Past clinical research with an attributional perspective has primarily addressed questions of self-perception (for a review see Harvey & Galvin, 1984). Perhaps the most notable example is that of the reformulated model of learned helplessness. Abramson, Seligman, and Teasdale (1978) posited that depression is the result of two factors: a belief that one’s responses have no bearing on response outcomes, and the attributions one makes for this noncontingency or sense of helplessness. Recent attention to other clinical matters from an attributional perspective reflects the same emphasis on self-perception (Antaki & Brewin, 1982; Brewin, 1988; Forsterling, this volume; Ickes, 1988). Much less attention has been given to questions of person perception, although there are exceptions (e.g., Bradbury & Fincham, in press; Jordan, Harvey, & Weary, 1988). In the present chapter, we aim to acquaint investigators and clinicians with the past and potential contributions in applying an attributional framework to the study of person perception within a clinical domain.

We examine two areas in which attribution theory has the potential to contribute to our understanding of person perception in a clinical context. First, we review research that examines the relationship between clinicians’ attributions and their clinical judgment. Second, we examine the literature concerning the relationship between family members’ views of the causes of their relative’s mental disorder, and their affective reactions and levels of support. We specifically consider the available research that investigates the level of “expressed emotion” in the relatives of patients with schizophrenia.

The attributional perspective that we use draws largely from the work of Weiner and his associates (Weiner, 1985, 1986). This theoretical model begins with the assumption that a given outcome leads to a search for the cause of that
theoretical orientation may influence locus attributions. It is of interest to consider why these factors might alter clinicians' use of attributions. Drawing from what Batson and associates identified as potential sources of the dispositional bias, it seems possible that ethnic and theoretical background are likely to alter the therapists' role perspectives as observer and as helper. Considering ethnicity, Black and Hispanic therapists may be able to move out of the role of the observer and consider the client's perspective more than White therapists. Or perhaps minority clinicians are able to bring to their training a healthy respect for the role environmental factors play in shaping client's presenting problems, thereby altering the typical helper-role perspective. Similarly, theoretical orientation may also shape the role perspective of the helper away from the usual dispositional bias. For example, therapists from a behavioral tradition may learn to emphasize environmental factors, whereas therapists from a psychodynamic tradition may learn to focus on intrapsychic factors.

A final aspect of the locus attribution research that we will consider is the relationship between locus attributions and clinical judgments, such as treatment recommendations and level of maladjustment. Batson (1975) examined the relationship between attribution-related judgments and treatment referrals. He found that when helpers judged the problem to be personal in nature, referrals were more likely made to services oriented toward changing the person, such as a psychiatric hospital. On the other hand, when the problem was viewed as situational in nature, referrals were most likely made to organizations that dealt with the community, such as a social service agency. With regard to the relationship between attributions and judgments of maladjustment there are mixed findings. Snyder (1977) found a positive correlation between ratings of maladjustment and locus of the problem. Specifically, the more the problem was judged to be an internal or person-based problem, the more clinicians judged the interviewee as maladjusted. López (1983) and Wolkenstein and López (1988), however, found no consistent relationship between clinicians' locus causal attributions and judgments of severity and need for treatment.

Critique. The general attribution and clinical judgment literature has a number of limitations. First of all, there is great diversity in conceptualizing and operationalizing attributions in clinical judgment settings. Therapists' locus attributions have been defined as (a) attributions of the client's responsibility for both the cause and the solution of presenting problems (Brickman et al., 1982; McGovern et al., 1986); (b) attributions of the problem, not the cause of the problem, as residing within the client or within the situation (Batson et al., 1982; Berman, 1979; Snyder, 1977); and (c) attributions of the client's problems viewed as being caused by dispositional or situational factors (Plous & Zimbardo, 1986; Snyder et al., 1976).

Each of these ways of conceptualizing and studying attributions contributes to identifying the many ways attributions are relevant to clinical judgment. However, adhering to these divergent formulations hinders the development of a clear, comprehensive body of research within any one conceptualization. For example, in examining the effect of clinicians' theoretical orientation on their attributions, Snyder (1977) found that psychodynamic therapists judged the presenting problem as more person-oriented (internal) and less situation-oriented (external) than did the behavioral therapists. Plous and Zimbardo (1986) found the same pattern for clinicians' perceptions of the causes of the presenting problem. Although these findings are parallel, the type of judgment may be different. In the former, the clinician is likely to categorize the problem as either personal or situational. In the latter, the clinician provides an explanation for the problem. Although there are occasions when problem description and problem explanation reflect the same dimension, there are also occasions when the problem is categorized in one direction (e.g., internal) and the causes of the problem are viewed as lying in the other direction (external). For example, the decompensation of a patient with schizophrenia is likely to be viewed as an internal problem, yet the cause of the decompensation could be perceived as either external (life stressors) or internal (failure to take medication). It may be particularly important to bear this distinction in mind when considering the potential consequences of such perceptions.

A second limitation of the available research is that it primarily concerns judgments of locus: locus of the problem's causality, locus of the problem, and locus of responsibility. This likely reflects the prominence that internal/external attributions have had historically in the nonclinical study of attributions. Nevertheless, there are other causal dimensions: stability, controllability, intentionality, and globality. These other dimensions have received little attention and might prove to be particularly significant to the clinical judgment process. A final limitation of the available research is that little attention is paid to uncovering the nature of the relationship between attributions and clinical judgments. Identifying the types of causal ascriptions clinicians use is of value. However, of most importance is how those attributions relate to clinical judgments and related therapist-patient interactions.

An Attributional Model of Clinical Judgment

We believe that Weiner's attribution theory has relevance for clinical decision making and has the potential to contribute to the available attribution and clinical judgment literature. Contrary to past research, which focused on locus attributions, Weiner's model considers two other causal dimensions, stability and controllability, and therefore has the potential to broaden the attributional perspective used in the study of clinical judgment. Stability refers to the perceived variability (unstable) or permanency (stable) of the causes of behavior. To use a clinical judgment example, an antisocial personality disorder would be considered a stable cause of violent behavior, whereas experimenting with phe-
The controllability dimension considers the degree to which the causes are perceived to be under the control of the individual. The causes of alcoholism are frequently perceived to be subject to volitional control, whereas the causes of posttraumatic stress are not perceived to be subject to volitional control. In this section, we review Weiner's model as it applies to clinical judgment, and we discuss the beginning research efforts in this area.

The main advantage of applying Weiner's theory to the study of clinical judgment is that perceived causes along the aforementioned dimensions have been found to be related to important psychological consequences. The consequences of causes categorized according to their stability and controllability are probably most applicable to clinical judgment. Stability has been shown to be clearly linked to the expectancy of behavior change, or, in clinical terms, prognosis. If the causes of the presenting problem are thought to be stable, then the patient's prognosis will likely be considered poor. On the other hand, if the causes are perceived as unstable, the prognosis will likely be much better. Referring back to the example of violent behavior, one would expect the person with an antisocial personality disorder (a stable cause) to continue to become violent, whereas one would expect the person who experimented with PCP (an unstable cause) to become violent much less frequently, depending on the further use of drugs.

There is both direct and indirect evidence that the stability—expectancy of change linkage applies to the clinical arena. López (1983) presented six case summaries based on actual patients to 96 mental health professionals and assessed their perceptions of the causes of the presenting problems and related psychological consequences. The case summaries represented a range of presenting problems: psychosis, marital problems, rape trauma, a gang-related problem, male sexual dysfunction, and parent–child conflict. López found that clinicians' attributions of stability for five of the six cases were significantly related to their prognostic ratings. As clinicians perceived the causes of the problems to be unstable, they viewed the patients' prognoses in a more positive light.

Indirect evidence of the stability—prognosis is also found in Perlick and Atkins's (1984) study of age bias. Clinical psychologists were presented with an audiotaped clinical interview in which the patient's age was manipulated (75 and 55 years old). Clinicians were more likely to implicate organic causes for the elderly patient's depressive symptoms and functional causes for the middle-aged patient with identical symptoms. Further, the evaluators judged the elderly patient as being less likely to benefit from antidepressant medication than the younger patient. These findings are consistent with the stability—expectancy of change linkage. Organic causes are likely to be perceived as more stable causes than functional causes. Responsiveness to medication is an expectancy judgment similar to prognosis. It may have been that the more the clinicians viewed the depressive symptoms as organic in nature, the less they expected the patient to respond to medication. Together, the López (1983) and Perlick and Atkins (1984) studies provide evidence that clinicians' attributions of the stability of their patients' presenting problems are related to their expectations that the patients' mental health status will improve.

The consequences of the controllability dimension also appear to be related to clinical judgments. Weiner (1980) demonstrated that help in a nonclinical setting may be offered more readily to those persons whose problems are perceived to have been caused by uncontrollable rather than controllable factors. For example, a man who stumbled and fell because he was blind (an uncontrollable cause) was more likely to elicit a willingness to help than a man who fell because he was drunk (a controllable cause). Weiner's research further established that affective responses appear to mediate people's desire to help; feelings of pity are elicited for the blind person whereas feelings of anger are elicited for the drunk person. Given these and related data, Weiner (1980) argued for a cognitive-affective model of help giving. The potential helper first assesses the cause of the person in need of help, then has an affective response which is linked to the perceived cause and, finally, depending on the specific cognitive-affective linkage, the potential helper is more or less likely to assist the one in need.

Although clinicians are taught to be objective and not to let affective reactions interfere with their evaluations, it is naive to ignore the fact that patients do elicit affective responses from clinicians. If so, the cognitive-affective model of help giving might also apply to the clinical judgment process. Clinicians may feel more pity or sympathy for clients whose presenting problems are judged to be less controllable than clients whose problems are judged to be more controllable. As a result, more help may be provided to those patients with problems perceived to be less controllable. For example, a therapist may be more inclined to help a marital couple whose problems stem from the death of a child (an uncontrollable cause) than a marital couple whose problems stem from both partners' extra-marital affairs (controllable causes).

In the only test of this second attributional linkage, López (1983) found an interesting twist to the controllability—affective reaction—help-giving linkages. Contrary to Weiner's attribution theory, judgments of the controllability of the perceived causes were virtually unrelated to the therapists' reports of their affective reactions and their interest in providing help. However, ratings of help giving were related to affective ratings; help was negatively correlated with anger and positively correlated with empathy. This represents at least part of the cognitive—affective—help linkage. Although controllability attributions were found to be in general unrelated to affective reactions and help giving, stability judgments and prognosis were related to help giving. These findings suggest that in a mental health setting, professionals' desire to help their patients is related to their perceptions that (a) the patient's problem is due to unstable factors and (b) the patient will respond to treatment. In other words, clinicians appear to be more inclined to help those who they believe can benefit from therapeutic efforts.
Although the controllability-based model of help giving is not supported by this research, evidence does support an attributional model of help giving, one that is based on stability attributions and proscriptive judgments.

The potential strengths of Weiner's attributional model are twofold. The model considers causal dimensions other than locus, and calls attention to specific linkages between attributions and important psychological consequences (i.e., expectancies, affective reactions, and help giving). The beginning research in applying this framework to clinical judgment suggests that it has considerable utility.

Critique. Weiner's model was derived from an achievement domain. Although there is ample evidence of its generalizability to other settings, it is important to be open to aspects of the model that might require some modification for the clinical judgment domain. Several issues arise when attempting to apply this model to the clinical arena. First, in the achievement domain, a more limited number of attributions may be used to explain success or failure than clinicians use to explain a given presenting problem or set of problems. In the clinical judgment setting, clinicians are likely to entertain multiple causal hypotheses. For example, the etiology of a patient's panic disorder could include any of the following causal factors: a biological vulnerability, childhood separation anxiety, a learned fear of panic symptoms, cognitive distortions (fear of dying or "going crazy"), and marital stress. Investigators of attributions and clinical judgments need to be cognizant of the multiplicity of causal factors, and the implications this has for understanding the role of causal attributions in the clinical judgment process. One implication concerns the location of a specific attribution in the temporal causal sequence or causal chain. Kelley (1983) and Abramson, Metalsky, and Alloy (1988) describe the location of a given attribution as either distal, toward the beginning of the causal chain in the clinical judgment context, or proximal, toward the end of the causal chain and closest to the presenting problem. The more proximal attribution will likely be judged as having the greatest impact on the development of the presenting problem. Studies of attributions and clinical judgments would do best to examine first the effects of proximal attributions on clinicians' judgments.

A second consideration that likely reflects the use of multiple causes in clinicians' perceptions of presenting problems is whether the cause is viewed as necessary and sufficient for the occurrence of the presenting problem or if the cause is viewed as only a contributory factor to the presenting problem. This dimension is modified from Abramson et al.'s (1988) discussion of necessary, sufficient, and contributory causes in depression research. A contributory factor is not likely to have as great an effect on clinicians' judgments as is a necessary and sufficient cause. For example, if marital difficulties were viewed as the necessary and sufficient cause of a woman's panic attack, the clinician would likely view the problem much differently than if marital difficulties were only one of many contributing factors. In studying the relationship of attributions to clinical judgments, investigators might best attend to how attributions are viewed along the dimension of sufficient/necessary (primary) causes and contributory (secondary) causes. A specific attribution may be manipulated in an experimental study, but if the attribution is only a secondary causal factor, then the impact of the manipulation may be minimal or nonexistent.

A third factor that might be considered is the distinction between causes and reasons. Buss (1978) cogently argues that causal explanations and reason explanations differ from each other. Causes imply lawfulness, predictability, and antecedent-consequent relationships. Reasons imply justifying or appraising the action; these types of explanations help make an action understood by attaching meaning to the action. Clinicians are likely to use both types of causal and reason explanations. They are interested in identifying precipitating causal factors, elements that directly precede the onset of a disorder or presenting problem, and they are interested in explaining or demonstrating an understanding of the presenting problem. Again, reconsider the example of a woman with a panic disorder. Marital discord precipitates the panic episodes and the intense fears of "going crazy" or "dying" serve to heighten the panic. Both of these factors may be viewed as causal; these are the factors that precede the panic attack and are viewed as necessary to the episode. In contrast, the panic episode could be perceived as reflecting the patient's loss of control, low self-esteem, poor coping skills, and perhaps unresolved feelings toward her father for having abandoned her, all of which are reasons or explanations for the episode. None of these reasons individually or together cause the panic episode, but they all contribute to understanding and explaining the patient's presenting problem. The distinction between causes and reasons may be difficult to make because one therapist's reason may be another therapist's cause. Nevertheless, it is important to note this distinction because reasons may not function in the same manner as causal ascriptions.

A final consideration in using Weiner's attributional model is that it cannot explain all potential clinical judgments. Judgments of categorization, whether they be symptom recognition or diagnostic judgments, are not within the theory's range of convenience. Also, the theory is limited in explaining judgments of symptom, disorder, or problem severity, although Snyder did find that more internal attributions correlated positively with judgments of maladjustment. Weiner's theory does not offer an appropriate explanation for such a finding. Therefore, to examine the full range of clinical judgments, it will be important to draw from other conceptual frameworks to complement the theoretical basis offered by Weiner's model. López (1989) identifies other areas in social cognition and decision making that have the potential to contribute to the study of attributions and clinical judgment in particular, and the study of clinical judgment in general. Among these areas are the investigation of base rates, memory, and hypothesis testing.
Conclusion. Clinical judgment is critical to the clinical work of mental health professionals. Therefore, research which can contribute to a better understanding of this person perception problem can eventually be used to improve clinicians' performance. Weiner's attribution theory has the potential to enhance our current understanding of clinical judgment. The theory provides a conceptual framework that builds on past attribution-clinical judgment research through its additional causal dimensions and noted psychological consequences associated with the given dimensions. Further research which addresses some of the aforementioned challenges in applying this theory to clinical judgment will contribute to the beginning efforts in applying this model.

FAMILIES' ATTRIBUTIONS OF A RELATIVE'S SERIOUS MENTAL DISORDER

In addition to considering clinicians' attributions for the patient's presenting problems, we believe it is important to consider the family members' attributions for their relatives' presenting problems. There is a growing body of research that examines the relationship between the emotional atmosphere of families and the course of schizophrenia that is consistent with an attributional analysis, though no direct studies of the families' attributions have been published. Several investigations have found that schizophrenic patients are more likely to relapse when they return to families who have a critical, hostile attitude toward the patient and/or who are emotionally overinvolved with the patient. This critical, hostile tone, and emotional overinvolvement has been referred to as "expressed emotion" (Brown, Birley, & Wing, 1972). In this section, we summarize the key research which has established the relationship between expressed emotion and relapse. Recent reviews of this literature (Hooley, 1985; Koenigsbett & Handle, 1986) have indicated that the mechanisms underlying the relationship between expressed emotion and relapse are poorly understood. We propose that attributions may be a critical mechanism in understanding this relationship. Specifically, we draw from Weiner's cognition-ffect-helping model and argue that the attributions family members make for their relative's mental disorder is central to the way they feel toward the patient (sympathetic or angry) and the manner in which they may help the patient remain relatively symptom-free. Of particular importance to this model is the family members' perceptions of how much control the patient has for the cause of his or her disorder.

Expressed Emotion

Brown and his colleagues originally brought attention to the role of family attitudes in the relapse of schizophrenic patients. In a retrospective study, they observed that the likelihood of relapse for chronic male schizophrenic patients was related to living arrangement, particularly the presence of parents or wives (Brown, Carstairs, & Topping, 1958). In an attempt to understand this relationship, a prospective study was carried out with particular focus given to the emotional involvement (emotionality and hostility) of a key female relative (Brown, Monck, Carstairs, & Wing, 1962). Patients returning to homes in which the relative was designated as high in emotional involvement relapsed at a greater rate than those patients returning to homes in which the relative was designated as low in emotional involvement. This initial research pointed to the significance of the family’s emotional atmosphere in the course of schizophrenia.

Further research was conducted to refine the assessment of the emotional climate of the household (Brown & Rutter, 1966), leading to the development of the Camberwell Family Interview (CFI), a reliable method to index relatives' emotional responses, or their expressed emotion (Brown, Birley, & Wing, 1972; Vaughn & Leff, 1976a, 1976b). The CFI is an open-ended interview which allows family members to discuss their feelings about the patient and his or her illness. Based on this interview, a rater assesses the number of critical remarks about the patient, the level of hostility, and the level of emotional overinvolvement, that together reflects the overall level of expressed emotion (EE).

Several studies have now demonstrated a significant association between the household level of expressed emotion as assessed by the CFI and the relapse rate of persons with schizophrenia. In a representative study of this relationship, Vaughn and Leff (1976a) found that 50% of the patients living with high-EE relatives relapsed within 9 months after their hospitalization, whereas 12% of the patients living with low-EE relatives relapsed within the same time period. This relationship is to some extent influenced by the patient's usage of medication and the amount of contact between patient and family member (Vaughn & Leff, 1976a). Patients living in high-EE households who maintain their medication regimen and who have fewer than 35 hours of contact per week with their family are less likely to relapse than those patients from households of high EE who do not regularly take their medication and who have greater amounts of contact with their family. Interestingly, medication and contact do not appear to influence the relapse rate of patients from low-EE households. The relapse rates of patients from low EE families were nearly identical for those who maintained their medication and for those who did not, as well as for those who had fewer than 35 hours of contact with their relative and for those who had greater than 35 hours of family contact. The findings of Vaughn and Leff replicated for the most part the original EE study of Brown et al. (1972) and have since been replicated cross-culturally (e.g., Karp et al., 1987) and for patients suffering from disorders other than schizophrenia, including depression (Hooley, Orley, & Teasdale, 1986; Vaughn & Leff, 1976a), manic bipolar disorders (Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988), and obesity (Fischmann--Havstad & Marston, 1984). Convincing evidence indicates that the hostile/critical posture of
a family and/or their emotional overinvolvement with the patient increases the likelihood of relapse among schizophrenic patients and patients with other disorders.

Treatment Studies

An important limitation of the family studies is that they are correlational in nature. A causal relationship cannot be inferred between the household's level of expressed emotion and the patient's relapse. To examine the causal relationship of EE and relapse, investigators have developed treatment studies which attempt to reduce the level of EE and in turn attempt to lower the relapse rate. If the treatment reduces the household's level of EE and relapse rate, then one can more confidently accept the causal relationship between EE and relapse.

In a representative investigation, Hogarty et al. (1986) examined the effect of various treatment components for patients residing in families with high EE: family treatment, individual treatment-social skills training, combined family treatment and social skills training, and individual supportive psychotherapy. Each treatment contained a medication component as well. An important part of both the family treatment and social skills training was to reduce the level of expressed emotion in the household. In the family treatment, the investigators sought to educate the family members regarding the nature and course of schizophrenia and to teach specific management strategies to help cope with symptoms on a day-to-day basis. The social skills training attempted to enhance the patients' verbal and nonverbal social behavior and also to assist them to perceive and judge more accurately their social world. This was viewed by the investigators as serving as an indirect means of lowering the emotional climate of the families.

The findings of the Hogarty et al. (1986) study indicated that relative to the patients in the control condition of supportive therapy, the patients in the family treatment and social skills training relapsed much less. Moreover, patients in the combined family-social skills treatment had no relapses during the 1-year postdischarge period. Most importantly, an assessment of whether the interventions changed the household's expressed emotion revealed that there was no patient relapse in households that changed from high EE to low EE, suggesting that EE is indeed an important mechanism underlying relapse. Although Hogarty et al. (1986) and Falloon and associates (1985) make a valid argument that intervention studies do not conclusively demonstrate the causal relationship between EE and relapse, these studies, in conjunction with the family studies, provide consistent evidence of this relationship.

Attributional Analysis

There is little question that expressed emotion plays an important role in the relapse of patients with schizophrenia and other disorders. However, the specific mechanism that underlies this relationship, as noted earlier, is poorly understood. Drawing from the work of Weiner (1985, 1986), we propose that the attributions family members impute for their patient's illness and symptomatology is central to the relationship between expressed emotion, particularly criticism and hostility, and relapse. Of particular interest in understanding the relationship between EE and relapse is the previously discussed cognitive-affective-helping model. High-EE family members may view the illness and related behaviors as within the personal control of the patient. As a result, they may feel anger and/or disgust toward the patient and offer little support or help. In contrast, low-EE family members may view the illness as outside the patient's volitional control, may feel sympathy or pity, and in turn may be more tolerant, helpful, and supportive.

Although no research has prospectively examined the attributions that family members ascribe to the patient's behavior, there are two qualitative studies which provide evidence that attributions of controllability are indeed important. Vaughan and Leff (1981) conducted analyses of their family interview data to illuminate further the concept of expressed emotion. They identified four "characteristic attitudes or response styles" that discriminate between households of high and low expressed emotion. One such response style is whether the family views the patient as suffering from a legitimate illness. Vaughan and Leff report that high-EE relatives generally doubt that the patient is genuinely ill and believe that the patient is responsible for his condition. In contrast, low-EE relatives are portrayed as accepting the patient's illness. The differing response styles of high and low-EE relatives were also identified among Mexican American families. Jenkins, Kanno, de la Selva, and Santana (1986) reported "some high-EE relatives, unlike those in low-EE families, more often doubted whether their family member was truly ill" (p. 45). These qualitative findings suggest that low-EE family members attribute the patient's problem behavior to mental illness, an uncontrollable factor, whereas high-EE family members attribute behavior to the patient's own volition, a controllable cause.

Further evidence that suggests attributions of controllability are significant in the relationship between EE and relapse concerns the study of symptomatology as it relates to families' views of the patient. In schizophrenia, two types of symptom clusters—positive and negative—have been identified (Andreasen & Olsen, 1982). Positive symptoms refer to behavioral excesses, specifically the florid symptoms of schizophrenia: hallucinations, thought disorder, and delusions. Negative symptoms refer to behavioral deficits, the affective flattening, limited communication, social withdrawal, and apathy. In one study, Vaughn (1977; as noted in Fadden, Bebbington, & Kuipers, 1987) examined the content of the critical comments directed toward the patient and found them to concern primarily behavior reflective of negative symptoms, that is, lack of communication, interest, and initiative. Family members were less frequently critical of positive symptoms. These findings suggest that relatives are likely to attribute positive symptoms to the patient's mental illness (uncontrollable) and negative
symptoms to the patient's longstanding personality characteristics (controllable) Falloon et al., 1985). In other words, family members are less critical when the patient exhibits clearly recognizable signs of psychosis (e.g., hallucinations and delusions) and more critical when the patient exhibits the less recognizable symptoms of schizophrenia, including apathy, limited communication, and social withdrawal.

Hooley, Richters, Weintraub, and Neale (1987) indirectly tested the symptom-controllability hypothesis suggested by Vaughn's work. Specifically, Hooley and associates hypothesized that spouses married to patients with schizophrenia or affective disorders would report greater marital satisfaction if the patient's predominant symptom pattern reflected positive symptoms than if their spouse's symptom pattern reflected negative symptoms. Although attributions were not assessed, these investigators expected that spouses would attribute the patient's problem behaviors to the patient's illness (an uncontrollable cause) given a symptom pattern of predominantly positive symptoms. Therefore the spouse would report marital satisfaction. Given predominantly negative symptoms, the spouse was expected to attribute the patient's problems to controllable causes and thus report marital dissatisfaction. The hypotheses were supported; spouse ratings of marital satisfaction were related to the positive/negative symptom profile of their patient-partners.

An examination of the family treatments devised to improve the emotional climate of families provides additional indirect evidence of the importance of attributions in the relationship between EE and relapse. A significant aspect of the family treatment of schizophrenia is the educational component concerning the nature and management of the disorder. This component is included in the interventions developed by three main groups of clinical investigators (Anderson, Hogarty, & Reiss, 1980; Falloon, Boyd, & McGill, 1984; Leff, Kuipers, Berkowitz, Eberlein-Vries, & Sturgeon, 1982). Attention is given to correcting misperceptions of this disorder. For example, the evidence to support the biological basis of schizophrenia is presented, as is the view that families are not the cause of the disorder. These efforts strike us as attempting to reframe the attributions family members and patients themselves might use to understand schizophrenia, particularly family members' perception that the patient is responsible for his or her disorder. As noted by Hogarty and colleagues (1986), "...more direct efforts at formal education concerning the illness and its management might alter unilateral views of the patient as being either 'hopeless' or 'obstructional,' thereby reducing the understandable criticism, hostility, or emotional involvement. . . ." (p. 634). These psychoeducational efforts are consistent with current research on stigma, which suggests that education can lessen the perceived responsibility of the stigmatized person (Weiner, Perry, & Magnusson, 1988).

Although there is no direct evidence supporting the role attributions play in the relationship between expressed emotion and relapse, the available evidence suggests that attributions play an important role. Furthermore, it seems reason-

able that the emotional climate of the household is related to the relatives' causal ascriptions. Qualitative data indicate that relatives with high levels of expressed emotion are more likely to express anger, disgust, and intolerance toward the patient (Vaughn & Leff, 1981; Jenkins et al., 1986). In contrast, relatives with low levels of EE are more likely to express sympathy, sorrow and tolerance (Vaughn & Leff, 1981; Jenkins et al., 1986). This is most consistent with Weiner's cognition-affect-helping model.

Our attributional analysis has focused exclusively on the critical and hostility components of expressed emotion. The hypothesized relationship between attributions and these components is clear given Weiner's theory. The attributional basis of emotional overinvolvement is less clear at this time. At the very least, the excessive involvement of the relative may be interpreted by the patient as indicating that he has no control over his illness and/or recovery and that he must depend on his relative. If the patient agrees, he learns to do nothing for himself. If he disagrees, he may feel resentment toward the significant other which will contribute to the heightened emotional tension that is associated with relapse. This brief analysis is speculative, however, it suggests that attributions and affect may play a role in understanding the emotional overinvolvement component of expressed emotion.

Future Directions

To advance an attributional perspective in the study of expressed emotion and relapse it is important to assess directly family members' causal ascriptions of the patient's problem behavior. This is the case for family studies that examine the relationship between EE and relapse, and for the intervention studies. Russell's (1982) Causal Dimension Scale, which measures the three dimensions of locus, stability, and controllability, may be particularly helpful as it has demonstrated reliability and validity. Furthermore, a more balanced assessment of the potential range of emotions expressed by the family member might be helpful. In addition to criticism, hostility, and emotional overinvolvement, the CFI also assesses warmth and positive remarks. However, to test the attributional model directly, assessments of pity, sympathy, and even likability will contribute to a more complete test of the attributional model. Also, the notion of help giving requires operationalization so that it can be directly assessed. If we can extrapolate from the family interventions, then perhaps help giving can be measured by effective communication, problem solving, and family coping. Some efforts have been made in this area (see Doane & Falloon, 1985). In addition, an important contribution could be made by identifying how relatives effectively negotiate the delicate balance of respecting the patient's desire for social distance and tolerating the problem behaviors, but still encouraging improvement in social functioning. We believe this to be the essence of help giving in the patient-relative relationship.

In future studies of attributions, expressed emotion, and relapse, two addi-
tional points might be considered. First, it is important that the investigator make efforts to distinguish between causal attributions of the disorder and causal attributions of the problem behaviors. The perception of the original cause of the disorder may be quite different than the perception of the day-to-day problem behaviors. As noted by Brewin (1988), causal ascriptions of present functioning may be more closely tied to the hypothesized psychological consequences than causal ascriptions of the onset of a given disorder. Second, although controllability appears to be central to the study of expressed emotion and relapse, family members’ views of the stability of the causes of the problem behaviors may prove to be significant. Family members’ perception of the illness’ chronicity may be related to the sense of burden and perhaps expressed emotion. Studies which examine both stability and controllability should be able to identify the independent contributions of both causal dimensions to the family member’s perception of their relative’s serious mental disorder. Third, attention should be given to examining the processes that underlie emotional involvement. Although an attributional analysis is not as apparent for this component of EE as it is for hostility and critical comments, we believe that attributions are likely to play a role.

CONCLUSION

Attribution theory has been applied to clinical psychology primarily from the perspective of self-perception. An examination of the role of attributions in clinicians’ judgments of patients and in family member’s views of relatives with serious mental disorders indicates that attribution theory has the potential to make important contributions in the person perception domain. The study of clinical judgment and perceptions of a family member’s mental disorder are only two examples of a clinical issue with a person perception focus. Two other examples include the perceptions of spouses in marital relations (e.g., Bradbury, Fincham, & Grych, this volume) and parent’s perceptions of their children’s behavior (e.g., Affleck, McGirade, Allen, & McQueeney, 1985; Larrance & Twemlow, 1983). By highlighting the available research in clinical judgment and expressed emotion, we wish to encourage the application of an attributional framework to the further study of person perception problems of a clinical nature.

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