

AN ABSTRACT OF THE THESIS OF

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REHABILITATION COUNSELING STUDENTS' PERCEPTIONS
OF A CLIENT'S PRESENTING PROBLEM:
AN ATTRIBUTIONAL ANALYSIS

Abstract Approved:



Rehabilitation counseling students, as everyone else, have been raised in a society which has generally neither perceived nor portrayed people with disabilities positively. How then do rehabilitation counseling students perceive those with whom they plan to work? The following study attempts to answer this question. Using attribution theory, the researcher hypothesized that certain demographic variables would be significant in determining the attributions made for the cause of a client's presenting problem. Russell's (1982) Causal Dimension Scale, in a modified form, was used to rate the causes of the problem. Results indicate that those subjects who have the most extensive background in rehabilitation, and/or knowledge of the latest rehabilitation research, perceived the client's problem as internal, or dispositional, to the client. Implications of these results are discussed, and recommendations made for the direction of further research as well as for rehabilitation counselor education.

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CHAPTER I

Introduction

"Why?" This is a question children start asking from their earliest years. In the beginning, they may be looking for answers adults are able to give, such as for "why is grass green?" Later on, as adults themselves, the questions become more difficult, often with no neat scientific answers. For people with disabilities, among all the questions with which they may struggle, "the 'why?' questions tend to be the most arduous to reconcile" (Emener, 1992, p. 268).

In their study of 1981, which was based upon the theory of attribution, Wong and Weiner point out some ways in which people attempt to answer their why questions. The authors proved, and it has become generally accepted, that people "spontaneously" search for answers when unexpected things happen. "Negative and unexpected outcomes appear to especially promote attributional thinking" (p. 27). As participants, people search for causal attributions that apply to their own circumstances; as observers, the search applies to circumstances of someone else.

In counseling, the attributional search explaining a client's issue is "a frequent precursor to initiating therapy" (Brewin & Antaki, 1982, p. 24). Different therapies rely upon different explanations of clients' lives. For example, an Existentialist might claim that someone is having problems because he or she is evading "responsibility for creating...[his or her] ways of thinking, feeling, and behaving" (Corey, 1991, p. 77). A Psychoanalyst might claim that the person is fixated at some early developmental stage. A Cognitive therapist may explain the problem as

due to "faulty thinking and believing" (p. 143). In rehabilitation counseling, the emphasis is less on trying to explain why, and more on moving ahead in a "process of restoration" (Power, 1991, p. xi), which includes seeking out practical, concrete goals and opportunities for the promotion of self-reliance and personal satisfaction. This process most often refers to teaching job-seeking skills, self-advocacy, and/or ways to live (more) independently and interdependently within the community, and the relationship between counselor and client is significant to the process. That relationship has been called "the moment in which...[counseling] empowers or fails to empower" (Holmes, 1992, p. 165).

Laying blame for a problem on delayed development, lack of responsibility for feelings, or faulty beliefs is attributing the cause of a problem within the client. It is a search for pathology, for something within the person that, presumably, only the expertise of the therapist can fix. In contrast, rehabilitation counselors are trained to look at the complete picture surrounding the individual: his or her disability, goals, skills, background, financial situation, family, friends, and more (Bitter, 1984). As this information is shared, both client and counselor begin to see the problem more clearly, what exactly the client can do about it, and how the counselor may be able to help. Rather than attributing cause inward to the client, the search is for the total situation of the person, finding how each part impacts upon his or her life. The distinction between these methods is searching for sickness, or searching for strengths.

Given the differences in goals between the previously mentioned therapies and rehabilitation counseling, one may expect counselors in

rehabilitation to have positive attitudes toward people with disabilities; however, this is not always true (Kilbury, Benshoff, & Rubin, 1992). In fact, Dumont and Lecomte (1987) refer to the potential everyone has for "self-deception, illusory influences, and attribution errors...especially if one has not been trained to look for them (p. 434). This hints at the level of unconsciousness on which people maintain attitudes, out of which come attributions. Given that one's attitudes about someone affect the attributions made about that person (Betancourt, 1990; Graham, 1990), the following study explored some of the facets within both society and the field of rehabilitation that have an influence on attitudes. The exploration culminated in discovering how rehabilitation counseling students at Emporia State University (ESU) attribute the cause of a client's presenting problem.

Background of the Problem

Students in rehabilitation counseling are "presumed to...have relatively positive attitudes toward persons with disabilities" (Chubon, 1992, p. 309). Chubon states that this presumption is a "fatal flaw" in research, one based solely on the fact that there has been no research to prove otherwise. It is arguable that researchers have not considered the possibility of negative attitudes among rehabilitation counseling students because, as in all fields of counseling (Batson & Marz, 1979), students are immersed in the tenets of their profession. In the program at ESU, graduate students learn about the rehabilitation process (Morgan, 1978) and philosophy (Wright, 1980), upon which the students base their understanding of counseling people with disabilities. This base leads to valuing the person as a unique individual (Thoreson, 1971), with his or

her own set of strengths (Bitter, 1984), skills (Olney & Salomone, 1992), supports, and resources (Jacques, 1970). According to Emener (1992), a core component of rehabilitation counselor education is the concept of "consumerism" (p. 265), which, as it relates to rehabilitation, is a shift in attitude toward protecting and promoting clients' rights such as autonomy, within both the rehabilitation setting and the community.

Rehabilitation counseling students have also been raised in the larger culture, subject to the same socialization process as the general population. This would indicate that they are not immune to the myths and stereotypes held by the public about people with disabilities. Therefore, there may be as much diversity in rehabilitation counseling students' attitudes toward people with disabilities as there is in attitudes held by the general public (DeLoach & Greer, 1981). These authors discuss a survey indicating that "while verbalized attitudes are positive, un verbalized attitudes remain influenced by hostile prejudice" (p. 17). It becomes "crucial," ultimately to rehabilitation clients, to "promote an appreciation for the development of...attitudes...in order to facilitate the future role of the student as a professional" (Batorski & McAlpin, 1992, p. 259).

In 1992, Chubon updated his earlier work from 1982, in which he had reviewed research published over two decades (1960-1979) related to the attitudes of rehabilitation professionals. He reports that attitudes of people in rehabilitation counseling have "little association with basic demographic variables" (Chubon, 1992, p. 308). Basic variables are usually considered to be gender, age, education level, and work experience. This researcher will introduce other variables, many of which are unique to students, such as membership in the student

rehabilitation organization, percentage of textbooks read for classes, and post-graduate work plans. Other variables include questions about students' familiarity with current research through the reading of professional rehabilitation journals, as well as their plans to contribute to that research. This researcher hopes to identify variables that are associated with rehabilitation students' attributions about clients. Basic variables of gender, age, education background, and work experience will be considered in this study, but as a launching pad to other variables. Unlike Chubon, Havranek (1991) claims that gender, education level, and work do "consistently influence attitude formation toward the disabled" (p. 16), as well as one's knowledge of disabilities and years of experience in dealing with individuals who have disabilities.

Some variables in this research are specific to students. For example, students will be asked about their habits of reading both textbooks and professional rehabilitation journals. Rehabilitation counseling, a profession since 1954 (Bitter, 1984), has "a specialized body of knowledge and theory-driven research....Textbooks tend to be the central means by which that knowledge is synthesized, compiled and transmitted to students" (Gilbride & Stenrud, 1991, p. 93). It would be pertinent to know, based on self-reports, how much of their textbooks students actually read, and whether or not this book knowledge (or lack thereof) impacts upon attitudes and attributions about clients. Rehabilitation journals represent an important link to new knowledge in the field (Gilbride & Stenrud, 1991), which may include breakthroughs in technology, advocacy, and laws, or generate new ideas about techniques for working successfully with clients, families, and employers. Students

who do not keep up at least peripherally with the latest information in rehabilitation may become closed-minded (Emener, 1992). Another factor which may close minds is the approach of learning "'what you need to know to pass the test'" (p. 269). Again, reading books and journals thoroughly and regularly indicates a student who absorbs more than the minimal amount needed to merely pass tests. Another variable in this vein is questioning students about membership in the Student Chapter of the Kansas Rehabilitation Association. Membership in the student organization allows students to acquire new information, meet and speak with leaders in the field, and is not a requirement to earning a degree.

Another set of demographic variables which will be considered in this study pertain to work: past and present experiences, and career aspirations, each of which has been stressed as important to the study of rehabilitation counseling students (Emener, Tannenbaum, & Cady, 1990). Knowing about past and present work experiences is important to planning an education tailored individually to each student, depending in part upon his or her work history, "thereby also modeling the 'uniqueness of the individual' philosophy of rehabilitation" (p. 134). Knowing about rehabilitation students' post-graduate work plans is important to future curriculum planning. If the rehabilitation counseling curriculum does not address the goals of its students, at least two outcomes are possible. First, there may be little incentive or motivation to acquire book knowledge beyond that required to pass tests. A second possible outcome is that students may begin to feel that neither they nor their goals really matter. It is vitally important in the field of rehabilitation that students are challenged in ways that meet their needs on an individual basis, as Emener (1992) explains:

If rehabilitation education students...are going to be empowering of others throughout their careers in rehabilitation, then it is only fitting that throughout their experiences as students they be in an empowering environment, be treated in empowering ways, and experience a sense of power, control, and authority within and regarding their own lives (p.266).

Havranek (1991) has claimed that racial and ethnic groups share identifiable "reactions to disabilities" (p. 15). Attributions, also, may be culturally determined. However, at ESU, there are several races and cultures that are represented by only one or two individuals, which would lead to easy identification of these persons and their CDS scores. Therefore, to protect the anonymity of these persons, race and ethnic variables will not be considered for this study.

Statement of the Problem

There are in this country an estimated 43 million people who have disabilities (Batorski & McAlpin, 1992). Myerson (1988/1990), possibly ignoring the minority status of women in the US, calls this figure "astonishing," saying that "people with disabilities constitute the largest minority in the United States" (p. 17, emphasis in original). As a minority, people with disabilities are "effectively ignored and devalued" by society (Batorski & McAlpin, 1992, p. 258). The continuation of a society depends upon its members behaving in ways that will sustain it; thus society itself is its own socializing agent. As a result, people's perceptions of each other are, in part, a matter of

"what one has been conditioned to see, what one wants to see, what one has been instructed to see, and what one is afraid to see. Both clients and clinicians suffer from these limitations" (Dumont & Lecomte, 1987, p. 433).

In any specialized training program, as in society, individuals are instructed and immersed in the constructs of that particular culture. In helping professions such as counseling and psychology, the training often emphasizes paying attention to the client's negative behavior (Karuza, Zevon, Rabinowitz, & Brickman, 1982). In other words, these professionals learn to focus on the client, and neglect or ignore his or her environment (Fine & Asch, 1988/1990). Thus "there is a bias in favor of attributing behavior to characteristics of the person rather than to the stimulus properties of his [or her] environment" (McArthur, 1972, p. 177). The implications of this progression are quite serious within the field of rehabilitation. Yunker (1977) felt so strongly about the possibility of such attributions creating "devastating consequences that he called for a screening out of persons who hold such attitudes from entering fields where interaction with persons with disabilities occurs" (Chubon, 1992, p. 307).

At ESU, the training in rehabilitation counseling is not focused so much on client behaviors, except as those behaviors relate to a specific need in the person's life (e.g., maintaining employment). Instead, the emphasis is on looking at and drawing out the person's skills, support system, available resources within his or her community, and personal goals, ambitions, and dreams: in essence, the person's strengths (Chamberlain, 1992). Working from a strengths perspective does not mean counselors ignore a client's weaknesses. To do so would demonstrate a

lack of wisdom, because acknowledging weaknesses is an important step when planning for success (Cowger, 1992). Focusing on client strengths sets this approach apart from other methods of "helping," and may do much to change the way counselors perceive their clients. Just as "the language of pathology and deficit gives voice to particular assumptions and leads to certain ends" (Saleebey, 1992, p. 3), so may the same be true about the language of strength.

Statement of Purpose

This study was intended to develop a profile of graduate students in the rehabilitation counseling program at ESU. These students, having diverse backgrounds and aspirations, have been trained, in varying amounts, in the rehabilitation philosophy, which emphasizes perceiving each client holistically and as a unique individual. In addition, these students should have been exposed to variations of a strengths perspective in most, if not all, rehabilitation-specific classes. A profile of rehabilitation counseling students ought to impart information that could be valuable to the program. Knowing the profile of current rehabilitation counseling students could benefit future program development. "The ultimate objective in gaining an understanding of attitudes is to enable the development of means by which to change those determined to be negative, thereby alleviating the basis of deleterious behaviors" (Chubon, 1992, p. 306). Emener, Tannenbaum, and Cady (1990) stress the importance of this type of research, stating that "it is critical for rehabilitation counselor education...to continue to investigate and explore rehabilitation counselor preparation and development phenomena" (p. 122). This research attempted to do just

that, by exploring rehabilitation students' perceptions of causal attributions about a simulated client.

Statement of Hypothesis

The subjects of this study, as described above, came from a variety of life experiences and have just as diverse hopes and plans for the future. Each was at one of several stages in the progression of the rehabilitation counseling program. These statements introduce several demographic variables, discussed previously, which may or may not influence the ways in which students attribute causes about clients' problems. The null hypothesis is that demographic variables are not significant in determining causal attributions (as measured by Russell's (1982) Causal Dimension Scale; see chapter III). The alternate hypothesis is that demographic variables are significant in determining causal attributions.

Statement of Significance

"The foremost barrier to equal opportunity [for people with disabilities] is an insidious obstacle: negative attitudes and unfounded beliefs, invisible and often disguised" (Kilbury, Benschhoff, & Rubin, 1992, p. 7). In a similar vein, Katz (1981) states, "characteristics of the audience will be more important than the behaviors of the individual in determining whether the latter will be typed [i.e., labeled] as deviant" (p. 122). The researcher attempted to explore the dynamic interplay between the socialization process that produces negative attitudes toward people with disabilities, personal characteristics of rehabilitation students, the effects of rehabilitation counseling

training and other student-related variables, and the attributions made about the clients most likely to be seen within a rehabilitation setting. Batorski and McAlpin (1992) claim that "an objective base of knowledge... includes an emphasis on developing self-awareness...by incorporating an understanding of cultural, physical, psychological, and sociological factors" (p. 259).

Since 1969, a number of studies have been conducted about rehabilitation counseling students. Emphases have been placed on students' levels of functioning, program choices, occupational outcomes, personal attributes, career goals, and even attitudes toward computers (Crimando & Bordieri, 1991; Emener, Tannenbaum & Cady, 1990). This researcher has found no published study of causal attributions made by rehabilitation counseling students about clients and their issues, based upon socialization in a society which fosters negative attitudes toward individuals who have disabilities, and demographic variables specific to students. "Determining the skills and knowledge required for professional practice" has been emphasized (Ebener & Wright, 1991, p. 82), but attitudes and attributions about clients have not, yet there is a call to determine how attitudes "are acquired and strengthened" (Chubon, 1992, p. 305). Examining demographic variables may give some insight into this. Also, Harris (1992) claims that until one's own attitudinal barriers have been confronted and dealt with, "one's effectiveness in this field [of rehabilitation] is lessened" (p. 208). Therefore, considering the profound effect of societal influences on attitudes toward and perceptions of people with disabilities, and that rehabilitation counseling students are not immune to those influences, this researcher believes this study to be vital to rehabilitation counselor education.

Summary

Attribution theory purports to determine ways people use to explain causes of unexpected events and outcomes; that is, it claims to uncover ways people answer the question "why?" Betancourt (1990) and Graham (1990) have shown that the causal attributions one makes are influenced in part by one's attitudes. Rehabilitation counseling students, being products of society, have been subjected to the same attitudes of prejudice, stereotyping, and devaluation toward persons with disabilities as has the rest of the general population. However, training in graduate level rehabilitation counseling may have had a moderating effect on these attitudes which, in turn, ought to have a similar impact on their perceptions and attributions about clients' problems. This study was intended to explore this possibility.

CHAPTER II

Literature Review

There are several issues surrounding the lives of people with disabilities, and about which much has been written. The following review will touch upon these issues, and will demonstrate how they are relevant to the study of attribution and students' perceptions of people with disabilities. The issues included herein are stigma, myths and stereotypes, personal appearance, the phenomenon known as spread, and professional attitudes toward people with disabilities, followed by a discussion of attribution theory.

Stigma

Thirty years ago, Goffman (1963b) explained that stigma is a residual reflection of the practice carried out in ancient Greece, where captured runaway slaves, criminals, and other unsavory sorts were branded or otherwise permanently marked, thus bearing an identifying stigma by which everyone would instantly recognize them as people to be avoided. Today, in United States (US) society, there are no longer slaves, and criminals have legal rights, but stigma of various groups remains, often implicitly and unconsciously. A partial listing of stigmatized states or traits includes: "old age, paralysis, cancer, drug addiction, smoking, crime, homosexuality, unemployment, being Jewish, obesity, blindness, epilepsy, receiving welfare, illiteracy, divorce, ugliness, stuttering, being female, poverty, being an amputee, mental retardation, and deafnessAll of [these] generate ridicule and scorn" (Stafford & Scott, 1986, p. 97). Also, all of these may be addressed, directly or indirectly, by rehabilitation counselors.

Stigma is a social construct, not a quality of an individual. There is nothing "inherent" in any person to qualify him or her as stigmatized. "Instead, people qualify as stigmatized only within the context of... culture, historical events, or economic, political, or social situation[s]" (Ainlay, Coleman, & Becker, 1986, p. 4). Scott and Miller (1986) say that "stigmatization is a form of stereotyping,...an expression of social control processes,...a form of social comparison, or labeling" (p. xii). In order to understand any stigma, it is necessary "to identify relevant stereotypic beliefs that exist in association with [that stigma]" (Crocker & Lutsky, 1986, p. 77). This will be discussed in more detail below.

People with disabilities are recipients of stigma, and it is often expressed through ambivalent behaviors by the nondisabled. Although verbally expressed attitudes toward people with disabilities tend to be positive, "deeper, largely unconscious feelings are often rejecting.... There is evidence of a general desire to avoid [people with disabilities]" (Katz, 1981, p. 17). This is but one example of the pervasive nature of stigma in society. Another example is the fact that people who are stigmatized also stigmatize others. People with disabilities also incorporate and mirror social norms of perfection by "comparing the severity of their disabilities, but not only in assessing their relative degrees of functional capacity. The ranking becomes a matter of self-respect as well. Culture coerces" (Perin, 1988, p. 156).

Stigmatization has gained legitimacy through social scientists who claim it is only human, or "'natural,' to perceive and rank differences between ourselves and others[,]...to perceive a them and an us" (Ainlay, Coleman, & Becker, 1986, p. 5, italics deleted).

For the person with a physical disability, the stigma of a deformity elicits emotional responses (Bernstein, 1990) and unusual reactions (Weiner, 1986), most often from the nondisabled, often leading to social rejection and isolation. The stigma also reduces the person from one who is whole to one who is tainted, from a usual to a discounted being (Goffman, 1963b). To be discounted means that the individual, in the minds of the nondisabled, is reduced to the status of being a nonperson (Goffman, 1963a) or, at best, as children (Perin, 1988). By making the person with a disability a nonperson, the nondisabled person feels free to focus on deficits and inabilities (Katz, 1981), thus legitimatizing the stigma. "Normal" people distance themselves from people with disabilities by freezing them "in a familiar system of meaning and conduct--the one reserved for children....because children are imperfect adults: the same concepts constitute their meanings--dependent, uncontrolled, unpredictable, and immature (Perin, 1988, p. 157-158, emphasis deleted).

Stigmatized individuals evoke "causal search and attributions from others" (Weiner, 1986, p. 142), after which there is little need to search further for causes or reasons about any event in the lives of such persons (Weiner, Perry, & Magnusson, 1988). This statement suggests the way in which stigma creates curiosity about "nonpersons," the surface satisfaction of which is enough for the nondisabled to make assumptive stereotypes. How one perceives the causes of stigma determines one's emotional reactions and behavioral responses. For example, if one determines a controllable attribution for a disability, the reaction toward that person most likely will be anger, and the response will be neglect. However, if the attribution is perceived to be uncontrollable,

pity and help are the likely results (Weiner, 1986). Inasmuch as stigma is related to failure (Weiner, 1986), a perceived stable attribution for that stigma can result in "future expectations of failure" (p. 222).

This author believes that if future--not to mention present--rehabilitation counselors harbor conscious or unconscious "expectations of failure" about those they serve, the stage is set for possible conflict between client and counselor as they set goals, creating struggle where empowerment should exist.

Myths and Stereotypes

There are several explanations about why and how perceptions about others are formed. One explanation is the motivational perspective, which embraces the just-world theory, according to which people become victims of undesirable conditions because they deserve it. Crocker and Lutsky (1986) argue that this theory is held by many people because thinking that "'bad things happen to good people' would lead to unacceptable feelings of vulnerability" (p. 103).

Another explanation is the sociocultural perspective. All societies decide what is normal for their members, what is ordinary and expected in, for example, what people should look like and how they should behave (Goffman, 1963b). Attitudes, perspective, and stereotypes of normalcy are aspects of any given culture, transmitted from one generation to the next through the process of socialization (Crocker & Lutsky, 1986; Goffman, 1963b). Expectations of normalcy, of what is obviously natural, are so pervasive that one is not aware of having them until confronting an individual who does not meet them. "Because so much of culture is unconscious...one may not think about or guard against [stereotypical]

attitudes at all" (Holmes & Karst, 1990, p. 21). The socialization process passes on cultural beliefs, values, and norms from birth throughout one's lifetime, the purpose of which is "to keep the society supplied with qualified members" (Lebra, 1976, p. 137). Children learn which groups are stigmatized through parents, teachers, books, movies, TV, "and other socializing agents. This...suggests that there will be widespread agreement...[about] which groups are stigmatized...[and] stereotyped" (Crocker & Lutsky, 1986, p. 101).

A third explanation is the cognitive perspective. Training in what is normal includes pointing out that which is considered abnormal. As members of a given culture, perceptions of others become automatically, unconsciously, and "naturally" selective (Townsend, 1990/1979), and stimuli received about others is quickly sorted into categories (Lippmann, 1930). Categorizing and stereotyping are viewed as normal consequences of the sheer amount of incoming stimuli. People vary one from another on an "infinite number of dimensions, [but] the perceiver's information-processing capacities are limited. Consequently, people need to simplify and organize social information" (Crocker & Lutsky, 1986, p. 104). This process of selective sorting leads to the stereotyping of others, which is a universal cognition, serving "to define the boundaries and relations between groups" (Townsend, 1990/1979, p. 103). While defining boundaries, stereotyping also fosters the formation of myths and assumptions about stigmatized groups. It also permits people to develop beliefs (Crocker & Lutsky, 1986) and infer characteristics (Holmes & Karst, 1990) about others without ever meeting, learning about, or getting to know any individuals from a stigmatized group.

Myths about people with disabilities permeate society, affecting the way they are treated by the nondisabled (DeLoach & Greer, 1981) and by other people with disabilities (Myerson, 1990/1988). The effects of these myths and stereotypes are often more disabling than the disability itself (Nagler, 1990) and have come to be termed disabling myths (DeLoach & Greer, 1981). Many disabling myths pervade US society, but several in particular are directly related to attributions made by an observer about a person who has a disability. One is that the "disability is located solely in biology" (Fine & Asch, 1990/1988, p. 64). Another is that "when a disabled person faces problems,...the impairment causes them" (p. 65). Still another is that the person's response to his or her "situation is a direct expression of his [or her] defect" (Goffman, 1963b, p. 6). These are only several examples of disabling myths, many of which reflect a dispositional attribution. Myths and stereotypes are used to explain the underlying perceived causes of attributions applied to behaviors of and outcomes for people with disabilities (Betancourt, 1990), and serve to keep the boundaries between people with disabilities and the nondisabled intact and solid.

There are consequences of myths and stereotypes that surround and support stigma, and consequences for people to whom stereotypes are applied. As previously mentioned, people with disabilities often elicit the emotion of pity in the nondisabled population (Bernstein, 1990), pity being associated with perceptions of uncontrollability which, when communicated, "could serve as a cue promoting the self-perception of difference deficiency, and inadequacy" (Weiner, 1986, p. 137). Myths are self-perpetuating, and often lead to self-fulfilling prophecies in that people with disabilities also believe the myths and learn to devalue

themselves (Matte, Crisler, Cambell, & Woodruff, 1991) and others with disabilities. This is referred to as "the suggestive influence of the majority [under which] most of the victims [of stigmatizing myths] themselves succumb to the same prejudice and regard their brethren [sic] as inferior beings" (Einstein, 1949, p. 78). There is little room in myths and stereotypes for situational attributions, but it has been noted that when people with disabilities "control their environment, [they] may not be...handicapped" (DeLoach & Greer, 1981, p. 52). Efforts by rehabilitation counselors, and training in rehabilitation counseling, therefore, ought to focus on ways that people with disabilities can, and do, control their environments to create and maintain personal dignity and integrity. The myth is that people with disabilities must utilize special techniques (e.g., always putting the nondisabled at ease, [Marini, 1992]) because of their stigmatizing stereotypes. Perhaps such is an example of the subtlety of disabling myths.

Appearance

When unexpected or troubling events occur, some ideas come to mind before others as to the cause of that event (Dumont & Lecomte, 1987). One idea that may come to mind immediately about someone is his or her appearance. Physical appearance is, mostly, unconsciously important. When an individual presents himself or herself with an appearance that is acceptable, no thought is given to it by onlookers. On the other hand, when the person deviates from socially regular or average appearance, notice of him or her is instant (Goffman, 1963a). There is a tendency on the part of most people "to pay more attention to salient features of... other people" (Dion, 1986, p. 16). DeLoach and Greer (1981) have

described appearance as encompassing "several areas of impression, including manner of dress, general physical stance, and overall facial expressions" (p. 233). Goffman (1963a) includes "dress, bearing, movement and position, sound level, physical gestures such as waving..., facial decorations, and broad emotional expression" (p. 33).

In US society, all the media define physical attractiveness. People consciously know and agree that media-defined beauty is the exception; nevertheless, the values held about beauty and attractiveness unconsciously reflect this largely unobtainable ideal (Bernstein, 1990). "Our culture teaches us that physical beauty is both important and desirable" (Reis, Nezelek, & Wheeler, 1980, p. 605). As part of this unconscious embracement is a "commonly held stereotype that there is an important connection between inner and outer beauty" (Langlois, 1986, p. 23). An attractive appearance is "inconsistent with physical disability" (Kaiser, Freeman, & Wingate, 1990/1985, p. 36). Although most people are restricted in the amount of control they have over appearance management, people with disabilities are often even more limited. Given that appearance management is a form of non-verbal communication (Kaiser, Freeman, & Wingate, 1990/1985), people with disabilities sometimes are at a particular disadvantage, because non-verbal communication may be limited, unintentional, or non-existent if the person's ability to control various body parts is restricted (Goffman, 1963a).

That which can be perceived about another person through the eyes, whether near or at a distance, is an impression which may or may not be confirmed (or disconfirmed), depending in part on prior knowledge and/or the level of relationship one has about and with the observed individual.

"It is through our sense of sight that the stigma of others most frequently becomes evident" (Goffman, 1963b, p. 48). The disability of one person can create anxiety in another person. With regard to appearance, Hahn (1990/1988) introduces the concept of "aesthetic anxiety" which, he says, comes about because "disabled individuals...do not present conventional images of human physique...[and] may result in a tendency to place those who are perceived as different or strange in a subordinate role" (p. 120). Visible disability, being readily noticed, often results in the person with a disability being reduced to a thing, and "the contents of an individual who is visibly marred are devalued" (Bernstein, 1990, p. 131, emphasis in original). Likewise, Vash (1981) argues that "people tend to see and respond to the clutter of a wheelchair, crutches and braces, or other appliances in evidence before they see and respond to the individual using them" (p. 45, emphasis in original).

Studies have shown, repeatedly, that there is a methodical reaction to the appearance of others, which is then evident in attitudes and beliefs extended toward those being observed (Cash, 1990). If there is a salient visible factor, such as an obvious physical disability, there is also a tendency to bias or distort attributions toward that factor (Zimbardo & Leippe, 1991). "One's attractiveness or lack of it is a sufficiently potent external cause to preclude more dispositional attributions about character, intelligence, personality, wit, charm, or mystery" (Reis, Nezlek, & Wheeler, 1980, p. 615). Appearance becomes a complex issue, touching upon a dispositional bias about the person--but about his or her surface characteristics, to the detriment of positive inner qualities. In addition, attributions which are biased toward a disability imply that the disability is the cause of an event, rather

than aspects of the environment (Miller, 1982). The seriousness of such distortion is explained by Jones, et al. (1984):

The most devastating attributional pattern is one in which the failure is perceived as global, stable, and internally caused. Examples are attributional assumptions concerning...physical unattractiveness. As explanations for failure, they are global ones, in that they apply to a broad range of situations. They are stable because they are unlikely to change, and they are internal because they refer to a specific characteristic of the person that most others do not share (pp. 249-250).

Spread

As noted above, one of the aspects of stigma is that when it is "very visible" (Goffman, 1963b, p. 49), it is immediately apparent to all who come into visual contact with the stigmatized individual. As a result of this ready information, people tend to superimpose other disabilities onto that person, presuming an array of nonvisible deficiencies simply on the basis of what is seen (Katz, 1981). This is the phenomenon known as "spread" (Wright, 1983). Of course, spread is not limited to persons with visible disabilities, but applies in all cases where a stigma is known about, even when the original source of stigma no longer exists (Goffman, 1963b); for example, beliefs about a former patient of a mental hospital. In addition, applying the concept of spread to people with disabilities is not limited to the nondisabled population. As part of society, people with disabilities are not immune to the prevailing attitudes and stereotypes. As such, they are generally subject to making inferences about people with "different or more severe disabilities" (Myerson, 1990/1988, p. 18).

Spread is an inferential phenomenon. Attributing additional, speculative disabilities to someone results in assumed expectations and perceptions about that person (Warr & Knapper, 1968). For example, many people perceive that a person's competence is low if he or she has a disability (Vash, 1981), and being perceived as incompetent, the person is assumed helpless (Fine & Asch, 1990/1988). To take the spread effect one step further, when assumed incompetence and helplessness are ascribed to someone on the basis of disability, the subsequent (presumed) dependency of that person is attributed to uncontrollable factors (Graham, 1990). Again, emotions of pity and responses of giving assistance are the result of this attribution. For many people, the stigma of disability is enough to approve of aid from a distance, such as welfare for the disabled, because the target of pity is believed to be incapable of meeting his or her own needs, regardless of the veracity of that belief. Rehabilitation counselors, however, must work directly with people who are subjected to demeaning stigmatization, myths, and stereotypes, the effects of which are made manifest in the phenomenon of spread. It becomes pertinent, therefore, to examine the attitudes of professionals trained to work with a stigmatized group, or groups, of people.

Professional Attitudes

It has been established that counselors and other professionals, in general, regard clients' problems as dispositional, whereas clients and laypersons tend to regard their problems as situational (Snyder, Shenkel, & Schmidt, 1976). It seems that clinicians believe clinical assessment is an accurate measure "of problems that arise from systematic social

injustice" (Myerson, 1990/1088, p. 19). Unlike the layperson, counselors are usually trained to focus on the client rather than his or her situation, and so collect information about the person rather than his or her environment. This action tends to be based upon the knowledge that available resources are directed toward changing people (Lopez & Wolkenstein, 1990) instead of "social environments that breed poverty, crime, depression, and despair" (Batson, O'Quin, & Pynch, 1982, p. 71). When helpers attribute the behavior or problems of others as dispositional, even while claiming an understanding of situational factors that often produce such behavior, the result is what is referred to as "blaming the victim" (Zimbardo & Leippe, 1991).

Rehabilitation counselors, although trained to examine environmental and situational factors in clients' lives (Roessler & Rubin, 1982), are also raised in society, which is biased against persons with disabilities. Two manifestations of the devalued status of people with disabilities are: 1) professionals treat clients according to their disabilities to the exclusion of other characteristics; and 2) as a result, the personal potential of clients is therefore underestimated or altogether negated (DeLoach & Greer, 1981). These authors explain that, in rehabilitation, devaluing attitudes of professionals toward people with disabilities stem from "continuing adherence to the medical model... which has as its goal the physical restoration of disabled persons...and is based on the [premise] that when a person has a disability, something can be done to reduce or eliminate [it]" (pp. 61-62). Not being able to cure or fix the disability, the stigma of disabled persons is passed along to the professionals who work with them. Deifying normalcy, a product of the socialization process, interferes with professionals'

being able to "differentiate between what is desirable and what is necessary in human appearance and behavior" (DeLoach & Greer, p. 43). This happens when counselors are unable to look beyond the label "disabled," which causes them to "exclude experience altogether" (Reinharz, 1984, p. 359). Certainly one would not expect rehabilitation professionals to knowingly express such attitudes; however, if the attitudes are present in the counselor, they are "debilitating" to clients (Kilbury, Benshoff, & Rubin, 1992).

Impressions of clients, subsequent diagnostic ideas, and sometimes formal diagnostic decisions are often made within the first few minutes (Sandifer, Hordern, & Green, 1970) or even seconds (Gauron & Dickinson, 1969) of observation (cited in Waxman, Rapagna, & Dumont, 1991). Accounting for a client's problems is "a frequent precursor of initiating therapy (Brewin & Antaki, 1982, p. 24), but counselors need also to be aware of possible differences between their own and their clients' attributions for a given problem. As an outsider, the professional's perception of a cause is inferred, and as such it is imposed upon the client (Weiner, 1986). Even if a dispositional attribution is a privately held opinion of the counselor, the client becomes vulnerable to manipulation (Cowger, 1992). In contrast, the more a counselor or other professional can empathize with a client, the more he or she attributes causes similarly to those perceived by the client. "'Putting yourself in the other person's shoes' is an effective procedure in changing the locus of attribution for a problem" (Snyder, Shenkel, & Schmidt, 1976, p. 471).

Attribution Theory

"Why?" is a universal question, asked in abundance by scientists, physicists, and 4-year-olds. Asking why is a completely natural response

in unfamiliar situations and to unexpected outcomes or events (Wong & Weiner, 1981). People search for causes of behavior--their own and others'--through the use of ordinary, everyday explanations (Antaki & Brewin, 1982). This, in essence, is the basis of attribution theory. As part of the socialization process, people learn to attribute causes to outcomes and behavior (Chubon, 1992).

Attribution theory, as proposed by Weiner (1986), rests on three bi-polar dimensions: internal vs. external locus of cause, stable vs. unstable cause, and controllable vs. uncontrollable cause. Other dimensions (e.g., global vs. specific, intentional vs. unintentional) have been reported, and there may be others as well, but locus, stability, and controllability have been consistently documented (see review in Weiner, 1986).

Locus of cause pertains to where the cause is perceived to be located, either within or outside of the person in question. An internal locus is considered to be a characteristic of the individual, and is termed "dispositional." An external locus has to do with something in the situation or environment, and is termed "situational." The locus of a cause has an influence on one's self-esteem (Weiner, 1986). Stability has to do with "perceived variability...or permanency...of the causes of behavior" (Lopez & Wolkenstein, 1990, p. 107), and influences future expectations, whether about one's self or someone else (Weiner, 1986).

Controllability is further divided into sub-dimensions. It "considers the degree to which the causes are perceived to be under control of the individual" (Lopez & Wolkenstein, 1990, p. 108), and influences emotions felt by self or others. For one's self, "internal, controllable causes of personal failure promote feelings of guilt,

whereas internal, uncontrollable causes generate shame....Among affects directed toward others are anger [when the perceived cause is controllable, and]...pity [when the cause is thought to be uncontrollable]" (Weiner, 1986, p. 164; see also Weiner, Graham, & Chandler, 1982). In addition, there are self-blame reactions which are separated along the controllability dimension: behavioral blame, which is controllable (e.g., "I should have worn my seat belt."), and characterological blame, which is uncontrollable (e.g., "I'm not a good driver.") (Janoff-Bulman, 1979).

Applying attribution theory to academics, which is where most studies have so far been conducted (see Graham & Folkes, 1990), Weiner (1986) illustrates the three dimensions of causality as follows:

Intelligence and study habits are perceived as stable, whereas mood and luck are unstable; exam preparation and study habits are internal, whereas teacher effort and exam difficulty are external; exam preparation and mood are perceived as controllable, in contrast to luck and test-taking ability, which are believed to be uncontrollable (p. 54).

Attribution theory is applicable in the field of counseling, because counselors, in working with clients, do look for "causal antecedents of the problem" (Dumont & Lecomte, 1987, p. 435). A counselor's perceptions of causality have been shown to be related to plans for intervention (Weiner, Perry, & Magnusson, 1988). If the cause is perceived to be dispositional to the client, intervention is focused upon a change in the client; a situational attribution leads to directly changing or helping the client take steps to change the environment (Batson, O'Quin, & Pynch, 1982).

Summary

When the cause of an outcome is not readily apparent, or not easily discernible, people tend to overestimate dispositional and underestimate situational factors. "We are too ready to read personality and character traits into the behavioral drama and too resistant to see stage settings as the basis for action" (Zimbardo & Leippe, 1991, p. 23). This tendency is predominant in US society and may be reflected in counselors' and other professionals' attitudes and causal perceptions of clients with disabilities. Even though rehabilitation counselors "have been trained to think and act from other perspectives,...myths and elements of myths may influence the human mind so subtly that counselors may be unaware of mythical thinking in themselves" (Holmes & Karst, 1990, p. 20). The perception that, for the disabled person, all of his or her problems are a result of his or her disability is a demonstration of the effects of stigma, disabling myths, and spread. A professional attitude that perceives a disability to be an uncontrollable cause of all subsequent failures of the individual (Weiner, 1990) is far more disabling to the person than looking with the client at his or her environment for causes (Watts, 1982). Although for some individuals, their disability may be the focus of counseling, for most, the problems they experience in psychosocial, interpersonal, or vocational areas are generally unrelated to their disabilities (Vash, 1981). Counselors who attribute the presenting problem of a client who has a disability to internal, stable, and uncontrollable factors may be doing a great disservice to the client, because that combination of dimensions can constitute an "artificial focus in their counseling efforts" (p.188).

CHAPTER III

Method

In the rehabilitation counseling program at Emporia State University (ESU), there is continual emphasis on looking at rehabilitation clients holistically--at both limitations and strengths of clients, with a view toward assisting the individual in securing gainful employment. Although living independently is addressed as a goal for some clients, most of the training at ESU is geared toward the vocational rehabilitation of persons with disabilities. As possible future vocational rehabilitation counselors, students must learn to dispel the myths about people with disabilities held by potential employers of such persons. The following chapter discusses the method used to ascertain attributions made about the problems presented by people with disabilities by students in the rehabilitation counseling program at ESU who, as a matter of course, have been exposed to and trained in the emphases previously described.

Population

In the United States (US), the general public is socialized in much the same way regarding people with disabilities (DeLoach & Greer, 1981). Students in rehabilitation counseling generally come out of the same culture as everyone else, and yet they are trained to work positively with, and present in a positive light to future employers, individuals who have been stigmatized by the stereotypes about disabilities. Because graduate rehabilitation counseling programs at other universities may vary in their training, the population for this study consisted only of

the students enrolled during the Spring 1993 semester in coursework (i.e., not enrolled in their internships) in Rehabilitation Counseling at ESU. (This is the graduate program. The undergraduate program is called "Rehabilitation Services.")

Every semester at ESU, there is at least one class which is required for all rehabilitation counseling students and which, therefore, is usually attended by a majority of current students. Arrangements were made with one professor to take time over three consecutive class periods in one such class to collect data from those students who would agree to participate in the researcher's study. At the beginning of one class period the researcher explained that she wished to collect data for her thesis from the rehabilitation counseling students, and asked for volunteers. Students from the described population who were not enrolled in this particular class were contacted personally by the researcher, and were asked to participate if they so desired. Two additional students agreed to participate. The researcher explained that the study would begin in two weeks' time, allowing for three consecutive class periods.

Instrument

The instrument for this study was Russell's (1982) Causal Dimension Scale (CDS), used to learn how students in rehabilitation counseling at ESU perceive the cause of a client's presenting problem. The CDS was originally designed to measure causal attributions one perceives in one's own life, for a variety of events or outcomes (Russell, 1982). The causal attributions made for events in one's own life are equally applicable to explain events in another person's life (McArthur, 1972).

The CDS was slightly modified, therefore, by changing the word "you" to "the client." An example of the CDS, modified for this study, is in Appendix A.

Chubon (1992) asserts that "measurement approaches only have potential validity if the concepts to which they supposedly relate are demonstrated to be valid" (p. 306). The CDS measures three domains of attribution theory which have been so demonstrated. Over a period of seven years, studies of various designs were conducted to determine and verify domains of causal attributions that people naturally draw upon to explain events and outcomes (Weiner, 1986). Stability and control were represented in most of these studies, and locus of causality was represented in every study.

Reliability and validity studies for the CDS have been positive. McAuley and Duncan (1990), Russell (1982), and Russell, McAuley, and Tarico (1987) show reliability coefficients of well over .7 for locus and over .8 for stability. Reliability for control is not as high; just over .5. One reason for this lower coefficient could be that the domain of control branches off twice, and it is not as clear-cut as locus and stability. However, Murdock and Fremont (1989) have found "significant relationships...between locus and controllability" (p. 419). Russell, McAuley, and Tarico (1987) also show significant construct validity for all three domains on the CDS.

At the top of each CDS was a copy of one of two photographs of a woman. For this study, a female model was used because women make up the largest minority group, worldwide. Although minority, very strictly speaking, is defined as smaller in number than the majority, this

definition is inadequate when referring to women as a minority group.

Wilkens (1992) describes how women, over time, have come to be an

oppressed minority:

Over time humans have socially constructed systems of domination by attaching cultural and political meanings to several physical...characteristics [which] have come to be linked with categorical constructs that...have been put forward as 'natural' and that incorporate expectations for dominant or submissive behavior...: gender constructs men...over women (p. 6-7).

Thus, women are doubly discriminated against when they have a disability.

When we look at a person with a disability (...especially if female), we

seldom see a future pharmacist, a CEO, a teacher, a chemist, or hundreds

of other occupations" (Harris, 1992, p. 209). In one photograph, the

woman was dressed in business attire, merely standing. In the other

photograph, the same woman was wearing the same clothes, but was sitting

in a wheelchair. A wheelchair was used because it is the international

symbol for disability, and there is "a common understanding of the basic

functional limitations of people who use [them]" (Katz, 1981, p. 35).

Harris (1992) states that "one of the most important indices of arriving

and belonging in this society is viable and gainful employment" (p. 207).

Because of the importance of achievement in the US (Weiner, 1986), there

is a tendency for many people to infer "traits of personal inadequacy to

the...jobless" (Katz, 1981, p. 121). Therefore, under each photograph

was the sentence "This woman has been trying unsuccessfully for six

months to find a job." Research shows that people naturally ask "why"

when negative events happen (Wong & Weiner, 1981), especially in achievement-related contexts (Weiner, 1986); therefore, that the subjects would perceive there to be a cause for the woman's situation was presumed.

Design

The interest of the researcher was to discover how students in rehabilitation counseling at ESU attribute cause about a very possible situation in the lives of future clients. In order to obtain a profile of current students, the research was descriptive, using the A-B-A single-subject design. The group itself was an n of one. Using the CDS, subjects attributed causes of the presenting problem of a woman in two photographs. The first photograph (the woman standing), was viewed the first week to get a baseline score (A), the second photograph (the woman sitting in the wheelchair) was shown the second week (B), and the first photograph was shown again the third week (back to baseline A). This method is explained more fully below.

Research Question

The research question of this study is, "Do graduate students in rehabilitation counseling at ESU vary in the attributions they make about the cause of a client's presenting problem, and if so, what demographic variables among them might be associated with this variance?"

Procedure

Students who agreed to participate in this study were already gathered together, with the exception of the additional students who

agreed to come to that room at a pre-arranged time, which was arranged with the professor to occur right before the class break. After all participating students were seated, the researcher distributed informed consent forms, which were then signed and collected. After collecting the consent forms, a demographic sheet was distributed. The students were told that all of the information was vital to the research, and were asked to answer all questions honestly. The researcher asked the students to write the final four digits of their social security numbers in the top right corner of the demographic sheet, in order to match them anonymously with the forms that would follow. However, assurance was given regarding the confidentiality of all information. A copy of the demographic sheet is shown in Appendix B.

After completion, the demographic sheets were collected and the first CDS distributed. This first CDS had the photograph of the nondisabled woman at the top. The students were instructed to put the last four digits of their social security numbers in the top right corner of the CDS. After completion of this CDS, the students were reminded that "part two" would take place the following week, and were then free to go on break.

The following week at the same pre-arranged time, the second CDS was distributed, which had the photograph of the woman sitting in a wheelchair at the top. The students were reminded to put the last four digits of their social security numbers in the top right corner of the form. When they had completed the second CDS, students were reminded that the final collection day would be the following week, and were then free to go on break.

The third week, unforeseen events occurred which made it necessary to collect data in other classes. The professors of these classes were made aware of the change and were willing to allow the researcher time to complete the data collection. In each class, the final CDS was distributed, which again had the first photograph of the nondisabled woman at the top. Students were again reminded to put the last four digits of their social security numbers in the top right corner of the form. When they had completed this final CDS, the students were thanked for their participation. After all data had been collected, the demographic sheet and CDS forms were matched by the students' numbers, which were then cut off and discarded, and which were replaced with the numbers 001, 002, 003, etc.

The results of the CDS scores were analyzed visually rather than statistically, using tables to present differences for each demographic variable. Because this was intended to be preliminary, descriptive research, replication is necessary in other studies before any attempt at generalization can be made.

Summary

At ESU, students in the rehabilitation program are trained in the philosophy and process of vocational rehabilitation. As professionals, these students will counsel and work with people with disabilities, a minority population which is surrounded by myths and stereotypes. In addition, students are expected to address stereotypes about people with disabilities that possible future employers also hold.

Using the CDS to measure attributions, the rehabilitation students rated two photographs of a woman who supposedly had been unable to secure employment. The woman represented a possibly typical client seen in a vocational rehabilitation setting. By viewing the first photograph, then the second photograph, and then the first one again, the subjects rated the client's presenting problem. The researcher figured the score showing the difference in attributions between photographs A and photograph B. This difference score was then compared against the previously described demographic variables to ascertain whether or not there is an association between any of these variables and difference scores on the CDS.

CHAPTER IV

Results

An analysis of the data gathered to test the hypothesis in Chapter I is presented in this chapter. Each demographic variable has its own table, where difference scores are presented according to locus of causality (Locus), stability (Stab.), and controllability (Control). Given the A-B-A design of this study, "A" was the photograph of a woman wearing business clothes, merely standing, and "B" was the photograph of the same woman in the same clothes, but sitting in a wheelchair. The mean scores for A-1 and A-2 were averaged. Mean "B" scores were then subtracted from the A-1/A-2 average to determine the difference score for each domain, representing the difference in how the subjects perceived the cause of the problem from photographs A (woman standing) to photograph B (woman sitting in a wheelchair). Higher scores mean the cause was perceived to be "internal, stable, and controllable" (Russell, 1982, p. 1143). It is the difference scores which may be associated with certain demographic variables, and which are therefore shown in the tables that follow. Complete tables of mean scores are in Appendix F.

Analysis of Data

The study used a sample of 23 rehabilitation counseling students at Emporia State University, representing 66% of the total population of 35 students in the program. Difference scores for the total sample are shown in Table 1.

Table 1

Total Sample Difference and Standard Deviation Scores

	Difference	Standard Deviation
Locus	.75	1.47
Stab.	-.75	1.53
Control	.50	1.56

Difference scores were .75 for locus, -.75 for stability, and .50 for controllability. The standard deviation for locus was 1.46, for stability 1.53, and for controllability was 1.56.

Of the total sample, 57% (n=13) were female, and 43% (n=10) were male. The difference scores by gender are shown in Table 2.

Table 2

	<u>Gender</u>	
	Females (n=13)	Males (n=10)
Locus	.35	1.20
Stab.	-.60	-.90
Control	.10	.95

Difference scores of the females for locus were .35, for stability were -.60, and for controllability were .10. Among the males, the difference scores were 1.20 for locus, -.90 for stability, and .95 for controllability. These scores show that males perceived the cause of the woman's presenting problem as more internal, temporary, and controllable than did the females.

Table 3 presents the difference scores according to work history. Of the total, 43% (n=10) had experience related to rehabilitation, while 57% (n=13) did not have any rehabilitation-related work experience.

Table 3

	<u>Work History</u>	
	Rehab (n=10)	Non-rehab (n=13)
Locus	.90	.55
Stab.	-1.00	-.45
<u>Control</u>	<u>.85</u>	<u>.20</u>

Note. Rehab = Rehabilitation.

Among those with previous work experience in rehabilitation, the difference scores were .90 for locus, -1.00 for stability, and .85 for controllability. Those without previous experience in rehabilitation had difference scores of .55 for locus, -.45 for stability, and .20 for controllability. These results indicate that subjects with rehabilitation related work experience perceived the client's problem as more internal, temporary, and controllable than did those without previous work experience in rehabilitation.

In Table 4 is shown the difference scores according to the subjects' current work status. Of the total sample, 61% (n=14) were currently working, and 39% (n=9) were not.

For those currently working, the difference scores for locus were .55, for stability were -1.05, and for controllability were .85. Among those not working, the difference scores were .95 for locus, -.15 for stability, and -0- for controllability. These scores indicate that those

who were not working perceived the woman's problem as more internal and stable, and less controllable than did those subjects who were currently working.

Table 4

	<u>Work Status</u>	
	Working (n=14)	Not working (n=9)
Locus	.55	.95
Stab.	-1.05	-.25
Control	.85	-0-

The subjects who were working were asked about their current work experiences. The total for this group was 14 (61% of the sample). Of this group, 64% (n=9) were working in rehabilitation, while 36% (n=5) were working in other fields. Mean scores for this group are presented in Table 5.

Table 5

	<u>Current Work Experience</u>	
	Rehab (n=9)	Non-rehab (n=5)
Locus	.80	.20
Stab.	-.75	-1.55
<u>Control</u>	<u>.20</u>	<u>2.10</u>

Note. n=14.

For those working in rehabilitation, difference scores were .80 for locus, -.75 for stability, and .20 for controllability. Difference

scores for those working in other fields were .20 for locus, -1.55 for stability, and 2.10 for controllability. These results show that those working in rehabilitation perceived the woman's presenting problem as more internal and stable, and less controllable than did those working in other fields.

Table 6 divides the sample according to the presence or absence of a disability. Of the total, 22% (n=5) have a disability, and 78% (n=18) do not have a disability.

Table 6

	<u>Disability Status</u>	
	Disability (n=5)	No disability (n=18)
Locus	1.20	.55
Stab.	.15	-.95
Control	.20	.60

The difference scores for those who have a disability were 1.20 for locus, .15 for stability, and .20 for controllability. For those without a disability, difference scores for locus were .55, for stability were -.95, and for controllability were .60. These results show that subjects who have a disability perceived the problem as more internal and stable, and less controllable than did those without a disability.

Data for the subjects was broken down by the presence or absence of a disability in a family member, and is shown in Table 7. Of the total sample, 35% (n=8) indicated having a family member with a disability, and 65% (n=15) said they do not have a family member with a disability.

Table 7

	<u>Family Member Disability Status</u>	
	Disability (n=8)	No disability (n=15)
Locus	.50	.90
Stab.	-1.20	-.50
Control	.90	.25

Subjects who have a family member with a disability had difference scores of .50 for locus, -1.20 for stability, and .90 for controllability. For those who do not have a family member with a disability, difference scores for locus were .90, for stability were -.50, and for controllability were .25. These results indicate that those subjects who have a family member with a disability perceived the client's problem as more external, temporary, and controllable than did subjects who do not have a family member with a disability.

The data in Table 8 breaks down difference scores by undergraduate major. Of the total, 48% (n=11) majored in rehabilitation, 26% (n=6) majored in other helping professions, and the remaining 26% (n=6) had other undergraduate majors.

Table 8

	<u>Undergraduate Major</u>		
	Rehab (n=11)	Helping Prof (n=6)	Other (n=6)
Locus	.95	1.10	-0-
Stab.	-.60	-2.15	.45
<u>Control</u>	<u>.40</u>	<u>1.70</u>	<u>-.50</u>

Note. Rehab = Rehabilitation. Prof = Profession.

The difference scores for rehabilitation majors were .95 for locus, -.60 for stability, and .40 for controllability. Of those subjects with undergraduate majors in other helping professions, the difference scores for locus were 1.10, -2.15 for stability, and 1.70 for controllability. Students who had other undergraduate majors had difference scores of -0- for locus, .45 for stability, and -.50 for controllability. These results show that those subjects with undergraduate majors in other helping professions saw the client's problem as more internal, less stable, and more controllable than did subjects in rehabilitation or other majors. Those subjects with rehabilitation majors also perceived the problem as more internal, less stable, and more controllable than did those with other majors.

Mean scores according to the number of semesters completed in Rehabilitation Counseling are shown in Table 9. Of the sample, 22% (n=5) had not yet completed a semester, 35% (n=8) had completed one semester, 22% (n=5) had completed two semesters, 9% (n=2) had completed three semesters, and 13% (n=3) had completed four semesters. (Due to rounding the percentages, this variable's total equals 101%.)

Table 9

Number of Rehabilitation Counseling Semesters Completed

	0 (n=5)	1 (n=8)	2 (n=5)	3 (n=2)	4 (n=3)
Locus	.10	1.65	.85	.10	-.50
Stab.	-.75	-.45	-1.00	-1.80	-0-
Control	-.15	1.30	-.55	1.10	.75

By semesters, those who had not yet completed one full semester had difference scores of .10 for locus, $-.75$ for stability, and $-.15$ for controllability. Those with one semester completed had difference scores of 1.65 for locus, $-.45$ for stability, and 1.30 for controllability. Those subjects who had completed two semesters had difference scores of .85 for locus, -1.00 for stability, and $-.55$ for controllability. Subjects with three semesters completed had difference scores of .10 for locus, -1.80 for stability, and 1.10 for controllability. Finally, those subjects who had completed four semesters had difference scores of $-.50$ for locus, $-0-$ for stability, and .75 for controllability.

These results indicate that subjects who had yet to complete one full semester saw the client's problem more external than did subjects with one and two semesters completed, and as more internal than did students who had completed four semesters; it was seen as less stable than was perceived by those with one and four completed semesters, but more stable than did those with two and three completed semesters; and less controllable than did subjects who had completed one, three, and four semesters, but more controllable than those who had completed two semesters. These results may be skewed by coincidence and individual idiosyncrasies, as will be discussed more fully in Chapter V.

Subjects with one semester completed perceived the client's presenting problem to be more internal to the client than did any other group, more stable than all but those with four completed semesters, and more controllable than all other groups. Subjects with two semesters completed perceived the problem as more internal than did those with no, three, or four semesters completed, and more external than did those having completed one semester; it was seen as less stable than for subjects with no, one, or four semesters completed, but more stable than

for those who had completed three semesters; and it was seen as less controllable than for any other group.

Among those subjects who had completed three semesters, their difference scores indicated they perceived the client's problem as more external than did those with one and two semesters completed, more internal than did those who had completed four semesters, and equally with those who had not yet completed a full semesters; it was perceived as more temporary than for any other group; and as more controllable than for those with no, two, or four semesters completed, but as less controllable compared to those having completed one semester. Finally, the subjects who had completed four semesters perceived the client's problem as more external and more stable than did any other group, and as more controllable than did subjects who had completed no and two semesters, but less controllable than did those who had completed one and three semesters.

The data in Table 10 breaks down the difference scores by whether or not subjects were members of the Student Chapter of the Kansas Rehabilitation Association (SCKRA). Of the total sample, 35% (n=8) were members, and 65% (n=15) were not members.

Table 10

Student Chapter of the Kansas Rehabilitation Association

	Member (n=8)	Non-member (n=15)
Locus	.90	.60
Stab.	-.95	-.60
Control	.60	.45

Members of SCKRA had difference scores of .90 for locus, -.95 for stability, and .60 for controllability. Among non-members, the difference scores for locus were .60, for stability were -.60, and .45 for controllability. These results indicate that SCKRA members perceived the client's presenting problem as more internal, less stable, and more controllable than did non-members.

In Table 11, subject difference scores were broken into groups by the stated average percentage of textbooks read for classes. Of the sample, 22% (n=5) read 25% of their texts, 26% (n=6) read 50% of their texts, 39% (n=9) read 75% of their texts, and 13% (n=3) read 100% of their texts.

Table 11

Average Percentage of Textbooks Read per Class

	25% (n=5)	50% (n=6)	75% (n=9)	100% (n=3)
Locus	1.30	.55	.35	.95
Stab.	-1.05	-.85	-.65	-.10
Control	.90	.40	.55	-.35

Subjects who read 25% of their textbooks had difference scores of 1.30 for locus, -1.05 for stability, and .90 for controllability. Of those who read 50% of their textbooks, the difference scores for locus were .55, for stability were -.85, and .40 for controllability. Among those who read 75% of their textbooks, the difference scores were .35 for locus, -.65 for stability, and .55 for controllability. For those who read 100% of their textbooks, the difference scores were .95 for locus, -.10 for stability, and -.35 for controllability.

Results show that those who read 25% of their texts perceived the client's problem as more internal, more temporary, and more controllable than did all other groups. Those who read 50% of their texts saw the problem as more external than did those reading 25% and 100% of their books, but more internal than did those who read 75% of their books; the problem was seen as more stable than for those who read 25% of the texts, but less stable than was perceived by those reading 75% and 100% of the texts; it was seen as less controllable than for those who read 25% and 75%, but more controllable than for those reading 100% of their books. Among the subjects reading 75% of their texts, the problem was seen as more external than for any other group; the problem was seen as more stable than for those reading 25% and 50% of their texts, but more temporary than was perceived by those reading 10% of their books; and it was perceived to be less controllable than was seen by those reading 25% of their books, but as more controllable than was seen for subjects reading 50% and 100% of their texts. Finally, those who read 100% of their textbooks perceived the client's problem as more external than did those reading 25% of the texts, but more internal compared to those reading 50% and 75% of the books; this group saw it as more stable and less controllable than did any other group.

Table 12 is also based on reading, this time by whether or not subjects read professional rehabilitation journals on a regular basis. Out of the total sample, 39% (n=9) reported reading the journals regularly, while 61% (n=14) said they do not read the journals regularly.

Table 12

	<u>Professional Journals</u>	
	Read (n=9)	Don't read (n=14)
Locus	.80	.65
Stab.	-.60	-.75
Control	.05	.75

Among the subjects who read professional rehabilitation journals regularly, the difference scores were .80 for locus, -.60 for stability, and .05 for controllability. The subjects who do not read these journals regularly had difference scores of .65 for locus, -.75 for stability, and .75 for controllability. These results show that those who read professional rehabilitation journals regularly perceived the woman's presenting problem to be more internal, more stable, and less controllable than did those who do not read the journals on a regular basis.

Similarly, Table 13 distinguishes between those who plan to contribute to professional rehabilitation research, and those who do not. Of the sample, 48% (n=11) plan to contribute to future rehabilitation research, and 52% (n=12) do not have any such plans.

Table 13

Plans to Contribute to Future Rehabilitation Research

	Yes (n=11)	No (n=12)
Locus	.75	.55
Stab.	-.10	-1.35
Control	.20	.75

Subjects who plan to contribute to rehabilitation research showed difference scores of .75 for locus, -.10 for stability, and .20 for controllability. Among those who have no plans to contribute to future rehabilitation research, the difference scores were .55 for locus, -1.35 for stability, and .75 for controllability. These results indicate that subjects planning to contribute to future rehabilitation research saw the client's problem as more internal, more stable, and less controllable than did those with no plans to contribute to the research.

The next demographic variable in this research pertains to future plans of the subjects. Some subjects indicated more than one answer, with 30% (n=7) planning to work for State Vocational Rehabilitation (VR), 22% (n=5) planning to work in private rehabilitation, 26% (n=6) planning to work in community-based programs, and 35% (n=8) indicating other plans. The difference score results are presented in Table 14.

Table 14

	<u>Post-Graduate Work Plans</u>			
	State VR (n=7)	Private (n=5)	Comm-Based (n=6)	Other (n=8)
Locus	.70	.75	.10	.85
Stab.	-.80	.05	-.45	-.90
<u>Control</u>	<u>1.95</u>	<u>.60</u>	<u>-0-</u>	<u>-0-</u>

Note. VR = Vocational Rehabilitation. Comm-Based = Community-Based.
n=26.

Those planning to work with State VR had difference scores of .70 for locus, -.80 for stability, and 1.95 for controllability. Those who plan to work in private rehabilitation had difference scores of .75 for locus,

.05 for stability, and .60 for controllability. Subjects planning to work in community-based programs had difference scores of .10 for locus, -.45 for stability, and -0- for controllability. Subjects with other plans had difference scores for locus of .85, -.90 for stability, and -0- for controllability.

These results show that those planning to work in State VR perceive the problem to be more external than did those with plans for private rehabilitation and with other plans, but more internal than did those planning to work in community-based programs; less stable than did those planning to work in private rehabilitation or community-based programs, but more stable than did those with other plans; and as more controllable than did any other group. Subjects who plan to work for private rehabilitation perceived the problem to be more internal than did those planning to work with State VR or in community-based programs, but more external than did those with other plans; as more stable than did any other group; and as less controllable than did those planning to work for State VR, but more controllable than did those planning to work in community-based programs or those having other plans.

The subjects who plan to work in community-based programs saw the woman's presenting problem as more external than did any other group; as more stable than did those planning to work for State VR or with other plans, but less stable than did those with plans to work in private rehabilitation; and as less controllable than did subjects planning to work for State VR or in private rehabilitation, but equally with those having other plans. Subjects who have other post-graduate plans perceived the problem as more internal and less stable than did any other group; and as less controllable than did subjects with plans to work for

State VR or private rehabilitation, but equally with those planning to work in community-based programs.

Table 15 presents the difference scores for the final demographic variable, which was broken down by the population with which subjects plan to work. As with the previous variable, (see Table 14), some subjects marked more than one answer, with 30% (n=7) indicating plans to work with people having physical disabilities, 30% (n=7) to work with people having mental disabilities, 35% (n=8) planning to work with people having various disabilities, and 30% (n=7) indicating "other."

Table 15

	<u>Intended Population With Which to Work</u>			
	Physical (n=7)	Mental (n=7)	Various (n=8)	Other (n=7)
Locus	.95	.65	.55	.30
Stab.	-.40	-.45	-1.10	-.80
Control	.75	.75	.90	-.40

Note. n=29.

Subjects planning to work with people with physical disabilities had difference scores of .95 for locus, -.40 for stability, and .75 for controllability. Those planning to work with people with mental disabilities had difference scores of .65 for locus, -.45 for stability, and .75 for controllability. Of those with plans to work with people having various disabilities, the difference scores were .55 for locus, -1.10 for stability, and .90 for controllability. Subjects planning to work with other populations had difference scores of .30 for locus, -.80 for stability, and -.40 for controllability.

These results show that those subjects planning to work with people with physical disabilities perceived the woman's problem as more internal and more stable than did any other group; and less controllable than did those planning to work with people having various disabilities, more controllable than did those planning to work with other populations, and equally with subjects planning to work with people having mental disabilities. Subjects planning to work with people with mental disabilities perceived the problem as more internal and more stable than did those planning to work with people having various disabilities or to work with other populations, but more external and more temporary than did those planning to work with people with physical disabilities; and less controllable than did those planning to work with people having various disabilities, more controllable than did those planning to work with other populations, and equally with those planning to work with people with physical disabilities.

Subjects planning to work with people having various disabilities saw the client's problem as more external than did those planning to work with people having physical or mental disabilities, but more internal than did those planning to work with other populations; and as more temporary and controllable than any other group. Subjects planning to work with other populations perceived the presenting problem as more external and uncontrollable than did any other group; but as more temporary than did those with plans to work with people having physical or mental disabilities, and more stable than did those with plans to work with people having various disabilities.

Of these data, there is only one score which stands out. Of those currently working in non-rehabilitation fields, (see Table 5), the

difference score for controllability leans heavily into controllability. Given that no other scores stand out, particularly, and given that controllability, as stated in Chapter 3, bifurcates twice and is less reliable than locus and stability, the researcher is not led to comment on this one score other than to say it is a more positive occurrence, based on attribution theory.

CHAPTER V

Discussion, Implications, and Recommendations

This research, intended as a preliminary, descriptive study, has raised more questions than it answered. The alternate hypothesis that demographic variables would be significant in determining causal attributions, as measured by Russell's (1982) Causal Dimension Scale, has been neither proven nor disproven. This chapter presents a discussion of this issue, implications of the results, and makes recommendations about the direction of future research.

Discussion

As mentioned previously, only one category in a demographic variable particularly stands out from the rest, and only with the somewhat less reliable domain of controllability. It should be noted that subjects not currently working in the field of rehabilitation perceived the cause of the woman's problem as more controllable than did anyone else, but definite implications of this solitary score cannot be made. Clearly, more sophisticated analyses need to be conducted to indicate the level at which the difference scores are statistically significant. Regardless of these unknown, precise statistics, however, it is possible to discuss observable differences among several demographic variables.

First of all is the face value difference that the male subjects perceived the cause of the woman's problem as more internal, temporary, and uncontrollable than did the female subjects. One could speculate that women were more able to empathize with the woman in the photograph

because the model was also female. Another possible explanation embraces the qualities in many women of "affiliation" (Minuchin & Nichols, 1993), and of "understanding human vulnerabilities" (Miller, 1986, p. 31). It would be interesting to find out what differences, if any, would exist if the model were male.

The following two observations were surprising to the researcher, who thought that education, training, and experience in rehabilitation would have lessened, if not erased, the effects of stigma, spread, and stereotypes levied against people with disabilities. For example, there is an issue about the situational/dispositional dichotomy. It is ironic that those subjects with more experience and knowledge of disabilities are also those who perceived the problem of the woman sitting in the chair to be more internal than for the woman standing. Specifically, individuals within the following categories of variables perceived the problem as within the client:

- * subjects with rehabilitation work history;
- * those currently working in a rehabilitation setting;
- * subjects with disabilities;
- * those with rehabilitation, versus "other," undergraduate majors;
- * SCKRA members;
- * those who read rehabilitation journals on a regular basis;
- * subjects who plan to contribute to rehabilitation research; and
- * those who plan to work with people with physical disabilities.

It seemed ironic to the researcher that these people perceived the problem as within the woman, but to quote from Chapter II:

Even though rehabilitation counselors "...have been trained to think and act from other perspectives,...myths and elements of myths may

influence the human mind so subtly that counselors may be unaware of mythical thinking in themselves" (Holmes & Karst, 1990, p. 20). The perception that, for the disabled person, all of his or her problems are a result of his or her disability is an illustration of the effects of stigma, spread, and belief in disabling myths.

Thus it would seem that individuals within certain variables who attribute cause more internally than do their counterparts within the variable are displaying "the effects of stigma, spread, and belief in disabling myths." But why do these particular sets of people seem more inclined to perceive the cause internally? There seems to be a marked cynicism among those subjects who are more involved in rehabilitation theory and learning than in those who are more removed from the training environment.

Another observable difference pertains to specific variables which may prompt a closer examination of rehabilitation education. As was noted in Chapter II, a great disservice may be done by counselors who perceive a client's reason for counseling as internal, stable, and uncontrollable--as something about the client that will not go away and about which no one can do anything anyway. Categories within eight demographic variables resulted in this specific, detrimental attributional combination:

- * subjects not currently working;
- * those currently working in a rehabilitation setting;
- * those who read professional rehabilitation journals regularly;
- * subjects planning to contribute to rehabilitation research;
- * those planning to work for private, versus State, rehabilitation;

- * those planning to work with people with physical disabilities, versus those planning to work with other populations;
- * those who read 100%, versus those reading 50% - 75%, of their textbooks; and
- * those who have completed one semester in graduate level rehabilitation counseling (except for the perception of "less stable" that was seen by those with four completed semesters).

It is interesting to the researcher that subjects who are more involved in current rehabilitation work and/or research also attribute cause to internal, stable, and uncontrollable elements. What does this say about current practices in working with people with disabilities? What does it say about the attitudes within much of the current literature?

Obviously, further research needs to be conducted to determine whether or not these variables would result in a similar response among other rehabilitation counseling students.

Implications

How do rehabilitation counseling students perceive clients' problems? Are there any definitive patterns to the causal attributions? Weaknesses of the research make answering these questions with confidence risky, at best. Several caveats, therefore, are in order: the small sample size, several very small group sizes (e.g., two or three in groups from the "number of completed semesters" variable), the descriptive design of the study, and the lack of hard statistical data combine to weaken the implications of the results. However, that directional patterns exist in the attributions must be considered. Many rehabilitation counseling students become rehabilitation counselors who

then work with people with disabilities, parents, families, teachers, employers, landlords, medical and psychiatric personnel, social workers, social agencies, and myriad other persons and services providers, all on behalf of their clients. If these rehabilitation counselors perceive their clients' problems as dispositional, then the most likely result will be to try to change the client. Generally speaking, such an approach runs counter to the Americans with Disabilities Act. Moreover, if the rehabilitation counselor perceives the problems as not only dispositional, but also stable and uncontrollable, what exactly does the counselor hope to accomplish in his or her work? Intentions may be good, but there may be too much focus on client limitations, and too little on his or her environment and its barriers (Fine & Asch, 1988/1990).

Yuker (1977) proposed that people "who hold such attitudes [be screened out] from entering fields where interaction with persons with disabilities occurs" (Chubon, 1992, p. 307). The researcher is inclined to agree with Yuker because, after all, counseling ethics demand first and foremost to do no harm. The researcher believes that perceiving a rehabilitation client's problem(s) as internal, stable, and uncontrollable is definitely not beneficial to the individual, but may, in fact, be harmful to his or her psyche, sense of self-worth, self-determination, and motivation to reach for goals. The fact that the subjects of this study who have worked or do work in a rehabilitation setting, who have an undergraduate degree in rehabilitation, who read rehabilitation journals and plan to contribute to future rehabilitation research, who are SCKRA members, and/or who plan to work with people with physical disabilities in the future all perceived the woman's presenting problem as internal is worrisome. It would be well worth the effort to

find out why these groups of people, who have the most apparent interest in and commitment to the field of rehabilitation, also perceived the problem in precisely the way considered most harmful to the client.

Recommendations

Without a doubt, more research into rehabilitation counseling students'--if not rehabilitation counselors'--perceptions of clients' problems needs to be conducted. Enough questions have been raised to warrant further investigation. Other samples from other universities would be a start. Other recommendations include conducting more powerful statistical analyses to determine with greater precision where the point of significance lies. It would be helpful to find out what--if any--difference exists in the scores when a male model is photographed rather than a female. Also, how would different disabilities affect the causal attributions?

Additionally, looking at the rehabilitation counselor education environment, (a situational view to counterbalance the dispositional view of focusing on the students), research should also be conducted into the effects of rehabilitation counselor training on the students. Questions such as the following ought to be pursued and, if answered affirmatively, ought to prompt a change in the way future students are taught.

- * Does the focus of rehabilitation counselor education nurture rather than challenge disabling myths?
- * Is too much attention focused on learning about differences of people with disabilities, and too little on the common humanity shared by all people?

- * Does continual examination of the stigma, stereotypes, and spread phenomena of disabilities lead more to the students believing and internalizing them, rather than refuting them?

Additionally, cynicism has its opposite of sensitivity. Finding a way to nurture an affective, sensitive approach to rehabilitation counseling, as opposed to pointing out all that hinders counselors in their roles, may go far to eradicate the dispositional causation as currently described in this study. Perhaps students should be asked, periodically throughout their academic careers, why they wish to work with people with disabilities. Answers of wanting to "help people" ought to be explored: Why do they want to work with people with disabilities? Why not get a degree in, for example, community counseling, or social work, or psychology? What is it about rehabilitation counseling that attracts them? Perhaps these questions should be asked at the beginning of students' programs, and then again halfway through. Rehabilitation counseling educators have a responsibility to their field to do all they can to reduce paternalism and to encourage empowerment.

Professionals in the field who contribute to the rehabilitation literature ought also to examine their own "behaviors and attitudes to determine if they, too, help create barriers for clients..." (Holmes, Karst, & Erhart, 1990, p. 29). A content analysis of professional rehabilitation journals may reveal attributions that are internal or dispositional to people with disabilities. As was mentioned previously, cultural and societal values are often so subtle that their transmittal is unconscious, but their force is unyielding and unforgiving toward

those who step outside of the norms of society. If the literature and current education practices perpetuate the attributional belief that any problem a person with a disabilities has is due to the disability (i.e., dispositional), then steps must be taken to reverse this direction.

CONCLUSION

This study into the perceptions rehabilitation counseling students have about clients' problems is meant to introduce possible biases-- attributional or otherwise--held by rehabilitation counselors in general. Much research needs to be done before any generalizations can be made, but this has been a beginning. To deny having biases at all is to deny being human. It is also to deny caring professionals in the field of rehabilitation the opportunity to correct for any tendencies they may have to attribute causes of clients' problems as internal, stable, and/or uncontrollable. To refuse to look at one's biases is to bury one's head in the sand. However, it is only by recognizing biases that a choice can be made to either embrace or fight them. The offer to look is here.

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APPENDIX A

Demographic Sheet

APPENDIX B

Modified Causal Dimension Scale



This woman has been trying unsuccessfully for six months to find a job.

The items below concern your impression or opinions about the cause of the client's problem(s). Circle one number for each of the following.

1. Is the cause(s):
something about the client? 9 8 7 6 5 4 3 2 1 something about others?
2. Is the cause(s):
controllable by the client or others? 9 8 7 6 5 4 3 2 1 uncontrollable by the client or others?
3. Is the cause(s) something that is:
permanent? 9 8 7 6 5 4 3 2 1 temporary?
4. Is the cause(s) something:
intended by the client or others? 9 8 7 6 5 4 3 2 1 unintended by the client or others?
5. Is the cause(s) something that is:
within the client? 9 8 7 6 5 4 3 2 1 outside of the client?
6. Is the cause(s) something that is:
stable over time? 9 8 7 6 5 4 3 2 1 variable over time?
7. Is the cause(s) something that:
reflects an aspect of the client? 9 8 7 6 5 4 3 2 1 reflects an aspect of the situation?
8. Is the cause(s) something that is:
unchanging? 9 8 7 6 5 4 3 2 1 changeable?
9. Is the cause(s) something for which:
someone is responsible? 9 8 7 6 5 4 3 2 1 no one is responsible?



This woman has been trying unsuccessfully for six months to find a job.

The items below concern your impression or opinions about the cause of the client's problem(s). Circle one number for each of the following.

1. Is the cause(s):
something about the client? 9 8 7 6 5 4 3 2 1 something about others?
2. Is the cause(s):
controllable by the client or others? 9 8 7 6 5 4 3 2 1 uncontrollable by the client or others?
3. Is the cause(s) something that is:
permanent? 9 8 7 6 5 4 3 2 1 temporary?
4. Is the cause(s) something:
intended by the client or others? 9 8 7 6 5 4 3 2 1 unintended by the client or others?
5. Is the cause(s) something that is:
within the client? 9 8 7 6 5 4 3 2 1 outside of the client?
6. Is the cause(s) something that is:
stable over time? 9 8 7 6 5 4 3 2 1 variable over time?
7. Is the cause(s) something that:
reflects an aspect of the client? 9 8 7 6 5 4 3 2 1 reflects an aspect of the situation?
8. Is the cause(s) something that is:
unchanging? 9 8 7 6 5 4 3 2 1 changeable?
9. Is the cause(s) something for which:
someone is responsible? 9 8 7 6 5 4 3 2 1 no one is responsible?

APPENDIX C

Application to the Human Subjects Committee

Subject:
Evaluation

APPLICATION FOR APPROVAL TO USE HUMAN SUBJECTS

This application should be submitted, along with the Informed Consent Document, to the Institutional Review Board for Treatment of Human Subjects, Research and Grants Center, Campus Box 4048.

1. Name of Principal Investigator(s) or Responsible Individuals:

Sue Six

2. Departmental Affiliation: Rehabilitation Counseling

3. Person to whom notification should be sent: Sue Six

Address 1201 Triplett, E-54; Emporia, KS 66801

4. Title of Project: Rehabilitation Counseling Students' Perceptions of Clients:
An Attributional Analysis

5. Funding Agency (if applicable): _____

6. Project Purpose(s):

The purpose of this project is to develop a profile of currently enrolled graduate students of Rehabilitation Counseling at Emporia State University (ESU). The study will be designed to determine whether or not there are differences among the students in their perceptions of possible clients, and if so, whether or not certain demographic variables can be associated with these differences.

Describe the proposed subjects: (age, sex, race, or other special characteristics, such as students in a specific class, etc.)

The proposed subjects of this study are currently enrolled graduate students in Rehabilitation Counseling at ESU. There will be no selection of persons based on any other criteria.

Describe how the subjects are to be selected:

Each student in the Rehabilitation Counseling Program will be contacted, either during a particular class which most of the enrolled students attend, or personally by the researcher. All will be asked to participate voluntarily. No one who chooses not to participate will be subjected to reproach of any kind.

Describe the proposed procedures in the project. Any proposed experimental activities that are included in evaluation, research, development, demonstration, instruction, study, treatments, debriefing, questionnaires, and similar projects must be described here. **Copies of questionnaires, survey instruments, or tests should be attached.** (Use additional page if necessary.)

Data collection will occur over the course of three weeks. The first week, after reading and signing an informed consent form, participants will complete a demographic sheet (Appendix B). Following completion of this sheet, each participant will receive a Causal Dimension Scale, (CDS, Appendix A), which will have a photograph of a model at the top. Students will be asked to rate the presenting problem of the model on the CDS. The second week the same scale with another photograph will be completed, and the third week the scale with the first photograph again will be completed. This plan is explained more fully in the attached Methods chapter under the "Procedure" heading, page 5.

10. Will questionnaires, tests, or related research instruments not explained in question #9 be used? Yes No (If yes, attach a copy to this application.)

11. Will electrical or mechanical devices be used? Yes No (If yes, attach a detailed description of the device(s).)

12. Do the benefits of the research outweigh the risks to human subjects? Yes No
Information should be outlined here.

There are no risks to human subjects.

13. Are there any possible emergencies which might arise in utilization of human subjects in this project? Yes No Details of these emergencies should be provided here.

14. What provisions will you take for keeping research data private?
All data will be kept strictly confidential. The last four digits of participants' social security numbers will be used by the researcher only for matching CDS forms with the corresponding demographic sheet. After collection of all data, these forms will be attached and the corner with the numbers cut off. The sets of papers will then be numbered 001, 002, 003, etc. The raw data will be securely maintained by the researcher alone until such time as it can be destroyed.

15. Attach a copy of the informed consent document, as it will be used for your subjects.

STATEMENT OF AGREEMENT: I have acquainted myself with the Federal Regulations and University policy regarding the use of human subjects in research and related activities and will conduct this project in accordance with those requirements. Any changes in procedures will be cleared through the Institutional Review Board for Treatment of Human Subjects.

Signature of Principal Investigator

3/8/93

Date

Signature of responsible individual
(~~faculty advisor~~)

3/8/93

Date

(thesis chairperson)

APPENDIX D

Informed Consent Form

...removed from the study or research.

...the educational planning
State University. It is
has ultimately benefited
care rehabilitation.

...no advantage.

INFORMED CONSENT DOCUMENT

The Department/Division of Counselor Education/Rehabilitation Prog. supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

Procedures to be followed in the study, as well as identification of any procedures which are experimental.

You will be asked to spend a total of about 45 minutes of your time (25 minutes today, and 10 minutes each for two additional meetings) to complete several forms. There are no right or wrong answers, only your honest answers. Your identity will not be known to the researcher nor anyone else. Parts of your answers may be used in the researcher's final thesis, but the information will in no way be presented that may indicate who you are.

Description of any attendant discomforts or other forms of risk involved for subjects taking part in the study.

There is absolutely no risk for participants in this study.

Description of benefits to be expected from the study or research.

Results of this study should be of use in future educational planning in the Rehabilitation Counseling program at Emporia State University. It is hoped that emphases in training will be enhanced, thus ultimately benefiting the people who will be clients or consumers of future rehabilitation counselors.

Appropriate alternative procedures that would be advantageous for the subject.

N/A

"I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach."

Subject and/or authorized representative

Date

APPENDIX E

Approval from the Human Subjects Committee Dean
Office of Graduate Studies
and Research



March 29, 1993

Sue Six
1201 Triplett, E-54
Emporia, KS 66801

Dear Ms. Six:

The Institutional Review Board for Treatment of Human Subjects has evaluated your application for approval of human subject research entitled, "Rehabilitation Counseling Students' Perceptions of Clients: An Attributional Analysis." The review board approved your application which will allow you to begin your research with subjects as outlined in your application materials.

Best of luck in your proposed research project. If the review board can help you in any other way, don't hesitate to contact us.

Sincerely,

Faye N. Vowell

Faye N. Vowell, Dean
Office of Graduate Studies
and Research

FV:pf

cc: Janice Stalling

APPENDIX F

Tables of Means Scores by Demographic Variable

-.60

.10

-

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Table 16

<u>Total Sample Mean and Standard Deviation Scores</u>						
	A-1	A-2	True	B	Difference	SD
Locus	4.3	4.2	4.25	3.5	.75	1.47
Stab.	3.7	4.0	3.85	4.6	-.75	1.53
Control	4.7	5.1	4.90	4.4	.50	1.56

Table 17

<u>Gender</u>					
	A-1	A-2	True	B	Difference
Female (n=13)					
Locus	3.5	3.6	3.55	3.2	.35
Stab.	3.8	3.6	3.70	4.3	-.60
Control	4.3	4.9	4.60	4.5	.10
Male (n=10)					
Locus	5.4	5.0	5.20	4.0	1.20
Stab.	3.7	4.5	4.10	5.0	-.90
Control	5.2	5.5	5.35	4.4	.95

Table 18

	<u>Work History</u>				
	A-1	A-2	True	B	Difference
Rehabilitation (n=10)					
Locus	4.8	4.8	4.80	3.9	.90
Stab.	3.7	4.3	4.00	5.0	-.10
Control	5.0	5.3	5.15	4.3	.85
Non-rehabilitation (n=13)					
Locus	3.9	3.8	3.85	3.3	.55
Stab.	3.8	3.7	3.75	4.2	-.45
Control	4.5	5.1	4.80	4.6	.20

Table 19

	<u>Work Status</u>				
	A-1	A-2	True	B	Difference
Working (n=14)					
Locus	4.3	4.2	4.25	3.7	.55
Stab.	3.5	3.6	3.55	4.6	-1.05
Control	5.0	4.7	4.85	4.0	.85
Not working (n=9)					
Locus	4.3	4.2	4.25	3.3	.95
Stab.	4.1	4.6	4.35	4.6	-.25
Control	4.3	5.9	5.10	5.1	-0-

Table 20

	<u>Current Work Experience</u>				
	A-1	A-2	True	B	Difference
Rehabilitation (n=9)					
Locus	5.0	4.8	4.90	4.1	.80
Stab.	3.7	4.0	3.85	4.6	-.75
Control	5.0	5.0	5.00	4.8	.20
Non-rehabilitation (n=5)					
Locus	3.2	3.0	3.10	2.9	.20
Stab.	3.1	3.0	3.05	4.6	-1.55
<u>Control</u>	<u>5.1</u>	<u>4.1</u>	<u>4.60</u>	<u>2.5</u>	<u>2.10</u>

Note. n=14.

Table 21

	<u>Disability Status</u>				
	A-1	A-2	True	B	Difference
Disability (n=5)					
Locus	4.3	4.1	4.20	3.0	1.20
Stab.	3.9	3.2	3.55	3.4	.15
Control	4.3	5.1	4.70	4.5	.20
No disability (n=18)					
Locus	4.3	4.2	4.25	3.7	.55
Stab.	3.7	4.2	3.95	4.9	-.95
Control	4.8	5.2	5.00	4.4	.60

Table 22

	<u>Family Member Disability Status</u>				Dated
	A-1	A-2	True	B	
Disability (n=8)					
Locus	4.8	4.8	4.80	4.3	.50
Stab.	3.8	3.8	3.80	5.0	-1.20
Control	5.6	5.2	5.40	4.5	.90
No disability (n=15)					
Locus	4.1	3.9	4.00	3.1	.90
Stab.	3.7	4.1	3.90	4.4	-.50
Control	4.2	5.1	4.65	4.4	.25

Table 23

	<u>Undergraduate Major</u>				Dated
	A-1	A-2	True	B	
Rehabilitation (n=11)					
Locus	4.8	4.5	4.65	3.7	.95
Stab.	3.7	3.9	3.80	4.4	-.60
Control	4.7	4.9	4.80	4.4	.40
Helping Profession (n=6)					
Locus	4.6	4.6	4.60	3.5	1.10
Stab.	3.5	4.2	3.85	6.0	-2.15
Control	5.7	5.5	5.60	3.9	1.70
Other (n=6)					
Locus	3.2	3.4	3.30	3.3	-0-
Stab.	4.1	4.0	4.05	3.6	.45
Control	3.8	5.2	4.50	5.0	-.50

Table 24

Number of Rehabilitation Counseling Semesters Completed

	A-1	A-2	True	B	Difference
0 (n=5)					
Locus	3.7	4.3	4.00	3.9	.10
Stab.	3.2	5.1	4.15	4.9	-.75
Control	3.9	5.6	4.75	4.9	-.15
1 (n=8)					
Locus	4.8	3.9	4.35	2.7	1.65
Stab.	4.0	3.7	3.85	4.3	-.45
Control	4.8	4.8	4.80	3.5	1.30
2 (n=5)					
Locus	3.9	4.0	3.95	3.1	.85
Stab.	3.7	3.7	3.70	4.7	-1.00
Control	4.8	5.1	4.95	5.5	-.55
3 (n=2)					
Locus	4.5	4.7	4.60	4.5	.10
Stab.	3.2	2.9	3.10	4.9	-1.80
Control	6.0	6.0	6.00	4.9	1.10
4 (n=3)					
Locus	4.4	4.8	4.60	5.1	-.50
Stab.	4.4	4.4	4.40	4.4	-0-
Control	5.1	4.8	4.95	4.2	.75

Table 25

Student Chapter of the Kansas Rehabilitation Association

	A-1	A-2	True	B	Difference
Member (n=8)					
Locus	5.0	4.4	4.70	3.8	.90
Stab.	3.4	3.5	3.45	4.4	-.95
Control	5.1	5.1	5.10	4.5	.60
Non-member (n=15)					
Locus	3.9	4.1	4.00	3.4	.60
Stab.	3.9	4.3	4.10	4.7	-.60
Control	4.5	5.2	4.85	4.4	.45

Table 26

Average Percentage of Textbooks Read per Class

	A-1	A-2	True	B	Difference
25% (n=5)					
Locus	5.3	4.9	5.10	3.8	1.30
Stab.	2.8	4.3	3.55	4.6	-1.05
Control	4.7	5.1	4.90	4.0	.90
50% (n=6)					
Locus	4.4	3.7	4.05	3.5	.55
Stab.	3.3	3.4	3.35	4.2	-.85
Control	4.4	4.6	4.50	4.1	.40
75% (n=9)					
Locus	3.3	3.8	3.55	3.2	.35
Stab.	4.2	3.9	4.05	4.7	-.65
Control	4.7	5.8	5.25	4.7	.55
100% (n=3)					
Locus	5.2	5.1	5.15	4.2	.95
Stab.	4.9	4.9	4.90	5.0	-.10
Control	5.3	4.4	4.85	5.2	-.35

Table 27

Professional Rehabilitation Journals

	A-1	A-2	True	B	Difference
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Read (n=9)

Locus	4.1	3.9	4.00	3.2	.80
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Stab.	3.6	3.0	3.30	3.9	-.60
-------	-----	-----	------	-----	------

Control	4.6	4.7	4.65	4.6	.05
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Don't read (n=14)

Locus	4.5	4.4	4.45	3.8	.65
-------	-----	-----	------	-----	-----

Stab.	3.8	4.7	4.25	5.0	-.75
-------	-----	-----	------	-----	------

Control	4.8	5.5	5.15	4.4	.75
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Table 28

Plans to Contribute to Future Rehabilitation Research

	A-1	A-2	True	B	Difference
--	-----	-----	------	---	------------

Yes (n=11)

Locus	4.0	3.7	3.85	3.1	.75
-------	-----	-----	------	-----	-----

Stab.	4.4	4.0	4.20	4.3	-.10
-------	-----	-----	------	-----	------

Control	4.7	5.1	4.90	4.7	.20
---------	-----	-----	------	-----	-----

No (n=12)

Locus	4.5	4.6	4.55	4.0	.55
-------	-----	-----	------	-----	-----

Stab.	3.1	4.0	3.55	4.9	-1.35
-------	-----	-----	------	-----	-------

Control	4.7	5.2	4.95	4.2	.75
---------	-----	-----	------	-----	-----

Table 29

	<u>Post-Graduate Work Plans</u>				
	A-1	A-2	True	B	Difference
State Vocational Rehabilitation (n=7)					
Locus	4.8	4.8	4.80	4.1	.70
Stab.	3.6	4.4	4.00	4.8	-.80
Control	5.1	5.2	5.15	3.2	1.95
Private Rehabilitation (n=5)					
Locus	5.3	4.2	4.75	4.0	.75
Stab.	4.1	4.6	4.35	4.3	.05
Control	4.3	4.7	4.50	3.9	.60
Community-Based Program (n=6)					
Locus	4.2	3.8	4.00	3.9	.10
Stab.	3.9	3.8	3.85	4.3	-.45
Control	4.9	5.5	5.20	5.2	-0-
Other (n=8)					
Locus	3.9	4.4	4.15	3.3	.85
Stab.	3.5	4.1	3.80	4.7	-.90
Control	4.4	5.2	4.80	4.8	-0-

Note. n=26.

Table 30

	<u>Intended Population With Which to Work</u>				
	A-1	A-2	True	B	Difference
Physical Disabilities (n=7)					
Locus	4.8	4.3	4.55	3.6	.95
Stab.	3.8	4.0	3.90	4.3	-.40
Control	4.5	4.4	4.45	3.7	.75
Mental Disabilities (n=7)					
Locus	4.5	3.6	4.05	3.4	.65
Stab.	4.0	3.9	3.95	4.4	-.45
Control	4.7	5.2	4.95	4.2	.75
Various Disabilities (n=8)					
Locus	4.2	4.3	4.25	3.7	.55
Stab.	3.8	4.0	3.90	5.0	-1.10
Control	5.1	4.7	4.90	4.0	.90
Other (n=7)					
Locus	3.9	4.1	4.00	3.7	.30
Stab.	3.4	3.8	3.60	4.4	-.80
Control	4.4	5.2	4.80	5.2	-.40

Note. n=29

57.18

0.50

APPENDIX G

Budget

1.00

361.27

BUDGET

Paper (1 ream @ \$3.00/ream + tax)	\$3.18
Copies -- Subjects' work (150 copies @ .03/copy):	4.50
* 30 subjects, 1 copy Consent Form	
1 copy Demographic Sheet	
3 copies Causal Dimension Scale	
Copies -- final thesis, 3 sets (321 @ .03/copy = tax)	10.20
Photographs (2 photo at \$2.00 each)	4.00
Half-toning	4.77
Word Processor Ribbon (2 packs @ \$6.95 plus tax)	14.72
Binding	<u>20.00</u>

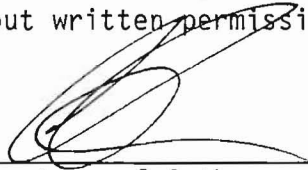
TOTAL \$61.37

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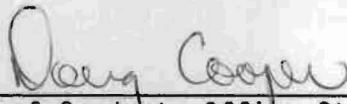
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