as such and begins to behave in accord with his self-perception. His theory postulates that the culture's conceptions of mental disorders largely determine the process of defining someone as mentally ill.

Goffman (1963) discusses labeling and stigma in terms of social identity and discrediting. People discriminate against stigmatized individuals and reduce their chances in life. The public rationalizes this discrimination by constructing a theory to explain the inferiority and danger

perceived in such persons or groups. Thus, a wide range of attributes are imputed on the basis of one or two observations, and the stigmatizing label can come to have meanings far beyond its original meanings. The stigmatized person is not accepted and not respected as are others; thus, his identity is "spoiled," as he begins to see himself as different and unworthy of such respect and acceptance.

Though the labeling theory of psychopathology may seem somewhat extreme, it cannot be denied that psychiatric labels do have some effect on perceptions of the mentally ill. In many cases, it seems that persons are reacting more to the label of "mental illness" or "emotional disturbance" than to the actual behavior of the labeled individual. It seems as though no one is completely immune to this labeling bias. Studies have shown that everyone from college students to clinical psychologists to mental patients to the man-on-the-street is susceptible.

Effects of Labels on the Perceptions of "Experts"

Langer and Abelson (1974) tested the hypothesis that the therapists' theoretical orientations influence the effects that labels have on clinical judgment. They suggested that the prior beliefs and attitudes that one brings to the situation affect the use of labels. They found that when an interviewee was labeled a mental patient, there

were significant differences in the type of ratings given to him: a group of traditional/psychodynamic clinicians saw the "patient" as much more disturbed than did a group of behaviorally-oriented clinicians. That is, the traditional group seemed to be more susceptible to labeling bias. Langer and Abelson note the important effects this may have in clinical situations.

Using psychology graduate students as raters, McCoy (1976) showed the strong biasing effects that parental reports may have on the perception of children's behaviors, particularly when the observer has limited opportunity to observe the child. And DiNardo (1975) found that psychology graduate students have greater weight to a "psychotic" label generated by a psychiatrist than one generated by a psychologist. In addition, there was a tendency to give poorer assessments (i.e., see more pathology) to lower-class persons after watching a taped interview. This finding suggests that the psychologist's assessment of a client may not always represent the clinical reality presented by that client.

In fact, research has shown that pretherapy information can have a strong impact on the manner in which the client and therapist relate and respond during their initial session (Gustin, 1970). Therapists commonly have advance information regarding the sex, age, educational

level, residence, ethnic background, race, and often the diagnosis of a perspective client. Such information might come from various sources, ranging from a full diagnostic work-up to the casual comments of the receptionist who has seen the new client in the waiting room. Regardless of the source, the therapist has this information and it will influence his behavior toward his client to some extent. Furthermore, impression formation literature has noted that first impressions tend to be global and highly resistant to change (Bieri, 1953). So biasing pretherapy information may have long range effects on the therapeutic relationship and eventual outcome of treatment.

Results by Pasamanick, Dinitz, and Lefton (1959) suggest that clinicians may selectively perceive and emphasize those characteristics and attributes relevant to their own systems of reference. Thus, the patient's diagnosis and subsequent treatment may be largely predetermined within the clinician's therapeutic orientation. In another study, a number of student and professional groups were presented with a tape of a person giving "healthy" responses to issues often raised in diagnosis (Temerlin, 1968). The experimental groups were told that a high prestige, knowledgeable person had diagnosed the interviewee as psychotic. Temerlin found that

60% of the psychiatrists, 28% of the psychologists and 11% of the graduate clinical students rated the interviewee as psychotic. Thus, the label, despite the absence of deviant behavior, can even affect the judgement (and, theoretically, the behavior) of trained professionals. Temerlin suggests that this is an effect of an interaction between the prestige suggestion and professional identity of his subjects.

Rosenhan (1973) questioned whether those characteristics that lead to a diagnosis of insanity truly reside in the person himself or whether they can also be considered a function of the context in which we consider that person. In an effort to determine whether or not a sane individual could be distinguished from an insane individual, regardless of the context, Rosenhan had eight "pseudopatients" sent to twelve different psychiatric hospitals. To gain admission, the pseudopatients reported that they had heard voices which were "empty" and "hollow." Other than the falsification of this symptom and changes in name and employment, the circumstances and histories of each pseudopatient was accurately presented. (There was no pathology in any of these histories.) Immediately after being admitted, the pseudopatients ceased exhibiting any symptoms and became as cooperative and "normal" as possible in an effort to gain discharge.

Length of hospitalization ranged from 7 to 52 days. All but one received a diagnosis of schizophrenia and was labeled schizophrenic in remission upon discharge. None of the pseudopatients were detected as frauds. He later showed that psychiatric hospital staff members could be made to believe that real patients were, in fact, pseudopatients merely by the suggestion that such frauds could exist in their patient populations. Rosenhan contends that the diagnostic process that allows for these errors is highly subjective and unreliable. He speaks to the issue that once a person is designated abnormal, all of his behaviors and characteristics are colored by that label.

Movahedi (1975) supports this and further proposes that the biographies collected from mental patients, and often used as the basis for classification and subsequent treatment recommendations are most often biased samples of the life events of the patient. He suggests that the biographies are usually taken by someone with a specific interest in the bleak and unhappy aspects of the patient's history -- for, after all, there must be some problem if this person has come for counseling! Movahedi further suggests (and his study supports) that if a "normal" person writes his history concentrating on the bleak or unusual aspects of his life, he may well be diagnosed as

pathological on the basis of this history. He calls this study a simulation of "one aspect of the madness-manufacturing process involved in the construction of psychiatric case histories". (p. 192)

Furthermore, Gauron and Rawlings (1973) suggest that there is a feeling particularly among beginning therapists that patients are fragile. This myth, they say, is likely to be based on the fears of the therapist with regard to outcome of therapy and their responsibility for that outcome. The effect of this myth is that the therapist tends to avoid confrontation and focusing on central issues. This "treading on eggs" can have an inhibiting effect on the therapeutic process.

Findings by Sushinsky and Wener (1975) suggest that for mental health workers, judgments of mental disturbance may be a function of variables other than those deemed theoretically/diagnostically relevant (i.e., the suggestion of a powerful and attractive prestige figure, ambiguity of desired response, and setting). In a series of three experiments, they note that both professionals and non-professionals are susceptible to labeling bias. The degree to which these extraneous variables affect their judgments depended not only on which variable was controlled but also on the combinations of such variables.

Antonio (1975) notes the various subtle means by which agencies for mentally disturbed may transmit messages and expectations of deviancy. These messages, he suggests, further validate the deviant self-concept of the mentally disturbed person, and can cause further deviant behavior. Thus, these covert messages can have self-fulfilling properties.

Effects of Labels on the Perceptions of Clients

Mental patients' attitudes are similar to those of non-patients of comparable age, education, and social class. (Giovannoni and Ullman, 1963) Being a patient did not seem to alter beliefs or judgments about mental illness. Studying veterans' hospital mental patients, it was found that the patients were no better informed about mental health and illness than the general public. Their attitudes toward the mentally ill were as strongly negative as those of normals.

Another study (Crumpton, Weinstein, Acker, and Annis, 1967) compared mental patients and normals in their attitudes toward mental illness, using the semantic differential. The researchers found that ratings given to "mental patients" by normals tended to resemble ratings given to "sick person" and "dangerous person". When rated by patients, "mental patient" ratings more closely

resembled those given to "sinner" and "criminal". They conclude that, compared to normals, mental patients tend to have more sympathetic but still highly negative attitudes toward mental illness.

Morrison and Nevid (1976) report the results of the Client Attitude Questionnaire (based on the work of Thomas Szasz) when given to previously hospitalized outpatients and several groups of mental health professionals. Sixteen psychologists and twenty-five social workers showed attitudes in line with the psychosocial "labeling" theory whereas twenty psychiatrists, twenty-three psychiatric nurses, and forty patients tended to hold more traditional attitudes toward mental illness.

In looking at relatives' attitudes toward formerly hospitalized mental patients, Freeman (1961) found that better-educated relatives tended to hold somewhat more enlightened attitudes than those relatives with less formal education. But attitudes here were positively correlated with the type of diagnosis, duration and frequency of hospitalization, and problems in management. Freeman does not discuss the effects that such attitudes may have on the relationship between the ex-patient and his relatives.

Yarrow, Schwartz, Murphy, and Deasy (1967) presented a study of women coping with mental illness of their

husbands. They note that behaviors which were incongruent with what the women expected of their husbands were misperceived or perceived with great difficulty. They found that social pressures as well as individual fears, needs and conceptions of mental illness had a strong effect on how the wife reacted to her husband's emotional disorder. They suggested an educational program in terms of recognition and demythologizing of mental illness for the general public and especially for families of emotionally disturbed persons. They further proposed that interventions with the families of mentally ill persons is a valuable aspect of treatment.

Effects of Labels on the Perceptions of the Public

In 1958, Nunally and Kittross reported that public attitudes (as measured by the Semantic Differential) toward those professionals associated with physical medicine were more favorable than public attitudes toward those professionals identified as dealing with mental problems.

Another study showed that the label of maladjustment can have an effect on the credibility of the labeled individual. In a study by Jones, Hester, Farina, and Davis (1959), college students were more likely to discount the negative personal evaluations made of them when they were

told that the evaluator was maladjusted, even though there was no change in the evaluator's behavior.

Phillips (1963) discussed help-seeking in terms of its rewards and costs to the individual. He showed that individuals described as exhibiting identical behaviors were increasingly rejected if they were seen as receiving help from mental health professional. The range from acceptance to rejection spanned from person receives no help (accepted), receiving help from clergymen, physician, psychiatrist, mental hospital (rejected). Thus, the source of help sought by the emotionally disturbed person is strongly related to the degree to which others stigmatize and reject him.

How, then, does the label of mental illness influence the behavior of the perceiver? After encouraging subjects to interact on a simple motor task, Farina and Ring (1965) concluded that believing a person is mentally ill strongly affected others' perceptions of that person despite the fact that the person's behavior was not at all deviant. They found that when the co-worker was seen as mentally ill, subjects preferred to work alone and tended to blame the co-worker for inadequacies in performance. It is conceivable that such negative effects could be reduced with longer exposure, but Farina and Ring point out that a negative perception of another tends to cut down on subsequent interactions.

In another study, Farina, Holland, and Ring (1966) found that stigma and the extent to which a person is held responsible for that stigma play a significant role in interactions. In this experiment, subjects were given some "background information" about a confederate. The information varied with respect to good or bad childhood experiences and treatment for emotional disorders or no treatment. On both behavioral and opinion scale measures, they found that the effects of the stigma are tempered when the mentally ill person is seen as having had a bad childhood (i.e., not himself responsible for his problems). But a bad childhood in itself is stigmatizing. In effect, the normal and rather typical person is treated as deviating from the norm. The stigmatized person was perceived as doing a poorer job than the non-stigmatized person in the absence of any real difference. In addition, subjects indicated that they preferred not to have any future contact with the persons perceived as mentally ill: he was liked less than "normal" persons.

This tendency to fear and avoid the mentally ill has important ramifications. Bieri (1953) tested the hypotheses that a person's perceptual system varies as he successively construes events and that the way in which one person understands another affects the way in which they will interact. Bieri found that after a constructive

interaction, one's perception of the other changed in the direction of increased similarity to himself. If there was no interaction, there was no increase in perceived similarity.

This is borne out by a study (Kish and Hood, 1976) which showed that after voluntary contact with mental patients, undergraduate students tended to see patients as less dangerous, less irritable, and more competent than before their experience. The most notable and greatest change was in that patients were seen as less dangerous after contact than before contact. Thus, such contact may be valuable in promoting less fearful attitudes toward the mentally ill.

Dohrenwend and Chin-Shong (1967) used unlabeled behavioral descriptions of a number of psychiatric disorders. Subjects were asked if the behavior was indicative of a problem, if they considered the problem serious, and if they considered the person described to be mentally ill. Only the description of paranoid schizophrenia was considered as serious illness a significant number of times. The descriptions of behaviors manifested in other types of disorders did not seem to evoke a great deal of concern. These researchers found their subjects particularly reluctant to regard behavior as serious or as a sign of mental illness if it was not seen as dangerous.

Rhodes and Sagor (1975) present a model to explain, in part, the alienation of several abnormal groups. They suggest that the community does not understand and, therefore, fears abnormal individuals. So the public categorizes and segregates such persons, thereby avoiding direct contact. This process results in the dissolution of some of the fears and a mythologizing of the others. But the segregated group is still misunderstood and mistreated. This can be the start of a circular reaction.

In their study of the attitudes in a small town in Canada, Cumming and Cumming (1957) found that the public reacted more negatively to identified mental illness than to unlabeled behavioral descriptions of deviant behaviors. They then set out to re-educate the town and promote a shift in attitudes. The attitudinal shift did not occur and, in fact, the public became hostile toward the mental health team. They had stressed three propositions in their educational program: 1) the range of normal behavior is very wide; 2) deviant behavior is not random, but it has some cause; 3) normal and abnormal behavior fall on a continuum. Cumming and Cumming suggest that the hostility that was encountered was a result of the threat that their ideology posed to the community. They explained that the public would prefer to deny the existence of mental illness rather than take responsibility for the

causes of mental illness.

In 1961, Nunnally suggested that the public was not well-enough informed about mental illness and that this caused anxiety and hostility towards the mentally ill. He asked respondents to indicate the extent of their agreement with a number of statements about mental illness. Factor analysis uncovered ten factors which represent a general attitude toward mental illness:

- 1) the mentally ill care characterized by identifiable actions and appearance;
- 2) will power is the basis of one's personal adjustment;
- 3) women are more prone to mental ill-health than men;
- 4) if one can avoid morbid thoughts he can avoid mental illness;
- 5) if one can obtain support and guidance from stronger persons he can avoid mental illness;
- 6) one who is emotionally ill is in a hopeless condition;
- 7) mental disorders are caused by immediate environmental pressures;
- 8) emotional difficulties are not a matter of great concern;
- 9) older people are more susceptible to mental illness;
- 10) mental illness is attributable to organic factors. (p. 17)

The lay public tended to agree more with these statements than did mental health workers ("experts"). Persons of higher education responded more like mental health workers than if they were less educated, especially if they were young. He also used the Semantic Differential and found that public attitudes are generally negative toward those labeled mentally ill.

A study by Lemkau and Crocetti (1962) suggested that the public's knowledge of and acceptance of mental illness had increased in terms of maintaining certain types of emotionally disturbed individuals in the community.

But in 1970, Sarbin and Mancuso reviewed the literature on the public's attitudes toward mental illness and concluded that the "moral enterprise" of trying to sell the public on the idea of mental illness as comparable to somatic illness has failed. In fact, the public tends to more readily tolerate the deviant behavior when it is undiagnosed: persons who are labeled as mentally ill are stigmatized and rejected. In general, they came to the following conclusions: 1) the public is not sympathetic toward persons labeled mentally ill, and, in fact, prefers distance from the mentally ill; 2) the public does not tend to label deviant behaviors as signs of mental illness except in extreme cases; 3) the public does not regard happiness and mental health as synonymous; 4) the public expresses little confidence in the state of knowledge in mental health fields, but sees a shortage in mental health professionals. In short, the public seems to be holding a different definition of mental illness as compared to that held by mental health professionals. Sarbin and Mancuso suggest that the metaphor of "illness" is really inapplicable, unnecessary, and counter-productive.

In that "mental illness" has taken on mythical value, perhaps it is best to change the frame of reference with regard to deviant and perplexing conduct.

Rabkin (1972) reviewed the literature from 1957 to 1972 regarding studies of attitudes about mental illness, mental hospitals, and mental patients. Based on the assumptions that labels strongly influence attitudes and behavior toward someone considered deviant, Rabkin traced a short history of these labels and attitudes. She held that the problem is not with the negative evaluation of mental illness itself, but rather with the accompanying rejecting attitudes manifested toward persons who are mentally ill (or formerly mentally ill). She pointed to a combination of the "scientific" and "moral treatment" models as the basis for current trends in opinions about mental illness, especially among professionals (who are themselves heterogenous with respect to these opinions). Rabkin presented an adequate review of the major measures used in the study of attitudes toward mental illness, citing Nunnally's questionnaires, the Star abstracts, the Custodial Mental Illness Ideology Scale and the Opinions of Mental Illness Scale, as well as several others. In reviewing studies dealing with attitude change, Rabkin concludes that it is feasible to modify attitudes about mental illness through programs including personal contact with

the mental hospital and mental patient and a supplementary educational program. She notes that one problem faced by such studies is that they deal with attitudes and not necessarily behaviors, and she discusses the notion of attitudes in interaction with situational factors and personal factors.

Olmstead and Durham (1976) reported the results of their study, measuring the attitudes of similar groups of college students in 1962 and 1971. They found that contrary to what could be expected from the literature, the two groups were quite similar in their attitudes. The only exception was that "ex-mental patient" was rated as highly similar to "average man", which suggests that this stigma may be changing, at least for a limited group (i.e., educated young people). The authors noted that studies with broader samples of the general public indicate a similar tendency toward more liberal attitudes, but that this tendency is less pronounced in the general population than with their college samples.

Furthermore, results of a study of attitudes (as reflected on a semantic differential scale) of home-owners in two middle-class suburbs in New York suggest that there has been a positive change in attitudes toward ex-mental patients (Fracchia, Canale, Cambria, Ruest, and Sheppard, 1976). Compared to Nunnally's (1961) results, their

sample saw ex-mental patients as more worthwhile and as less deserving of blame for their problems. However, this group still saw ex-mental patients as potentially explosive and not able to be understood. The authors suggest that there is an important interaction between unpredictability and perceived dangerousness.

Methodological Issues

A number of factors enter into any measurement of the effects of labeling mental illness. Some researchers (Page and Yates, 1975) have stressed the importance of the context in which the attitudes toward mental illness are measured. They found that by varying the supposed identities of the testers, they received different responses. For example, they got more humanistic responses when the tester was "humanistic". Kirk (1976) found that labels themselves did not have a significant effect on the attribution of personal traits, but that when taken into consideration with other variables (the labeler and the behavior of the person being labeled) there were significant results. In addition, it has been suggested (Pollack, Huntley, Allen, and Schwartz, 1976) that more specificity is needed in describing the effects of labeling bias. They suggest that the effect of the stigmatizing label is a function of the particular label

assigned, the nature of the group to whom the stigma is assigned, and various aspects of the perceiver and the perceived (i.e., sex, social status, degree of perceived similarity).

The methodologies employed in investigations of social perceptions and behavioral judgments as influenced by diagnostic labeling biases are varied, but there do seem to be some common components. All such research includes some procedure for imposing labels and the biasing set. There is some type of stimuli to be evaluated and some way of measuring that evaluation.

In devising a means of inducing psychological set in terms of psychodiagnostic labels, investigators face a number of issues. The technique used must be effective, ethical, include a minimal amount of deception, and should draw little undue effort or attention to itself. Rosehan's (1973) pseudopatients reported standard symptoms which caused their evaluators to impose the diagnostic labels. Termerlin (1968) used a "credible source" as the origin of his diagnostic statement about the stimulus subject. Phillips (1963) used written character descriptions, and Gustin (1969) had a written statement in a "staff report" about his stimulus subjects. All of these studies employed deception to a greater or lesser degree, as does the present research. It is hoped that through the pro-

cedures used in this study (see Methods Section), the experimenter kept deception to a minimum and did not unduly infringe on the rights or freedom of the observer/evaluators or the children in the films and on the tapes.

The way in which the stimuli are presented will, of course, have an important effect on the observers' judgments. Researchers have employed stimuli ranging from still photographs (Rosenthal, 1964) to live stooges (Rosenhan, 1973). Questions arise in such investigations as to the kinds of behaviors sampled by such stimuli: are such behaviors true-to-life? Does the amount of information emitted by the stimuli permit accurate judgments (in the absence of the biasing effect)? Still photographs do not seem to impart adequate information for judgements. On the other hand, live models present problems of standardization across observers. Saper (note 1, 2) took a compromise approach by using silent, color films. He reports that the child stimulus subjects adapted quickly to the cinematographic situation; therefore, these films should be representative samples of their real-life-behaviors. The present investigator used these same films and added audio tapes in an attempt to provide further information upon which observers could base their judgments.

The stimulus subjects themselves would seem to be an important factor influencing observers' judgments. Live stimulus subjects are usually actors or "normal" persons instructed to either act "normally" or fake pathology. When films or audio recordings have been used, they have often used actors asked to behave normally or acting out scripts of interview situations. In either case, the evaluators are usually presented with inaccurate psychodiagnostic labels or unrealistic expectancies for the stimulus subjects. The present study employs two films -- one of a normal subject (female) and one of an emotionally disturbed subject (male). In addition, there were four audio tapes -- one normal female, one emotionally disturbed female, one normal male, and one emotionally disturbed male. Each observer saw both films and heard one tape of a female and one tape of a male, the tapes played at the same time as the corresponding films. This should answer many of the concerns about the faking of symptoms and the unrealistic and limited aspects of stimuli. This design should also allow for a clearer picture of the effects of labeling on the perception of stimulus behaviors, as the observations and ratings regarding each stimulus subject can be compared in the diagnosed versus the undiagnosed state.

Measuring the effects of labels on observers' perceptions is not an easy task. Reading the above-mentioned

studies, one finds literally dozens of ways of assessing biasing effects. Some of the most commonly used methods are clinical descriptions, self-reports of observers, behavior checklists, and trait rating scales. Both self-reports and clinical descriptions are difficult to quantify and validity and reliability can be problems. Therefore, the present study used a semantic differential as a measure of the observers' perceptions of the subject's global adjustment, and a behavior checklist (Peterson Problem Checklist) to detect observers' expectations of the stimulus subjects.

Hypotheses

In view of the methodological issues just discussed and the research on labeling effects reviewed above, the present investigation tested the following hypotheses:

Hypotheses 1: There will be a significant main effect for the independent variable of labeling. Specifically, ratings will be more negative and abnormal under the "emotionally disturbed" label than under the "normal" label.

Hypothesis 2: There will be a significant interaction between the independent variable of labeling and the independent variable of groups. Specifically, it is hypothesized that the experienced observers' perceptions and judgments will be less affected by diagnostic labeling than the perceptions and judgments of unexperienced observers.

This study is concerned primarily with the set a traditional psychiatric label imposes on observers and the way

this set influences observers perception and interpretations of behavior. It is also concerned with the effect that experience with emotionally disturbed children has on the extent to which observers are biased by an imposed psychodiagnostic label when interpreting a child's behavior.

CHAPTER III

METHOD

Subjects

Subjects were sixty undergraduate students from Loyola University of Chicago. The majority of the subjects were freshman and sophomores. The median age was nineteen.

Subjects were divided into three groups on the basis of expressed interest in working with emotionally disturbed children and actual volunteer experience with such children. Groups I and II were students in Introductory Psychology and Personality Theory courses, Group I consisted of twenty students who, after viewing a presentation on emotionally disturbed children, indicated that they had never worked with emotionally disturbed persons and that they would not be interested in volunteering to work with emotionally disturbed children. Group II involved twenty students who, after seeing the same presentation, indicated that they had had no previous work with emotionally disturbed persons, and that they would be interested in doing this type of volunteer work; these subjects further indicated that they would like someone

to contact them about volunteering to work at a school for emotionally disturbed children. Group II consisted of twenty subjects who had worked as volunteers for at least three months (median time - five months) at the Loyola Day School, a school for severely emotionally disturbed children who have been excluded by the public school system.

Subjects across groups reported a total of eleven different major fields of study, with at least five different major fields in each group. In addition the ages of subjects and the amount of college completed were similar for all groups.

All subjects were randomly assigned to conditions within groups.

Recruitment of Subjects

Recruitment of subjects for Groups I and II was done by the experimenter who made a presentation to the psychology classes in which the subjects were enrolled. The presentation consisted of a twenty minute clip from a video tape about an autistic boy who attends a school for emotionally disturbed children, and a thirty minute talk and question-answer session about autism, childhood emotional disturbance, therapeutic intervention, etc. Class members were then asked to fill out a form (see Appendix

A) giving identifying information and asking a number of questions about the respondents' interest in and past experience with emotionally disturbed persons, particularly emotionally disturbed children. Respondents were sorted into groups (see above) on the basis of their answers to this questionnaire, and were contacted by phone by the investigator and asked if they would be willing to participate in some research. Names of subjects in Group III were taken from a list of volunteers at the school. They were simply telephoned and asked if they would be willing to participate in a research study. All subjects were told that this research would take about one hour of their time and would involve watching some films and filling out some questionnaires about the children in the films.

Materials

This study utilized two eight-minute color 8mm films which had been previously used in two studies by Saper (notes 1, 2) and which he found to be reliable tools in the discrimination of the effects of labeling. The first film focuses on a normal six year old girl whose father was an administrator at the Loyola Day School. The criteria for "normality" employed in picking stimulus subjects is that the child has never been involved in psychotherapy and is functioning adequately at home and school. The second

film focuses on a five-and-one-half year old boy who was excluded from the Chicago Public School System and was attending a special day school (Loyola Day School) for severely emotionally disturbed children. The actual diagnosis ascribed to him by the Chicago Board of Education and his psychiatrist was "severe emotional disturbance; childhood schizophrenia involving pre-psychotic symbiotic ties; mild mental retardation; and epilepsy".

Four eight-minute audio segments taped on high quality recording cassettes were also used. The design of this experiment necessitated two tapes of a female child and two tapes of a male child. The children on the films were not used for audio taping. There were two major reasons for this. First, the films were two years old at the time of the audio taping, and it was felt that the voices and language of the now seven-and-one-half year and eight year old children would be inappropriate matches for the movies taken at younger ages. Secondly, since two of the children on tapes would, in any case, be different than the two of the children on the films, it was felt that it would be better to have four completely different children, thereby avoiding the remote possibility of observers correctly matching faces and voices on the basis of extraneous variables. The first tape is of a normal (see above) six year old female. The second tape is of a six year old

female diagnosed as "withdrawing reaction of childhood, with mild mental retardation; borderline tendencies." The third tape is of a normal (see above) five-and-one-half year old boy; and the fourth tape is of a six year old boy with a diagnosis of "childhood schizophrenia, with hyperkinesis." Appropriate releases were obtained.

The setting for all films and tapes is the Loyola Day School and the grounds of Loyola University. Both children in the films were seen in similar structured and unstructured activities. Films were taken indoors and outdoors, and each child was filmed alone, with peers (on structured and unstructured activities), and with a teacher or teachers (in both structured and unstructured tasks). Each film was equally divided among these segments. The tapes followed the same general pattern for each child, but no attempt was made to exactly synchronize the tapes to the actions on the films. When the child on the film was seen alone, the child on the tape was heard alone; when the child on the film was seen in a group, the child on the tape was heard in a group, etc. The children were asked to be spontaneous, and much of the time they were not aware of the filming or taping. Initial moments of filming and taping when the children seemed uncomfortable with the procedures and those times when the children were "playing to" the camera or recorder were edited out of the footage to be presented to



the observers. It was felt that those tapes and films shown were adequate representations of the respective child's real-life behavior.

Semantic Differential

The first measure administered to all subjects after they had viewed each film and heard the corresponding tapes was a semantic differential devised by Foley in 1970 and adapted by Saper in 1975 (Appendix B). The semantic differential (Osgood, Suci, & Tannebaum, 1967) is based on a scale sampling the personality domain outlined by Cattell (1957). Each item in the measure is a bipolar trait. The traits are rated on a scale from one to six, with one being very negative and six being very positive. Some items go from the negative (undesirable) aspect of the trait to the positive (desirable) aspect; others go from the positive to the negative.

Foley's version of the semantic differential (1980) was first used by Foley to compare the pre-therapy ratings of children with post-therapy ratings. Foley found that the semantic differential is an adequate measure of behavioral change. She also found that the total score on the semantic differential (the sum of all the item ratings) is a useful statistic. The higher the total score, the more positive the overall rating. In Foley's study, the total

score on the semantic differential discriminated between "disturbed" (children in therapy) and "normal" (judged to not be in need of therapy) children; and disturbed children were rated more negatively than normal children. In view of these results, the present study uses the total score on the semantic differential rather than factor scores.

Peterson Problem Checklist

The second measure completed by the subjects in this study was the Peterson Problem Checklist (Peterson & Cattell, 1958). This questionnaire (Appendix C) is also based on work by Cattell (1957) and contains 55 behavioral descriptions of possible problem areas for the child. The total score of all items on the checklist is the degree of disturbance or maladjustment. The lower the total score, the more positively the evaluator's perception and expectations of the child's current and future behavior.

Subjects in this study were instructed to circle 0 (no problem), 1 (mild problem), or 2 (severe problem) depending on the degree to which the rater perceived or "guessed" that the statement would apply to the child. The written instructions stated that the subjects should "use their imagination to predict or extrapolate answers from the child's filmed behavior."

Procedure

At the time of the phone contacts in the recruitment procedure (see above), the experimenter established a time when the subjects could participate in the study. Subjects were repeatedly assured of their anonymity. Experimental sessions took place on the Loyola campus, and an effort was made to suit the convenience of the subjects in terms of the times offered to them. This experimenter presented the films and tapes to subjects in sessions including between five and twelve subjects. Since the diagnostic labels for the filmed children were not imposed verbally, it was possible to run experimental sessions that included members from two or more predetermined experimental groups, with subjects within these groups in different experimental conditions on the labeling variable. That is, in any given experimental session, there might be subjects from Groups I, II, and/or III; and within these groups, subjects could receive either correct or incorrect information regarding the actual labels of the children in the films.

The three experimental groups were determined in the manner described above (see Recruitment of Subjects). Within each of these groups, there were four experimental conditions: 1) correct diagnoses, regular audio condition -- subjects viewed a normal child labeled normal with normal audio and then saw an emotionally disturbed child

labeled emotionally disturbed with emotionally disturbed audio; 2) incorrect diagnoses, regular audio condition -- normal child labeled emotionally disturbed with a normal audio, emotionally disturbed child labeled normal with an emotionally disturbed audio; 3) correct diagnoses, mixed audio condition -- normal child labeled normal with an emotionally disturbed audio, emotionally disturbed child labeled emotionally disturbed with a normal audio; 4) mixed diagnoses, mixed audio condition -- normal child labeled emotionally disturbed with an emotionally disturbed audio, emotionally disturbed child labeled normal with a normal audio.

Saper's (note 1) research with these films had determined that it was not necessary to counterbalance for the effects of the order in which the films were shown. Thus, all subjects were first presented with the films and tapes of the female child and the films and tapes of the male child were always presented second. The experimenter began each session with an explanation that she was interested in their perceptions and evaluations of the children in the films. Subjects were then presented with the test packet corresponding to their experimental condition on the first film. Labels were set and instructions given in a short typed statement on the first page of each test packet.

(Appendix D) Written instructions for each test were also

included in the packet. Subjects were asked to not turn the page and begin the ratings until the film and tape were over. At the end of the first film and tape, subjects were asked to complete the first rating packet. When all subjects had completed the first rating packet, the second film and tape were presented in the same manner.

Each experimental session lasted approximately one hour. At the end of each experimental session, debriefing was accomplished via a short discussion of the purposes and hypotheses of this investigation. At this time, the experimenter elicited comments regarding which filmed child the subjects felt was actually emotionally disturbed.

CHAPTER IV

RESULTS

This investigation examined whether the imposition of a psychiatric diagnostic label on a child biases the perception and evaluation of that child's behavior. Further, this study sought to determine whether volunteer experience with emotionally disturbed children would lessen the effects of labeling. The following hypotheses were offered for evaluation:

Hypothesis 1: There will be a significant main effect for the independent variable of labeling. Specifically, ratings will be more negative and abnormal under the "emotionally disturbed" label than under the "normal" label

Hypothesis 2: There will be a significant interaction between the independent variable of labeling and the independent variable of groups. Specifically, it is hypothesized that the experienced observers' perceptions and judgments will be less affected by diagnostic labeling than the perceptions and judgments of inexperienced observers.

The results do not completely support the first hypothesis. A multivariate analysis of variance showed no main effect for the variable Labels, nor were there significant univariate Labeling effects for either dependent variable. That is, labeling in and of itself did not effect the subjects' ratings on either the semantic

differential or the Peterson Problem Checklist or on the two measures taken together. Thus, Hypothesis 1 was not supported.

There is a main effect for the independent variable Visual ($F(1,48)=5.86, p .05$), but there are no statistically significant main effects for the Audio input. This implies that subjects were not judging the children only on the basis of actual behavior, but that other factors or combinations of factors affected the subjects' ratings of the children.

There are trends toward an Audio X Labels interaction effect ($F(1,48)=3.68, p .10$), which may be confounding a main effect of Audio ($F(1,48)=3.36, p .10$).

The analyses further reveal an interaction effect of Labels X Visual ($F(1,48)=17.0348, p .01$). An examination of the cell means (Table 1) indicates that when the film of the normal child was labeled as "normal", the child was rated more positively on both measures than in any other condition. When the film of the normal child was labeled "disturbed", that child was rated more negatively than in the previous condition. The disturbed child was evaluated more positively when he was labeled "normal" than when he was labeled "disturbed". The mean ratings on both measures

Table 1 -- Mean Scores on Two Measures Showing Labels X Visual Interaction

<u>Measure</u>	<u>Normal Child Labeled "Normal"</u>	<u>Normal Child Labeled "Disturbed"</u>	<u>Disburbed Child Labeled "Normal"</u>	<u>Disturbed Child Labeled "Disturbed"</u>
I. Semantic Differential	224.46	211.20	204.43	193.23
II. Peterson Problem Checklist	27.43	39.56	33.70	41.16

Note: High scores are positive on the Semantic Differential.
Low scores are positive on the Peterson Problem Checklist.

was most negative for the disturbed child labeled "disturbed". On the semantic differential, the disturbed child was rated more negatively than the normal child despite the labels imposed. This seems to indicate that subjects were able to use the cues from the films to some extent, but that their perceptions of the children's actual behavior were colored by the diagnostic labels imposed on the children.

Hypothesis II finds minimal support in the results of the analyses of variance. There is no statistical evidence for Labels X Groups interaction. However, the analyses show a main effect for Groups ($F(2,48)=3.70, p .05$), meaning that the groups differed significantly in their ratings of the children. Table 2 shows the means of each group on the semantic differential and the Peterson Problem Checklist. Note that Groups I -- inexperienced, uninterested subjects -- and II -- inexperienced, interested subjects -- differ from Group III -- experienced subjects -- on the Peterson Problem Checklist. Group I differs from Groups II and III on the semantic differential. That is, the experienced subjects evaluated the children more positively on the Peterson Problem Checklist than either group of inexperienced subjects. However, on the semantic

Table 2 - Mean Scores on Two Measures Showing Main Effect of Groups

<u>Measure</u>	<u>Group I</u>	<u>Group II</u>	<u>Group III</u>
I. Semantic Differential	216.82	204.72	203.45
II. Peterson Problem Checklist	42.15	38.25	26.00

Note: High scores are positive on the Semantic Differential.
Low scores are positive on the Peterson Problem Checklist.

differential, the inexperienced, uninterested group tended to rate the children higher than either the inexperienced, interested group or the experienced group.

CHAPTER V

DISCUSSION

Despite the questionable validity and reliability of traditional psychodiagnostic labels, the use of such labels is routine for most mental health professionals. Psychodiagnostic labels are usually meant to impart information regarding the present condition and prognosis of the client, and they may point to treatment recommendations. However, traditional psychiatric labels may carry other messages as well -- messages which often go unrecognized but which nonetheless affect one's perceptions of the labeled individual. The current research presents some evidence that the imposition of psychodiagnostic labels on a child biases the perception of and response to that child's behavior.

Perceived Pathology: A Function of Imposed and Actual Diagnosis

The analyses found no support for a main effect of Labels. However, when imposed labels are examined in relation to the actual diagnosis of the child, a strong interaction effect emerges. This interaction effect is seen more clearly for the Visual input than for the Auditory input. The perception of the child's behavior

is dependent to some extent on the child's actual behavior. In general, when a child was labeled "disturbed" he was seen as more abnormal and negative than when the same child was labeled "normal". The Peterson Problem Checklist gives a measure of the observer's expectations of the child in terms of specific problem behaviors. On this checklist, the behavior of children who were labeled "disturbed" was consistently judged more negative or pathological than the behavior of the children labeled "normal". Thus, observers expected that children who were given pathological labels would behave negatively and abnormally. Such expectations could affect the behavior of observers in response to labeled individuals (Goffman, 1963; Scheff, 1966) and a self-fulfilling spiral may begin (Rosenthal, 1964).

On the other hand, on a more global trait rating scale (semantic differential) observers were better able to utilize the cues from the films. On this measure, the normal child (actual diagnosis) was commonly evaluated as more positive and "emotionally healthy" than the disturbed child (actual diagnosis). It is possible that subjects could discriminate real differences in mental health between the two children in terms of broad personality traits. However, the evaluations on the semantic differential of each child still seemed to depend to a great extent on the label imposed on that child. The observers

rated each child as more pathological and negative when that child was labeled "disturbed" than when that same child was labeled "normal". The critical point here is that each child was compared against himself. These results, therefore, lend support to the notion that a psychodiagnostic label imposes a response set on an observer which tends to make his/her perceptions and judgments inaccurate.

Other investigators (Farina & Ring, 1965; Jones, Hester, Farina, & Davis, 1959; Rosenhan, 1973) have reported main effects of a labeling bias. It should be noted that a careful reading of the other research referenced above (see Chapter II) reveals that these other studies were, in fact, dealing with interaction effects of labeling. The failure of the present study to find a main effect for the variable Labels might best be understood if one looks at the differences between the current study and the earlier research which found the main labeling effects. Farina and Ring (1965), Jones, Hester, Farina, & Davis (1959) and Rosenhan (1973) all use live stooges who interacted with subjects in their experiments. It is quite possible that such interactions with live actors who have been labeled "disturbed" have a profoundly different effect on subjects' behavior and judgments than does the use of filmed and taped subjects. It is difficult to control for standardization of stimulus subjects' behavior in such

studies. It is also possible that the interaction with these stooges may tap more powerful reactions, as the subjects perceive and seek to rationalize their own behaviors and attitudes toward the stooges (Goffman, 1963; Scheff, 1966).

In addition, none of these studies which found main effects of labeling had more than one stimulus subject per observer. In each study, observers dealt with only one normal stimulus subject upon whom was imposed some form of "emotionally disturbed" label. In the current research, observers saw two stimulus subjects, one of whom was labeled "normal", while the other was labeled "disturbed"; at the same time, one of the stimulus subjects actually carried a psychiatric diagnosis while the other did not. The methodologies of the earlier studies did not introduce the possibility of the confounding interactions of actual diagnosis and imposed diagnosis. On the other hand, these studies did not allow for comparisons between subjects' reactions to normal people and reactions to people who are, in fact, disturbed, regardless of the labels imposed.

Perceived Pathology: A Function of Experience and Interest

When experienced subjects evaluated and predicted the behaviors of the children, as measured by the Peterson Problem Checklist, they tended to see the children's

behaviors as more positive and healthy than when the same behaviors were evaluated by inexperienced subjects. These positive behavioral ratings persist despite the actual behavior of the child or the label imposed on the child. It might be the case that those subjects who have had experience working with emotionally disturbed children are not shocked or offended by such specific problem behaviors as are mentioned in the Peterson Problem Checklist, as inexperienced observers might be. In addition, the school at which these experienced subjects volunteered, relies heavily on behavioral techniques. It is possible, therefore, that these experienced subjects may have been trained to expect and search for positive behaviors (e.g., in terms of behavioral reinforcement procedures). Another possibility is that people who actually volunteer to work with disturbed children for several months simply like children more than do people who have not put themselves in the volunteering situation. Interest in such work alone does not seem to affect the subject's ratings of the children on the Peterson Problem Checklist, whereas actualization of such interest may have such effect.

On the other hand, when one looks at the more global ratings (semantic differential) of the children, a different pattern emerges in reference to the groups of observers. The group of subjects who had stated that they were

inexperienced and uninterested in working with emotionally disturbed children tend to rate all of the children as more positive and healthy. These results are in contradiction to those on the Peterson Problem Checklist. But let us look at the difference between the tests. The Peterson Problem Checklist deals with specific behaviors which are, for the most part, obviously negative and abnormal. The semantic differential deals with more amorphous personality traits, many of which are difficult to assess on an absolute positive-negative continuum. The face validity of the checklist is greater, and the judgments are more clearcut.

It is also possible that for these different groups, the items on the semantic differential are scaled differently on the positive-negative aspects of the traits. Perhaps those persons who have no interest in volunteering with emotionally disturbed children have different values than those persons who are interested and/or are, in fact, doing such volunteer work. For example, subjects in the first group may have seen such qualities as "self-contained", "quiet", "inactive", and "introverted" as positive; however, these aspects are scored negatively on the semantic differential. A quick inspection of the protocols reveals that these and other items were often checked on the negative aspects for this group. It might

be worth further investigation with a statistically tested item analysis to check on this apparent trend. Such analyses could not be done with the present population due to the constraints of time and the relatively small numbers of subjects in each group.

Methodological Issues

At this point, it seems appropriate to discuss the methodology employed in the current research. It is felt that this present study was, in many ways, an improvement on earlier studies.

As explained in Chapter II above, the use of video tapes with audio overlays is a compromise between studies employing live stooges or models (Farina & Ring, 1965; Jones, Hester, Farina & Davis, 1959; Rosenhan, 1973) and still photographs (Rosenthal, 1964). It was the judgment of the present author that still photographs did not provide adequate information in order for observers to judge the stimulus subjects, and that in studies employing this methodology the biasing effects of labeling were artificially high. On the other hand, the behavior of live models cannot be standardized completely, thereby introducing extraneous variables into the observers' evaluations of the stimulus subject. The present investigation followed Saper (note 1, 2) in his use of video tapes, but

added an audio overlay in an effort to increase the relevant cues available to the observers, and to further validate the research and broaden the applicability of the results.

The Audio dimension did not contribute significantly to the variance in this experiment. It is possible that the labeling bias, in and of itself was not completely responsible for these diminished Audio effects. It might be a good idea to have the unlabeled audio tapes rated by persons who have both knowledge and experience with both normal and emotionally disturbed children, but not with the particular children on the tapes. This would give an idea of how well cues from the audio tapes would differentiate between the normal children and emotionally disturbed children if there were no labeling bias. Furthermore, this procedure would strengthen any implications based on any trends toward main Audio effects or interaction effects of Audio.

Another limitation of previous research was briefly discussed earlier in this chapter. In the present study, observers reacted to two different films and tapes. One of the filmed stimulus subjects was actually emotionally disturbed -- attending a special school after having been excluded from the public school system -- and the other filmed stimulus subject was actually normal -- had never

been involved in psychotherapy and was functioning adequately at home and school. There were four different audio tapes: two normal children and two emotionally disturbed children. The audio tapes were matched with the appropriate sex films. Since observers saw two presentations with different actual diagnoses, observers' responses to the disturbed stimulus subject when labeled "normal" could be compared to the responses to the disturbed subject when labeled "normal", and similarly for the stimulus subject who was actually normal. Thus, there was no acting or faking of symptoms involved, and observers saw films of the actual behavior of persons who actually carried different diagnoses. This, again, increases the realism of the study and increases the generalizability of the results.

The way in which the groups were determined -- before the actual experimental sessions -- and the way in which the labels were imposed -- by written statements handed to observers before each film and tape -- allowed for the possibility of presenting the films and tapes to observers in different groups and different conditions at the same time. This eliminated the problem of different subject groups receiving instructions or conditions which differed on variables other than those tested in this investigation.

After each experimental session, the subjects were casually asked which child they thought was actually

disturbed. Approximately 50% of the subjects said that they had perceived the girl (actually normal) to be less disturbed than the boy; 50% thought that the girl was more disturbed than the boy. This conforms to the expectations due to the fact that half of the subjects received a "normal" label for the girl and half received a "disturbed" label for the girl. About 75% of the subjects expected that there was some type of deception involved in the experiment, but only about 20% guessed that the deception had to do with the labels attached to the children. Most subjects (approximately 60%) thought that the experiment was actually measuring some personality variable of subjects or the subjects' ability to attend to and comment on the film and tapes. The large number of subjects who expected deceptions can be seen as a commentary on the cynicism with which college undergraduates -- who have traditionally been used as subjects in psychological research -- approach the experimental situation.

Future Research

The present investigation concerned itself primarily with the effects of diagnostic labeling and the way in which experience with disturbed persons changes the labeling bias effects. Further research in this area might include some formal means of assessing the process by which

subjects attend to and integrate diagnostic information. This would give the mental health professions more information upon which to build an effective and efficient means of providing diagnostic information while avoiding some of the problems inherent in the present system.

Future research might also investigate the differential effects of information about emotional disturbance and experience with emotionally disturbed persons on labeling biases. Such research seems as though it might be of interest to those persons involved in the planning of training programs for professionals and paraprofessionals. It would also provide useful information regarding the way in which the profession can improve the public image of mental health services.

Further work might also investigate the differential results of psychodiagnostic labeling of children as compared to the labeling of adults. More attention could be paid to the impact of other variables -- such as the race, sex, socioeconomic status, and religion of both stimulus subjects and observers -- on the reactions of observers to psychiatrically labeled individuals. Researchers could also look at the way in which subjects react to different kinds of labels, for example, labels pertaining to physical handicaps versus labels of emotional disturbance. The strength of the label imposed and the

status of the person imposing the label might also have an effect on the way in which labeling colors the perceptions of behaviors.

It is easy to find research support for criticizing the existing psychodiagnostic classification system. It is more difficult to develop constructive and reasonable alternatives to the current system. This is the challenge currently facing mental health professionals and researchers. It is hoped that the present investigation provides some insight which might be helpful to the development of a humane and useful means of communicating information regarding those persons who seek psychological services.

REFERENCES

- Antonio, R. J. On ignoring the subtle dimensions of labeling: The case of mental disorder. Kansas Journal of Sociology, 1975, 11, 3-13.
- Bieri, J. Changes in interpersonal perceptions following social interaction. Journal of Abnormal and Social Psychology, 1953, 48, 61-66.
- Cattell, R. R. Personality and motivation: Structure and measurement. New York: World Book, 1957.
- Caveny, E. L., Wittson, C. L., Hunt, W. A., and Herman, R. S. Psychiatric diagnosis, its nature and function. Journal of Nervous and Mental Disease, 1955, 121, 367-373.
- Crumpton, E., Weinstein, A. D., Acker, C. W., and Annis, A. P. How patients and normals see the mental patient. Journal of Clinical Psychology, 1967, 23, 46-49.
- Cumming, E., and Cumming, J. Closed Ranks. Cambridge: Harvard University Press, 1957.
- Diagnostic and Statistical Manual of Mental Disorders. (2nd edition) Washington, D.C.: American Psychiatric Association, 1968.
- DiNardo, P. A. Social class and diagnostic suggestion as variables in clinical judgment. Journal of Consulting and Clinical Psychology, 1975, 43, 363, 368.
- Dohrenwend, B. P., and Chin-Shong, E. Social status and attitudes toward psychological disorder: The problem of tolerance of deviance. American Sociological Review, 1967, 32, 417-433.
- Farina, A., Holland, C. H., and Ring, K. Role of stigma and set in interpersonal interaction. Journal of Abnormal Psychology, 1966, 71, 421-428.
- Farina, A., and Ring, K. The influence of perceived mental illness on interpersonal relations. Journal of Abnormal Psychology, 1965, 1, 47-51.

- Fracchia, J., Canale, D., Cambria, E., Ruest, E., and Sheppard, C. Public views of ex-mental patients: A note on perceived dangerousness and unpredictability. Psychological Reports, 1976, 38, 495-498.
- Freeman, H. E. Attitudes toward mental illness among relatives of former patients. American Sociological Review, 1961, 26, 59-66.
- Foley, J. Training future teachers as play therapists: An investigation of therapeutic outcome and orientation toward pupils. U.S. Dept. of H.E.W., Office of Education, Bureau of Research, Project No. 8E059, 1970.
- Gauron, E. F., and Rawlings, E. I. The myth of the fragile patient. Psychotherapy: Theory, Research, and Practice, 1973, 10, 352-353.
- Giovannoni, J. M., and Ullman, L. P. Conceptions of mental health held by psychiatric patients. Journal of Clinical Psychology, 1963, 19, 398-400.
- Goffman, E. Stigma: Notes on the Management of a Spoiled Identity. Englewood Cliffs, N.J.: Prentice-Hall, 1963.
- Gough, H. Some reflections on the meaning of psychodiagnostics. American Psychologist, 1971, 26, 160-167.
- Gustin, A. Biased therapists: the effects of prior exposure to case history. Dissertation Abstracts, 1970, 12, 777.
- Jones, E. E., Hester, S. L., Farina, A., and Davis, K. E. Reactions to unfavorable personal evaluations as a function of the evaluator's perceived adjustment. Journal of Abnormal and Social Psychology, 1959, 59, 363-370.
- Kirk, S. A. Labeling the mentally ill and the attribution of personal traits. Journal of Consulting and Clinical Psychology, 1976, 44, 306.
- Kish, G. B., and Hood, R. W. Voluntary activity promotes more realistic conceptions of the mentally ill by college students. Journal of Community Psychology, 1976, 2, 30-32.

- Klopfer, W. The role of diagnostic evaluation in clinical psychology. Journal of Projective Techniques, 1962, 26, 3, 295-98.
- Langer, E. J., and Abelson, R. P. A patient by any other name. . . clinician group differences in labeling bias. Journal of Consulting and Clinical Psychology, 1974, 42, 4-9.
- Lemkau, P. V., and Crocetti, G. M. An urban populations' opinion and knowledge about mental illness. American Journal of Psychiatry, 1962, 118, 692-701.
- McCoy, S. A. Clinical judgments of normal childhood behavior. Journal of Consulting and Clinical Psychology, 1976, 44, 710-714.
- Meehl, P. A. Wanted: A good cookbook. American Psychologist, 1956, 11, 263-272.
- Morrison, J. K., and Nevid, J. S. Attitudes of mental patients and mental health professionals about mental illness. Psychological Reports, 1976, 38, 565-566.
- Movahedi, S. Loading the dice in favor of madness. Journal of Health and Social Behavior, 1975, 16, 192-197.
- Nunnally, J. Popular Conceptions of Mental Health. New York: Holt, Rinehart, & Winston, 1961.
- Nunnally, J., and Kittross, D. Public attitudes toward mental health professions. American Psychologist, 1958, 13, 589-594.
- Olmstead, D. W., and Durham, K. Stability of mental health attitudes: A semantic differential study. Journal of Health and Social Behavior, 1976, 17, 35-44.
- Osgood, C., Suci, G., & Tannenbaum, P. The measurement of meaning. Chicago: University of Illinois Press, 1967.
- Page, S., and Yates, E. Effects of situational role demands on measurement of attitudes about mental illness. Journal of Consulting and Clinical Psychology, 1975, 43, 115.

- Pasamanick, B., Dinitz, S., and Lefton, M. Psychiatric orientation and its relation to diagnosis and treatment in mental hospital. American Journal of Psychiatry, 1959, 116, 127-132.
- Peterson, D., & Cattell, R. Personality factors in nursery school children as devised from parent ratings. Journal of Clinical Psychology, 1958, 14, 346-55.
- Phillips, D. L. Rejection: A possible consequence of seeking help for mental disorders. American Sociological Review, 1963, 28, 963-972.
- Pollack, S., Huntley, D., Allen, J. G., and Schwartz, S. The dimensions of stigma: the social situation of the mentally ill person and the male homosexual. Journal of Abnormal Psychology, 1976, 85, 105-112.
- Rabkin, J. Opinions about mental illness. Psychological Bulletin, 1972, 77, 153-171.
- Rhodes, W. C., and Sagor, M. Community perspectives. In Hobbs, N. (ed.), Issues in the Classification of Children, Vol. I. San Francisco: Jossey-Bass, 1975.
- Rosenhan, D. L. On being sane in insane places. Science, 1973, 179, 250-258.
- Rosenthal, R. The effect of the experimenter on the results of psychological research. In Maher, B. (Ed.). Progress in personality research. Vol. I. New York: Academic Press, 1964. PP. 80-112.
- Sarbin, T. R., and Mancuso, J. C. Failure of a moral enterprise: attitudes of the public toward mental illness. Journal of Consulting and Clinical Psychology, 1970, 35, 159-173.
- Scheff, T. Being Mentally Ill: A Sociological Theory. Chicago: Aldine, 1966.
- Sushinsky, L. W., and Wener, R. Distorting judgments of mental health: generality of the labeling bias effect. Journal of Nervous and Mental Disease, 1975, 161, 82-89.
- Szasz, T. S. The myth of mental illness. In Scheff, T. J. (ed.) Mental Illness and Social Processes. New York: Harper & Row, 1967.

- Temerlin, M. K. Suggestion effects in psychiatric diagnosis. Journal of Nervous and Mental Disease, 1968, 147, 349-353.
- Yarrow, M. R., Schwartz, C. G., Murphy, H. S., and Deasy, L. C. The psychological meaning of mental illness in the family. In Scheff, T. J. (ed.) Mental Illness and Social Processes. New York: Harper & Row, 1967.
- Yates, A. Behavior Therapy. New York: Wiley, 1970.
- Zubin, J. Classification of the behavior disorders. Annual Review of Psychology, 1967, 18, 373-406.

REFERENCE NOTES

1. Saper, C. The effect of diagnostic labeling on the perception of behavioral abnormalities. Unpublished master's thesis, Loyola University of Chicago, June 1975.
2. Saper, C. The effect of diagnostic labeling on the clinician's perception of behavioral abnormalities. Unpublished doctoral dissertation, Loyola University of Chicago, August, 1976.

APPENDIX A

Please answer all questions truthfully. All information is confidential and for experimental purposes only. The instructor will not have access to your responses.

NAME _____

PHONE _____
(Local and/or home phone)

YEAR 1st 2nd 3rd 4th

MAJOR _____

Have you ever worked with emotionally disturbed persons?

YES _____ NO _____

Do you think you would like to volunteer to do work with emotionally disturbed children?

YES _____ NO _____

Do you have the time to volunteer this semester? (The Loyola Day School requires a minimum of 6 hours per week.)

YES _____ NO _____

Would you like someone from the Loyola Day School to contact you regarding their volunteer program?

YES _____ NO _____

Thank you!

Lori D'Asta

Please answer each item on this scale on the basis of your observation of the BOY GIRL you saw in the film. In answering these items do not try to remember how you checked similar items before, and do not look back and forth. Make each judgment separate and independent. Work fairly quickly. Do not worry or puzzle over individual scales. There are no right or wrong answers; it is your first impression, the immediate "feelings" about the children that we want. On the other hand, please do not be careless as we want your true impressions.

Place your check-marks in the middle of the spaces, and never put more than one check-mark on a single scale. Please be sure you check every scale -- do not omit any. Try to form a judgment on each of the descriptive scales. Remember that the closer you get to the middle of the scale, the less descriptive your ratings become. A rating in the middle of the scale is essentially non-descriptive, so try to avoid this zone unless you get absolutely no feeling for the particular scale that you are rating.

ACTIVE	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	INACTIVE
EXTROVERTED	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	INTROVERTED
SOCIABLE	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	UNSOCIABLE
CRUEL	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	KIND
CONSCIENCELESS	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	CONSCIENTIOUS
HAPPY	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	DEPRESSED
DULL MINDED	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	INTELLIGENT
LOVING	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	NOT LOVING
TRUSTING	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	DISTRUSTING
QUICK	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	SLOW
CURIOUS	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	UNINQUIRING
OPTIMISTIC	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	PESSIMISTIC
WARM	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	COLD
RESPONSIVE	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	ALOOF

ADVENTUROUS	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	TIMID
SOFT-HEARTED	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	HARD-HEARTED
COLORFUL	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	COLORLESS
OUTGOING	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	SELF-CENTERED
IRRITABLE	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	NOT PRONE TO ANGER
MEANINGLESS	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	MEANINGFUL
INTERESTING	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	BORING
CONFIDENT	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	FEELS INADEQUATE
FORMED	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	FORMLESS
NOISY	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	QUIET
BOY FILM	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	B
MASCULINE	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	FEMININE
GIRL FILM	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	G
LIKES SCHOOL	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	DISLIKES SCHOOL
POOR MEMORY	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	GOOD MEMORY
EXCITABLE	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	CALM
INTERESTED	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	BORED
DISOBEDIENT	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	OBEDIENT
TRUTHFUL	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	LYING
TENSE	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	RELAXED
EMOTIONAL	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	SELF-CONTAINED
STRONG-WILLED	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	WEAK-WILLED
INDEPENDENT	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	DEPENDENT
ATTENTION AVOIDING	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	ATTENTION SEEKING
IRRESPONSIBLE	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	RESPONSIBLE

NOT HELPING	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	HELPING
OBSTRUCTIVE	<u>1</u> : <u>2</u> : <u>3</u> : <u>4</u> : <u>5</u> : <u>6</u>	COOPERATIVE
EFFECTIVE	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	INEFFECTIVE
ADJUSTED	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	MALADJUSTED
FRIENDLY	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	NOT FRIENDLY
HAPPY	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	SAD
LEADER	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	FOLLOWER
ALWAYS ON THE GO	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	NOT ACTIVE
NEVER SEEMS TO TIRE	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	TIRES EASILY
OUTDOOR TYPE	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	INDOOR TYPE
EMOTIONALLY HEALTHY	<u>6</u> : <u>5</u> : <u>4</u> : <u>3</u> : <u>2</u> : <u>1</u>	EMOTIONALLY DISTURBED

PLEASE BE CERTAIN THAT YOU HAVE PUT ONE CHECK-MARK

ON EACH LINE THANK YOU.

APPENDIX C

PROBLEM CHECKLIST

Please complete this form as if you had been observing the child in the film at home and in school over a long period of time. Indicate which of the following might constitute problems as far as this child is concerned. If you guess that an item would not constitute a problem, circle zero; if you guess that an item would constitute a mild problem, circle one; if you guess that an item would constitute a severe problem, circle the two. Please use your imagination to predict or extrapolate answers from the child's filmed behavior and complete every item.

Circle one: The child in the film was a BOY GIRL

- | | | | | |
|---|---|---|-----|---|
| 0 | 1 | 2 | 1. | Thumb-sucking |
| 0 | 1 | 2 | 2. | Restlessness, inability to sit still |
| 0 | 1 | 2 | 3. | Attention-seeking, "show-off" behavior |
| 0 | 1 | 2 | 4. | Skin allergy |
| 0 | 1 | 2 | 5. | Doesn't know how to have fun; behaves like a little adult. |
| 0 | 1 | 2 | 6. | Self-consciousness; easily embarrassed |
| 0 | 1 | 2 | 7. | Headaches |
| 0 | 1 | 2 | 8. | Disruptiveness; tendency to annoy and bother others |
| 0 | 1 | 2 | 9. | Feelings of inferiority |
| 0 | 1 | 2 | 10. | Dizziness, vertigo |
| 0 | 1 | 2 | 11. | Boisterousness, rowdiness |
| 0 | 1 | 2 | 12. | Crying over minor annoyances and hurt |
| 0 | 1 | 2 | 13. | Preoccupation; "in a world of his own" |
| 0 | 1 | 2 | 14. | Shyness, bashfulness |
| 0 | 1 | 2 | 15. | Social withdrawal, preference for solitary activities |
| 0 | 1 | 2 | 16. | Dislike for school |
| 0 | 1 | 2 | 17. | Jealousy over attention paid other children |
| 0 | 1 | 2 | 18. | Prefers to play with younger children |
| 0 | 1 | 2 | 19. | Short attention span |
| 0 | 1 | 2 | 20. | Bedwetting |
| 0 | 1 | 2 | 21. | Inattentiveness to what others say |
| 0 | 1 | 2 | 22. | Easily flustered and confused |
| 0 | 1 | 2 | 23. | Lack of interest in environment, generally "bored" attitude |
| 0 | 1 | 2 | 24. | Fighting |
| 0 | 1 | 2 | 25. | Nausea, vomiting |
| 0 | 1 | 2 | 26. | Temper tantrums |
| 0 | 1 | 2 | 27. | Reticence, secretiveness |
| 0 | 1 | 2 | 28. | Truancy from school |

- 0 1 2 29. Hypersensitivity; feelings easily hurt
- 0 1 2 30. Laziness in school and performance of other tasks
- 0 1 2 31. Anxiety, chronic general fearfulness
- 0 1 2 32. Irresponsibility, undependability
- 0 1 2 33. Lack of self confidence
- 0 1 2 34. Excessive daydreaming
- 0 1 2 35. Tension, inability to relax
- 0 1 2 36. Disobedience, difficulty in disciplinary control
- 0 1 2 37. Depression, chronic sadness
- 0 1 2 38. Uncooperativeness in group situations
- 0 1 2 39. Aloofness, social reserve
- 0 1 2 40. Passivity, suggestibility; easily led by others
- 0 1 2 41. Clumsiness, awkwardness, poor muscular coordination
- 0 1 2 42. Stuttering
- 0 1 2 43. Hyperactivity, "always on the go"
- 0 1 2 44. Distractibility
- 0 1 2 45. Destructiveness in regard to his or her own and/or others' property
- 0 1 2 46. Negativism, tendency to do the opposite of what is requested
- 0 1 2 47. Impertinence, sauciness
- 0 1 2 48. Sluggishness, lethargy
- 0 1 2 49. Drowsiness
- 0 1 2 50. Profane language
- 0 1 2 51. Prefers to play with older children
- 0 1 2 52. Nervousness, jitteriness, easily startled
- 0 1 2 53. Irritability, hot-tempered, easily aroused to anger
- 0 1 2 54. Stomach aches, abdominal pain
- 0 1 2 55. Specific fears; e.g., of dogs, of the dark, of riding in or on a vehicle

APPENDIX D

The child in the movie you will be seeing now is a six year old boy who has been excluded from the Chicago Public Schools and attends a special school for emotionally disturbed children in the area. He is being filmed at this school. Your task is to carefully watch the short film and listen to the tape which focuses on this child. Do not turn the page until you are told to do so when the film is over.

The child in the movie you will be seeing now is a six year old girl who has been excluded from the Chicago Public Schools and attends a special school for emotionally disturbed children in the area. She is being filmed at this school. Your task is to carefully watch the short film and listen to the tape which focuses on this child. Do not turn the page until you are told to so when the film is over.

The child in the film you are about to see is a normal six year old girl who was filmed while visiting a special school at which her father is an administrator. This child is enrolled at her local public school, but came to work with her father on a free day. Your task is to carefully watch the short film and listen to the tape which focuses on this child. Do not turn the page until you are told to do so when the film is over.

The child in the film you are about to see is a normal six year old boy who was filmed while visiting a special school at which his father is an administrator. This child is enrolled at his local public school, but came to work with his father on a free day. Your task is to carefully watch the short film and listen to the tape which focuses on this child. Do not turn the page until you are told to do so when the film is over.

APPROVAL SHEET

The thesis submitted by Lorraine D. D'Asta has been read and approved by the following Committee:

Dr. James Johnson, Chairman
Associate Professor, Psychology, Loyola

Dr. John Shack
Associate Professor, Psychology, Loyola

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts in the Department of Psychology.

4/21/78

Date


Director's Signature