

EFFECTS OF ATTRIBUTIONAL STYLE AND HEALTH LOCUS OF CONTROL  
ON EMOTIONAL SUPPORT: YOUNG ADULT PARTNERSHIPS  
SHAPED BY MENTAL ILLNESS

by

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A THESIS

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## ABSTRACT

The purpose of the research was to investigate the effects of both attributional style and health locus of control on emotional support within potential partnerships that are affected by mental illness. The research focused on the young adult population due to the prevalence of mental illness. Based on previous scholarship, the research posed two central research questions: How does the perceived controllability of a mental illness influence people's willingness to give emotional support to a partner living with a mental illness? How does the attribution of the mentally ill partner's actions affect the supporter partner's willingness to lend emotional support?

Using an experimental design with participants ( $N=136$ ) answering the established measures based on hypothetical scenarios, the research manipulated the mental disorder presented (i.e., Bipolar Disorder and Substance Abuse Disorder), and how the potential actions associated with the illness could be attributed (i.e., internal or external). Independent measures included health locus of control, attributional style, perceived controllability, and willingness to lend emotional support. The results suggested several important implications. Participants reported that the mental illnesses presented were moderately to highly controllable. The results also inferred that their willingness to lend emotional support is effected by the perceived controllability of the illness. Lastly, the research suggested that being able to attribute certain behaviors to the diagnosis is a factor in the participants' willingness to lend emotional support.

## DEDICATION

This thesis is dedicated to those who inspired me not only to become the best student I could be, but also to be a better person. Thank you to the friends, family, and mentors who have guided me every step of the way.

## LIST OF ABBREVIATIONS AND SYMBOLS

ANOVA	Analysis of variance
<i>df</i>	Degree of freedom
<i>f</i>	Frequency
F	Fisher's <i>F</i> ratio
H	Hypothesis
<i>M</i>	Mean (Arithmetic average)
<i>n</i>	Number in a subsample
<i>N</i>	Total number in a sample
<i>p</i>	Probability associated with the occurrence under the null hypothesis of a value as extreme as more extreme than the observed value
SD	Standard deviation
SE	Standard Error
<i>r</i>	Pearson product –moment correlation
RQ	Research question
<i>t</i>	Computed value of <i>t</i> test
$\alpha$	Alpha; probably of a type I error; Cronbach's index of internal consistency

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## INTRODUCTION

Each day people try to make sense of the behaviors of others, and this is especially prevalent within our close relationships. The practice of creating the causes of behavior in our mind is also known as forming *attributions*. How we *attribute* certain behaviors influences communication processes within the relationship including how and if we will lend emotional support. The purpose of the research was to investigate relationships in which the boundaries of understanding the causes of behavior could be affected by one partner's mental illness<sup>i</sup>. The present research was based on the common understanding that with most mental illnesses symptoms include variations in personality and action (NAMI, 2008). The research set to investigate several questions involving both attribution and controllability. The current research manipulated hypothetical relationship scenarios in which a person is asked questions based on if their potential partner<sup>ii</sup> was to be diagnosed with a mental illness. Thus, if a relationship is shaped by a diagnosis of a mental health illness, does the supporter role change based on how they attribute their partner's actions and behaviors? As a result, can a supporter attribute their partner's actions directly to the illness, or do they blame it on personality or mood? In addition, how does attribution affect their willingness to lend emotional support? If the partner can attribute their partner's actions to the illness, do they believe that the behaviors potentially caused by the illness are controllable?

The National Alliance on Mental Illness (NAMI) defines mental illnesses as “medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to

others, and daily functioning.” Mental illnesses are medical conditions that often result in diminished capacity for coping with the ordinary demands of life (NAMI, 2009). Examples of mental illnesses/disorders include: Anxiety Disorders, Attention Deficit Hyperactivity Disorder (ADHD; ADD), Bipolar Disorder I and II (Manic-Depressive Illness), Borderline Personality Disorder, Depression, Eating Disorders, Panic Disorder, Post-traumatic Stress Disorder (PTSD), Substance Abuse Disorders, and Schizophrenia. According to the National Institute of Mental Health (NIMH), mental illnesses are common in the United States and internationally. Mental illness can affect persons of any age, race, religion, or income (NAMI, 2009). An estimated 26.2 percent of Americans ages 18 and older (approximately one in four adults) live with a diagnosable mental illness in a given year (NIMH, 2008). Six percent, or one in seventeen of those diagnosed, suffer from what is considered a serious mental illness (NIMH, 2008). In addition, mental illness is the leading cause of disability in the United States and Canada for persons between the ages of 15 and 44 years (NIMH, 2008). Remarkably, the impact and implications of mental health issues are often underestimated and understudied outside of certain fields. The present study extends the research on mental health and mental illness to understand how it affects our communication processes. More specifically, the research is focused on mental health and communication within close interpersonal relationships among young adults.

It is through communication that we come to socialize and create understanding about our health. However, communication can produce stigmas regarding certain illnesses. The following discussion will review research that indicates mental illness is often still stigmatized. Examining how people communicate about mental health,

including the lack of ability to communicate about mental illness and/or the lack of ability to communicate with a person with a mental illness, is pivotal in exploring mental health holistically. The goal of the research was to examine mental illness as a variable in communication processes within interpersonal relationships. More specifically, the researched explored the “supporter role” in romantic relationships. One of the most pivotal communication processes that helps to maintain a healthy relationship is that of emotional support. Those living with mental illness often seek out emotional support from their families, professional caregivers, shelters, friends or roommates, case managers, and/or community support groups (NIMH, 2008). Thus, understanding why emotional support is given or withheld is critical. There are several variables that affect a person’s willingness to lend emotional support. The present research focused on how daily attributions of behaviors affect a person’s willingness to lend emotional support within partnerships dealing with one partner’s mental illness.

The research used both attribution theory and the concept of locus of control in guiding the investigative inquiry. The goal of using attribution theory was to gain understanding of when emotional support is given or not given based on how a person attributes their partner’s actions that are often associated with their mental illness. Based on reviewed research attributions are often biased, that is based on previous knowledge, experiences and expectations, thus leading to insight into why people might stigmatize certain mental illnesses. The research is important because of the lack of understanding of how daily attribution affects emotional support in interpersonal relationships dealing with a partner’s mental illness. The intended use locus of control (LOC) was to gain a deeper understanding of the act of asserting judgments of

controllability when it applies to another person's health. Often there is a focus on generic relationships and/or the role of a caregiver. The present research focused on the supporter/supportee relationship in young adult partnerships. The following literature review highlights mental illness and the young adult population, emotional support, attributions, and stigma. It also establishes the theoretical approaches of attribution theory and locus of control.

## DISCUSSION OF LITERATURE

### *Mental Health in Young Adults*

Recently, the New York State Psychiatric Institute, the NIMH, and the American Foundation for Suicide Prevention released the results of an in depth study examining the prevalence of mental illness among young adults (*Associated Press*, 2008). Their report stated that an estimated one in five young American adults have a mood/personality disorder that interferes with everyday life, including the abuse of alcohol or drugs. The disorders mentioned included obsessive or compulsive tendencies and anti-social behavior that could lead to violent tendencies. The results also suggested that fewer than 25 percent of college-age Americans with mental problems get treatment (*Associated Press*, 2008). Beyond substance abuse disorders, the study found that nearly half the young people within the study had some sort of diagnosable psychiatric condition including personality disorders that were the second most common problem. The study points to acts of violence on campuses to increase the need for awareness of mental health across the United States. The college population is considered to be a particularly vulnerable age group (*Associated Press*, 2008). Though the rate of cases is momentous, research on mental illness has an added complexity. Mental health issues are for the most part “invisible disorders,” in that there are no physical cues. Therefore, people who are diagnosed must typically be willing to disclose and discuss their health. There are several factors that impact a person’s willingness to discuss or disclose information on their mental health. Although

the present research is not specifically investigating the disclosure of mental health, it is imperative to understand it as an added variable in the study. The research reviews the decision-making and disclosure process of young adults; in addition, the research reviews studies that have drawn significant results on how mental illness affects relationships, and lastly, the research examines the connection between stigma and mental illness.

In regard to the present study, it was important to examine current research on the college student decision making process when disclosing and sharing information with their friend or partner. In Mathews, Derlega, and Morrow's (2006) study, 238 college students were asked to describe an experience, feeling, or private characteristic that they considered to be very personal. The descriptions were coded into ten different categories, including self-concept/self-image, romantic relationships, sex, psychological problems, abuse/assault, death/illness, family relationships, moral issues/illegal activities, unplanned pregnancy, friendships, plus a miscellaneous category. The results showed that disclosure was more frequent to same-sex friends (61.3%) and dating partners (63.4%), less frequent to mothers (39.1%), and least frequent to fathers (26.5%) (Mathews et al., p. 87). The rate of disclosure to dating partners is part of the rationale of looking closer at young adult partnerships.

The dynamics of changing relationships are also an added complexity of the college student population. Students are entering into new friendships, and starting to develop deeper partnerships. In a follow up to the previously cited research, Derlega, Winstead, Mathews, & Braitman (2008) examined open-ended responses of college students concerning disclosing personal information. The researchers looked directly at



the causal attributions generated for disclosing or not disclosing personal information to one's mother, father, same-sex friend, and dating partner. The results suggested that participants frequently mentioned having a close relationship within which they trusted another person to seek support from and disclose private information. The majority of participants also stated the reason for not disclosing information was for fear of losing the other's respect. Both the number of cases of mental illness in the young adult population, paired with the willingness to disclose and discuss personal health within romantic relationships/partnerships is the rationale behind the present research's population focus.

Relationships dealing with mental illness have been studied through other communication processes, including power, control, and expressed satisfaction. Duggan (2006) researched romantic partnerships wherein one person experienced depression. "I'm More Comfortable When You are Depressed: Family Systems and Attempt to Control Others as Predictors of Satisfaction in Romantic Relationships," set to uncover the paradoxical nature of the power structure in romantic relationships with a depressed individual, and how the power structure limits the types of control strategies the non-depressed partner can use through the theoretical model of Inconsistent Nurturing as Control Theory (INC). The research sampled couples that included one depressed individual (N=148) and a group of 68 non-depressed couples that enacted as the control group. The results suggested that individuals who perceive they have limited family control and who use more direct attempts to control others also indicated attributions of greater external control within the relationship. The same participants also reported more frequent use of communication strategies that reinforce depression

and discourage alternative emotional outlets. In addition, the subjects who used more consistent sequences of negatively-valenced communication strategies, have poorer mental health, and indicate less cohesiveness within the relationship. Though some research has examined relationships dealing with one partner's mental health diagnosis, little research has linked the theory of attribution and LOC to show how it affects communication processes. For the present research, the communication process of emotional support is the focal point.

### *Emotional Support*

Emotional support is an essential element in helping sustain relationships. Emotional support includes expressions of care, concern, love and interest that support the emotional experience of another person and validates the person's thoughts, feelings, and behaviors (Wood & Duck, 2006, p.195). Within friendships and partnerships, people seek out others who will provide comfort in times of distress and will help work through a problem with sensitivity and concern for our well-being (Burleson & Samter, 1994). While relationship dynamics and variables are often unique, certain values are still consistent across. Relationships often work best when feelings are listened to and affirmed rather than criticized and discounted (Metts, 2006, p.83). However, within relationships dealing with one partner's mental illness, there are added strains on the availability and the continuing of emotional support. Often supporters risk for themselves depression, burnout, and other negative health effects while dealing with the variability in their partner's behavior due to symptoms of their mental illness. Emotional support in interpersonal relationship is clearly linked to a person's psychological well-being (Forst€rling, 2001, p. 166).

As an example of the role emotional support plays in relationships dealing with mental illness, Brewin, MacCarthy, Duda, and Vaughn's (1991) research analyzed interviews with family members of schizophrenics. The research confirmed that the relapse rate of individuals who were treated for schizophrenic episodes and who returned to their families and relationships after hospitalization were greatly affected by the atmosphere and support provided. Relationships that express hostility, anger and criticism to the person with the illness may make the person feel that they are responsible for their symptoms. There are several studies that link expressed emotions from an attributional viewpoint (Forst rling, 2001, p. 167). In summary, families and relationships that expressed a high level of emotional support and attributed illness-related behavior to uncontrollable causes expressed sympathy and pity towards the person with the illness, supported him/her socially, and therefore, prevented relapses (Forst rling, 2001, p. 167). Another variable influencing both the theoretical framework and the communication process of emotional support is the notion of stigma and its connection with mental illness.

### *Stigma*

The present research examined how attributes encourage or discourage stigmatizing mental health issues. Erving Goffman (1963) researched disabilities and stigma. According to Goffman, (1963) stigma is "an attribute that is deeply discrediting" (p. 3). Attributes that have been previously labeled as discrediting someone socially include: "mental illness, homelessness, facial disfigurement, HIV/AIDS, and physical disability" (Weiner & Magnusson, 1988). It is important to note that often what is stigmatizing can change over time and may differ across contexts and cultures. There

are several variables that link mental illness, and stigma, one of which is the element of controllability. Therefore, the research addresses notion of controllability through both attribution style and locus of control.

Weiner and Magnusson (1988) examined the perceived controllability and stability of the causes of ten different stigmas including: AIDS, Alzheimer's disease, blindness, cancer, child abuse, drug addiction, heart disease, obesity, paraplegia, and Vietnam War Syndrome. The research asked 59 participants 13 questions, three questions regarding responsibility and blame for a stigma and its changeability, five questions pertaining to liking, pity, anger, charitable donations and personal assistance, and five questions examining the likelihood of improved life satisfaction given job training, professional-educational training, welfare, medical treatment, and psychotherapy (Weiner et al., 1988, p. 740). By using attribution theory, the results suggested that physically based stigmas were perceived as "onset-uncontrollable and elicited pity, no anger, and judgments to help." However, mental-behavioral stigmas were perceived as "onset-controllable and elicited little pity, much anger, and judgments to neglect." In addition, the research concluded that physically based stigmas were perceived as stable, or irreversible; whereas mental-behavioral stigmas were generally considered unstable or reversible (Weiner et al., 1988). Present reviewed research still indicates a high level of stigma associated with mental illness. Despite research on both mental health and stigma, research has been unable to link modes of application to lower this connectivity. In continuing to understand how controllability and attribution effects communication processes the present research uses the concept of locus of

control and the theoretical model of attribution theory. The research also links locus of control to the theory of attribution.

### *Health Locus of Control*

The term locus of control (LOC) refers to a person's belief that the events which occur in life are either a result of personal control and effort or an outside force (e.g. fate, luck). Perception of positive and negative events that are considered a consequence of one's own actions (i.e., under one's personal control) are known as internal LOC. In contrast, external LOC references the perception of positive or negative events being unrelated to one's own behavior and in so doing beyond personal control. For example, it can be determined that a person with internal LOC believes that events in their lives are under their personal control. Individuals then believe that good health (or poor health) is directly related to their own actions. They often attribute a diagnosis of illness to current or past personal behaviors (Wallston, Wallston & DeVellis, 1978). While individuals with external LOC feel that their lives are controlled by the environment (Graffeo & Silvestri, 2006, p. 593). External LOC allows an individual to place the cause of illness outside his or her personal control and responsibility, permitting an individual to avoid a sense of blame or guilt (Wallston, et al., 1978).

The theory of LOC was first derived from Rotter's Social Learning Theory of 1954 (Rotter, 1982). Rotter developed the Locus of Control Scale to measure generalized perceptions of individuals toward internal or external control. It was Wallston et al. (1978) who expanded on Rotter's theories by developing the construct of A Multidimensional Health Locus of Control scale (MHLC) in 1976. The MHLC, as a measure, could identify not only an individual's tendency toward internal or external

behaviors, but also “further divide those who perceived control as coming from somewhere other than from within as blaming fate and luck, or what became known as “powerful others” (Graffeo & Silvestri, 2006, p. 594). In a review of Mackey (2002), an abundance of research has linked internal LOC to positive health beliefs and behavior. For example, a person with an internal LOC is more likely to seek out health-related knowledge (Mackey, 2002). It was also added by MacArthur and MacArthur (1999) that a sense of control such as experienced by internals led to improved emotional and mental health. For the following study, the concept of health locus of control is extended. The MHLC is used to determine the perception of internal and external control a person has on their own health, for the purposes of this study, an adaptation was used to determine the perception of internal and external control a person believes his/her partner has on their health. The following conceptualizes locus of control to attribution theory.

### *Attributions*

Social cognition is the study of “mental processes and structures used to make sense of, remember, and think about people and interactions” (Canary, Cody, & Manusov, 2000, p.80). Our cognitive structures and processes influence our perceptions of people and events, thus affecting how we communicate (Canary, et al., 2000, p.80). The study of social cognition includes how we create and use attributions in daily communication interactions. Each day when we perceive others and make judgments about them or about ourselves we are making attributions about behaviors (Canary et al., p. 83). The term *attribution* refers to the assessments of the cause of an action or behavior (Galvin & Cooper, 2006, p.83).

In a review of Jones and Davis' (1965) work, the addition of examining decision making behind attributions is critical in understanding the process of attribution completely (Galvin & Cooper, 2006, p.83). For example, before making an attribution, a person must decide if the person acted with intent. The behaviors judged to be intended are thought to say more about the person than those thought to have occurred without intent (Galvin & Cooper, p. 84). There are concepts to help aid in understanding attribution, include: *consistency*, the extent to which a person's behavior is the same over time. For example, if a partner has always received high grades he/she should exhibit the ability and or motivation to continue to make good grades, however, if a partner started receiving bad grades, one might look for external causes for the recent bout of bad grades. Next is *distinctiveness*, whether or not a person's behavior is clearly different in one situation than in other situations. For example, if a partner got good grades in all classes but one, one might look for an external attribution (e.g., tough class, bad professor, etc). However, if a partner received all bad grades, one might be more than likely make an internal attribution (e.g., he/she is not very smart, unmotivated, etc.). Lastly, the concept of *consensus*, is the perception of similar others in similar situations. For example, when it comes to grades a person would base a partner's performance on the census within the class. If the partner did poorly, and the class census was high grades, then one might make an internal attribution on their performance (Galvin & Cooper, p. 84). The study of attributions is important for understanding interpersonal communication, in that the causes we give for behaviors are part of the meaning we derive from them (Galvin & Cooper p. 85). The meaning created is then a fundamental part of what is communicated in an interpersonal

interaction, thus influencing interactions within our relationship. After understanding the concept of attribution within the study of social cognition, the next step in the present study is to establish attribution as the applied theoretical framework.

### *Attribution Theory*

Heider (1958) proposed attribution theory based on the assumption that people strive to predict and control their environments. Often prediction and control can be researched through an understanding of the causes of behavior. Heider (1958) suggested that observed behaviors are attributed to the person (internal/dispositional) or the environment (external/situational). People then choose to respond to the observed behaviors based on whether it is dispositionally or situationally attributed. Weiner (2008) added to Heider's attribution theory by arguing that the dimension of controllability must be included. Before, dispositional and situational factors referred to the perceived causes of behavior. The addition of controllability allows for focus on behavior that is seen as voluntarily produced and how individuals are viewed as responsible for it (Weiner, 2008). Thus, the addition of controllability advanced the theory within the general notion of causality.

Attribution theory was then once again extended by linking causality and controllability to the idea of responsibility (Bradbury & Fincham, 1992). For example, a person can conclude that it would be unreasonable to hold someone responsible for a behavior he or she did not cause. Heider (1958) created a three-stage process of attribution during which a person (a) perceives or observes a behavior, (b) believes the behavior was intentional, and (c) determines if she or he believes the person was forced to perform the behavior. Weiner (1980) suggests the perceptions of controllability will



produce more negative feelings than uncontrollability. Thus, within a romantic relationship dealing with a mental illness, if a partner thought the actions of his/her diagnosed partner could be easily controlled but were not, the partner would express overall frustration with the relationship and the person. It also provides insight to how people perceive controllability in correlation to responsibility when it comes to health.

The addition of controllability is central in understanding one of the present research's main arguments and assumptions. In regard to another person's health, people still enact judgments of responsibility and controllability, especially in regard to behaviors and emotional state. The research also gained an understanding of which health conditions elicit certain judgments of responsibility and controllability and in return how that affects communication within the relationship. If, for instance, an illness/condition is generally stigmatized, what is the perception of controllability and responsibility for that illness? As stated previously, mental illnesses are often stigmatized. In review of research that has linked attribution theory to stigmas, Haider-Markel and Joslyn (2008) research used an empirical test of attribution theory to discuss beliefs about the origins of homosexuality and the support for gay rights. Haider-Markel and Joslyn (2008) elaborated "for example, there are causes for which a stigmatized person may not be held responsible- uncontrollable - and others for which there is personal responsibility -controllable." Haider-Markel and Joslyn (2008) assert that, in general, attributing stigmas to a controllable cause elicits a greater anger and negative affect towards the stigmatized. The research links feelings of anger and negativity to the diminish capacity and willingness to give emotional support within a relationship.

Based on the reviewed literature regarding controllability, the research proposes the following question:

RQ 1: How does the perceived controllability of a mental illness influence people's willingness to give emotional support to a partner living with a mental illness?

Studying attributions are important for several reasons. Attributions help people predict future behavior, and often accurate attributions can reduce uncertainty (Heider, 1958). We use attributions to help explain unexpected behavior and make sense of the world. However, people's attributions are often biased for several reasons. In addition, there is a lack of research on attribution theory in regard to mental health and partnerships. However, attribution theory has been thoroughly used in the relationship of caregiver and patient.

Williamson (2005) researched caregiver resentment in relationships with a person affected by Alzheimer's disease. Attribution depends on the perceptions of others' abilities to control their own behavior. Frequently, people are more sympathetic or less angry towards those who demonstrate disturbing behavior through no fault of their own. Therefore, if the behaviors accurately reflect what are known symptoms of the disease, then the caregiver/supporter can attribute such a behavior to the illness (p. 216). Often our belief about one's behavior is connected with an overall disposition while knowing them. Thus, if a long-term relationship was interrupted by the diagnosis/onset of a mental illness, then what can be determine as complications from the illness, may be attributed wrongly by the partner based on previous and on-going expectations (Williamson, 2005, p. 216). It is also easier to blame the person for their behavior, than it is to seek out and understand alternative explanations. The research

concluded that caregivers are most resentful when care recipients are difficult in ways that can be attributed easier to the person rather than to the illness (Williamson, 2005). Polk (2005) in a qualitative study guided by attribution theory and problematic integration theory (PI) investigated the emergence of themes related to family caregiving issues involving a loved one with Alzheimer's dementia. Polk (2005), concluded that attributions might result in "more negative caregiver reactions to mild disabilities and less negative creations for severe disabilities." In addition, caregivers may be drawn into conflict more easily because they perceive the disabled person to be responsible for their behavior (Tynan & Allen, 2002). Attribution theory has been used in research involving identity (Surra & Bartell, 2001), stigma (Pittman & Gallois, 1997), and various relationships (Manusov & Koenig, 2001) (Polk, 2005). Thus, using the theory in the area of researching attribution of mental health issues within relationships is fitting. Based on the reviewed studies of attribution and caregiving the present research proposed the following research question:

RQ 2: How does the attribution of the mentally ill partner's actions affect the supporter partner's willingness to lend emotional support?

To elaborate how attributions could affect emotional support in relationships an example is needed. If a couple had been dating for several years and at some point one partner is physically attacked by an intruder. Following those events, the partner experienced persistent frightening thoughts and memories of the ordeal and began feeling emotionally numb, especially with people they were once close to, including their partner. The partner also experiences sleep problems, feels detached and is easily startled. The partner is diagnosed with Post-Traumatic Stress Disorder (i.e., an anxiety disorder). The supporter partner may be able to give support if they can attribute the

behavior directly to the attack (i.e., an external attribute). However, if the supporter partner does not attribute the behaviors to the attack (i.e., rather attribute it internally) or have thoughts about how the attack could have been prevented (i.e., controllability), she/he may feel disappointed or frustrated with their partner, thus lowering their level of emotional support to them. Not only is attribution a factor in lending emotional support, but also the perceived controllability of that attribute. Frequently, previous held expectations of her/his partner and the need for certainty within the relationship can impede continuing the relationship.

As previously mentioned, the use of attribution theory in this study is to explain how people use attributions to understand and react to the actions of others. People not only make attributions with regard to their own behavioral outcomes and the events that happen to them, but also people want to explain the behavior outcomes of other individuals (Forstöring, 2001, p. 149). Understanding attributional approaches assumes that the causal descriptions that people make for other individuals' outcomes influences the reactions toward these individuals with regard to these outcomes (p. 149). In review, it has been shown that important interpersonal behaviors, interpersonal emotions, and interpersonal motivation depend, at least in part, on causal explanations made for the other individual's behaviors and behavioral outcomes. Often in interpersonal relationships reactions that are guided by attributions are often of an evaluative nature, such as praise or blame, anger or sympathy, or help or punishment. What influences these evaluations include aspects and dimensions of controllability, responsibility, intentionality, or culpability (Forstöring, 2001, p. 149). For the present research, the focus was on the element of *controllability*. Weiner (1995) researched the

importance of the casual dimension of controllability for interpersonal evaluation, emotions, and behaviors. Weiner (1995) argued that it is not only the controllability interference, but also the judgment of responsibility that triggers the differences in reaction. Weiner (1995) states, “causal controllability refers to the characteristics of a cause... Responsibility, on the other hand, refers to the judgment made about a person” (p. 8).

In a review of Weiner’s work on the controllability dimension, a cause is regarded as controllable if the individual is personally able to guide, influence or prevent it. Forst rling (2001) used “drunkenness” as an example to describe the controllability of causes. He suggests that “drunkenness” is perceived as a controllable cause. He continues, “Causes that can neither be influenced nor guided, such as a “physical handicap”, blindness or being crippled, are regarded as being uncontrollable” (Forst rling, 2001, p. 157). However, what the current research investigated is illnesses that don’t carry along physical indicators. Mental illness is often only known through the communication process of disclosure. Therefore, judgments on a person’s behavior are sometimes created before a person realizes someone has a condition. Meaning mental illness, based on the symptoms and signs, is often misattributed as both internal and controllable. Additionally, the relationship between perception of controllability and the actual act of helping is not direct, but mediated through emotions (Forst rling, 2001, p. 157). Weiner extends that attributions lead to emotions and that these guide behavior (p. 157). Pilliavin, Pilliavin, and Rodin’s (1969) study revealed high correlations between controllability judgments and emotions. For example, anger correlated with actions that were seen as controllable, whereas pity and sympathy correlated to actions that were

viewed as uncontrollable. Pilliavin et al. (1969), along with Weiner's studies have had a history of successful replication (Forst€rling, 2001, p. 158). Further, these studies support the idea that there is a motivational sequence in which cognition leads to emotions and as a result, guide behavioral intentions (Forst€rling, 2001, p. 159).

Attribution theory has also been applied to scenarios of disease. Weiner (1995) imagined that an important aspect of disease consists of the causal attributions for the disease (p. 163). For instance, if a person gets cancer we don't just register she/he is sick, but we often ask why a person got cancer (Forst€rling, 2001, p. 163). For example, with cancer, we may ask if she/he were a smoker. Or does cancer run in the family. Weiner et al. (1988) investigated the idea that various types of diseases and illnesses differ in perceived controllability and that these controllability perceptions influence reactions toward the "ill or stigmatized persons" (p. 163). In continuing the review of Weiner et al. (1988) research that presented their participants with 10 diseases (that varied in perceived stigma) including: AIDS, Alzheimer's disease, blindness, cancer, child abuser, drug addiction, heart disease, obesity, paraplegia, and Vietnam War Syndrome. Weiner asked participants to rate how responsible the persons were for these conditions (Forst€rling, 2001, p. 164). The results were that Alzheimer's disease, paraplegia, and cancer yielded relatively low responsibility ratings. However, obesity, AIDS, and drug addiction yielded comparatively high responsibility judgments (p. 164). In addition, the experiments of Weiner et al., (1988) supported that conditions in which the "ill" person was perceived responsible (e.g. drug use) yielded less pity and more anger, and less assistance. It is noted that perceptions of "responsibility of diseases and illness are not fixed, but they may vary from case to

case, person to person, and across time periods (Forstërling, 2001, p. 165).” It is important to note that providing a person with new information (i.e., that is attributionally relevant) of certain diseases or illness can alter his/her reaction towards the “ill and stigmatized persons (p. 165).”

### *Research Questions*

The present research posed two central research questions based on theory and previous research.

RQ 1: How does the perceived controllability of a mental illness influence people’s willingness to give emotional support to a partner living with a mental illness?

RQ 2: How does the attribution of the mentally ill partner’s actions affect the supporter partner’s willingness to lend emotional support?

Using an experimental design, the research manipulated through a narrative stimulus the mental disorder presented (i.e., Bipolar Disorder or Substance Abuse Disorder), and how the potential actions associated with the illness could be attributed (i.e., internal/external). H1: Based on the reviewed literature, it was hypothesized that people who perceived their partner’s condition as controllable would be less willing to lend emotional support than those who believe the illness is uncontrollable. H2: It was also hypothesized that people who could accurately attribute certain behaviors to sign/symptoms of the illness would be more likely to lend emotional support than those who attribute the actions as internal and or dispositional.

## METHOD

### *Participants*

The present study was specifically interested in the young adult population. Students from a southeastern university were asked to participate. The study included 136 undergraduate participants ( $N=136$ ). The participants of this study comprised a sample of convenience, because they were obtained through the university in introductory courses. All solicitation of participation for the research was conducted within the classroom setting. At the discretion of the instructor, course bonus points were made available to the students who successfully participated. Those students who did not wish to participate were not obligated and received other methods of obtaining course bonus points. In certain courses, participating in research was a component of the class. The study population included both men (36%) and women students (64%). The average age of participation was 20.35 years old ( $SD= 2.82$ ), with the range being 18-45 years. The study was extended to all ethnicities. Reported ethnicities included: American Indian/Alaskan Native ( $n=1$ ), Asian ( $n=1$ ), 14% Black ( $n=19$ ), Hispanic/Latino ( $n=1$ ), and 83% White ( $n=113$ ). A variety of educational backgrounds were also reported. Majors included: communication studies, political science, engineering, business, psychology, music, art, English, human environmental sciences, and education. Also reported were the participants' relationship statuses. Participants reported the following relationship statuses: 37% Single ( $n=51$ ), 19% Single & Actively Dating ( $n=27$ ), 41% in a Relationship ( $n=56$ ) and/or 1% Married ( $n=2$ ).



## *Materials*

The research used a 2 x 2 (i.e., Type of disorder presented x Implied Attribution) experimental design. Appendix A is a diagram of how condition groups were formed. The experiment consisted of two different variables being manipulated at two different levels measured by pre and post testing. In each experimental group, the participants were randomly assigned 1 of 4 narratives (i.e., the stimulus). Based on random assignment and successful participation, the number of participants per condition was: Condition A ( $n=30$ ), Condition B ( $n=38$ ), Condition C ( $n=24$ ), Condition D ( $n=31$ ), and Control Group ( $n=13$ ). The narratives were presented to the participants immediately following the completion of the pretest. The two independent variables that were manipulated within the narrative included: Type of mental disorder presented (Mood Disorder (i.e., Bipolar Disorder) or Substance Abuse Disorder (i.e., Alcoholism) and how the narrative constructed certain behaviors that could be associated with the mental illness (i.e., How it was attributed--internal or external causation). The narratives represented hypothetical relational interactions, and behaviors the participant could have encountered with a relationship partner if he or she was diagnosed with the presented mental illness. The narratives were created based on personal narratives from accredited support group sites for mental health issues, and based on well-studied and identifiable symptoms located within the research of the National Institute of Mental Health. Each narrative clearly identified the disorder in which their potential partner was diagnosed. The narratives were produced by the principal investigator, with direction from outside faculty researchers to ensure best reliability and manipulation. In each narrative the partner who has been diagnosed with the disorder confronts aspects

of seeking help, being diagnosed, understanding symptoms of the disorder, interacting with environment, seeking support systems, and reflecting on relationships. Appendix B contains the full narratives used.

*Stimulus Condition: Bipolar Disorder*

For the narratives the mental illnesses of Bipolar Disorder and substance abuse disorder were chosen. Bipolar Disorder, also known as manic depression, is a medical illness that causes extreme shifts in mood, energy, and functioning (NAMI, 2009). Bipolar Disorder is a chronic and generally life-long condition with recurring episodes of mania and depression that can last from days to months. A person with Bipolar Disorder may experience behavioral changes that can be subtle or dramatic, and could vary greatly over a course of their lifetime. Over 10 million people in America have Bipolar Disorder (NAMI, 2009). Often the onset of Bipolar Disorder is during adolescence or early adulthood. The proposed treatment for Bipolar Disorder includes medication, psychotherapy, support and education. The commonly identified symptoms of the mania stage of Bipolar Disorder include: dramatic shifts in mood, increased physical and mental activity, and energy, racing thoughts and flight of ideas, increased talking with rapid speech pace, ambitious plans, risk taking, impulsive activity such as spending sprees, sexual indiscretion, and alcohol abuse, and decreased sleep without the experience of fatigue. Symptoms of the depression stage include: loss of energy, prolonged sadness, decreased activity and energy, restlessness and irritability, inability to concentrate or make decisions, increased feelings of worry and anxiety, less interest or participation in activities normally enjoyed, feelings of guilt and hopelessness, thoughts of suicide, changes in appetite and changes in sleep patterns (NIMH, 2008).

In regards to the narrative and the implications of the results it is important to understand the cause of Bipolar Disorder.

The underlying cause of Bipolar Disorder is unknown; the research suggests that Bipolar Disorder is likely caused by multiple factors that interact with each other to produce a chemical imbalance affecting certain parts of the brain (NAMI, 2009). Bipolar Disorder is also seen to have a hereditary/genetic component. In addition, a stressful environment or negative life events may interact with the underlying “biological vulnerability” to produce the disorder (NAMI, 2009). In regard to the present research, Bipolar Disorder was selected as a variable because of the age of the emergence of symptoms in accordance with the sample, it is equally identified in both males and females, and because mood/personality disorders are highly common within the young adult population, second only to substance abuse disorders. Within the narrative stimulus used, behaviors that were described that could be linked to known symptoms/signs included: postponing the start of medicine and or treatment (e.g. irrational decision making), abuse of alcohol, spending spree, sexual indiscretion (e.g. impulsive activity), and excessive changes in sleep pattern.

*Stimulus Condition: Alcoholism*

Substance abuse is the most common mental illness within the young adult population. The present research focuses on Alcoholism. Alcoholism is a chronic disease that makes your body feel dependent on alcohol. People become obsessed with alcohol and are unable to control how much they drink, even if it causes serious problems within relationships, health, work and finances (Mayo Clinic, 2009). Some people have a problem with alcohol, but do not display all characteristics of Alcoholism,

this is referred to as “alcohol abuse” (Mayo Clinic, 2009). Signs of Alcoholism and alcohol abuse include: denying having a drinking problem, drinking alone or in secret, being unable to limit the amount of alcohol consumed, not remembering conversations or commitments, often referred to as “blacking out,” ritual drinking, losing interest in activities/hobbies that once brought pleasure, feeling the need or compulsion to drink, increased irritability, keeping alcohol in unlikely places, becoming intoxicated intentionally to feel good or “normal,” and experiencing physical withdrawal symptoms- including nausea or shakes (Mayo Clinic, 2009).

Alcoholism occurs gradually. Over a period of time, drinking alcohol alters the balance of some of the chemicals in your brain, including gamma-aminobutyric acid (GABA), which inhibits impulsiveness, and glutamate, which over excites the nervous system (Mayo Clinic, 2009). Alcohol also raises the levels of dopamine in the brain, which is associated with the pleasurable aspects of drinking. Other factors that can lead to excessive drinking and the addiction process include: genetics, emotional state, psychological factors/other mental illnesses, and social/cultural factors. The present research focused on alcohol abuse/Alcoholism not only because of its prevalence among young adults, but also because the signs/symptoms are often mistaken as a part of the college culture. The narrative stimulus used with the research presented the following behaviors that could be attributed to Alcoholism/alcohol abuse: excessive spending on alcohol, excessive consumption, blackouts, ritual drinking, and increased irritability when drinking is unavailable. It is important to note that there are certain aspects of the college culture that are addressed in both narratives. The summary discusses how these aspects could affect the results and implications of the study.

### *Pretests*

For the experiment, each participant first completed a pretest. The pretest included descriptive statistics of sex, age, education level, and relationship status. The pretest used a 7-item semantic differential scale to obtain a measure of comfort level with personal health, partner health, and mental health, along with the comfort level of discussing each. The Cronbach's Alpha level of the comfort measure was .892. The response scale included: very comfortable (4), somewhat comfortable (3), a little uncomfortable (2) and very uncomfortable (1). The comfort level measure was created by the principal investigator (Appendix C).

Next, participants completed the four-item version of the Relational Attribution Measure (RAM) (Bradbury & Fincham, 1990). The RAM assesses the types of attributions people make for a partner's negative behavior (Fernandez-Ballesteros, 2002). Respondents read four hypothetical negative actions by their partner and rated the causes of that event along six dimensions including: locus, stability, globality, and responsibility (p. 119). For each behavior presented, the participant was asked to rate their agreement with several statements on a 6-point scale. Each scale point ranged from disagree strongly to agree strongly. Appendix D is the complete version of the RAM. Bradbury and Fincham (1992) state the use of hypothetical behaviors allowed for the advantage of having a standard stimulus across relationships and because the pattern of responses to such behaviors are similar to that found for attribution for relationship difficulties (Bradbury & Fincham, 1992, p. 458). The Cronbach's Alpha level for the RAM was a .927, which is addressed within the discussion. Previous research supports a composite of the all the attributional dimensions displays high internal

consistency and predicts relationship satisfaction. Partners who attribute negative partner behavior to internal, stable, and global causes are more likely to be dissatisfied with the relationship (Fernandez-Ballesteros, 2002). It can be assumed that dissatisfaction within a relationship would impact the willingness to lend emotional support.

Finally, the pretest included a general Mental Health Knowledge Quiz (Appendix E). The quiz consisted of 12-multiple choice questions created by the Canadian Mental Health Association (CMHA), a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness (CMHA, 2009). The basis for using the quiz is to ensure a complete understanding of basic knowledge and comfort level with mental illness. Participants could have reported a high level of comfort discussing mental health issues, but that is only one portion of understanding the communication processes about mental health. The test is not to represent a universal knowledge level for young adults, but used to gain a measure for the basic knowledge level the participants had at the time.

Following the pretest was the reading of the randomly assigned narrative stimulus, as previously described (Appendix B). After reading and understanding the narrative, the participants completed the posttest. The posttest asked the participants to respond based on the narrative and the hypothetical diagnosis of their potential or current partner. Dependent measures included ratings of controllability, emotional support level, and attribution style.

## *Posttests*

During the posttest participants first completed a variation of the 18-item Multidimensional Health Locus of Control scale (MHLC). The original version of the Multidimensional Health Locus of Control scale (Wallston, Stein, & Smith, 1994) was designed to be “condition-specific.” The measure was a locus of control of one’s own health. For the purpose of the present study, the wording was altered to describe a partner’s condition. The participants were asked to rate the degree in which they agreed or disagreed with a belief statement regarding their partner’s condition based on the hypothetical diagnosis. The scale ranged from strongly disagree to strongly agree. Wallston (2005) outlined that there is ample evidence to support that the MHLC scale validly assess health of locus of control beliefs. The MHLC is not a composite score, but rather made up of four dimensions including *internal* (Cronbach’s Alpha level of .763), *others* (Cronbach’s Alpha level of .636), *doctors* (Cronbach’s Alpha level of .684) and *chance* (Cronbach’s Alpha level of .861). Appendix F contains the full adaptation of the MHLC used within the research.

Next, the participants completed a 10-item semantic differential scale survey regarding their willingness to lend emotional support to the partner who has been diagnosed. Cronbach’s Alpha level for the emotional support scale was .841. The questions addressed love/affection, effort, confiding, and relying in their potential relationship (Appendix G). The survey was also reflective, in that it measured both the participant’s perceived ability in lending emotional support, and what level of support could be given in return to them by their potential partner. Both results of the partner’s ability and the participants’ ability are addressed within the summary.

Finally, participants completed an attribution measure created by the principal investigator resembling the RAM entitled Attributional Style Survey (Appendix H & I). The participants responded to four behaviors that occurred within the narrative and rated their level of agreement with each belief statement regarding several dimensions of attribution including perceived controllability. For example, one behavior presented in the narrative is prolonging the start of taking medication for the diagnosed condition. The participant rated their level of agreement based on several content categories that characterize attributions that were identified in Vangelisti and Young's (1999) research (p.47). The participants rated their level of agreement on if they thought the action was: *Expressive* -a consequence of the partner's emotional or physical state, *Accidental*- the partner was not aware of the emotional impact the action would have, *Self-centered*- the action was employed as a means to fulfill the partner's own wants or needs, and *Trait-Oriented*- the action was a result of the partner's enduring traits or characteristics. The participants also rated their level of agreement on if their partner's action was a sign/symptom of their partner's condition. The Cronbach's Alpha level for the attribution style survey was .870. The dimension of perceived controllability was also measured by their level of agreement to five controllability statements. The participants reported their level of agreement based on if their partner's condition was generally controllable, if the condition was controllable by their partner, could be controlled by outside help (e.g. the supporter) and if the condition is best controlled by a partner or others. The Cronbach's Alpha level for the controllability scale was .841.



### *Procedure*

All participation occurred through an online surveying tool. After solicitation of the participants occurred, the students were randomly assigned one of four links to complete participation. Courses solicited to participate in research included those taken by a variety of different majors and education levels. To insure randomization, an outside researcher used dice to randomly generate a number to form condition groups with the aid of class rosters. A control group was also conducted. Instructions, consent, and debriefing all took place online. Students were informed that they were able to choose to stop participating at any point if they felt uncomfortable, or could not complete the experiment to the best of their ability. Experiment duration was an estimated 40-60 minutes. During debriefing it was explained that though the present research included a narrative highlighting the experiences of someone dealing with a mental illness, and a quiz on mental health, I (i.e., the principal investigator) am not a healthcare professional. I obtained all information from the National Institute of Mental Health at <http://www.nimh.nih.gov>. I also encouraged participants to seek out information regarding health and relationships within campus resources, including those listed on the consent form.

### *Statistics*

Composite scores for all measures were produced for each participant to help generate significance between variables. Measures included: comfort level, mental health knowledge, attributional style (RAM), health locus of control (MHLC), and emotional support. In addition, frequencies, averages and percentages were calculated for needed descriptive statistics of the sample population. An alpha level of .05 was set

for all statistical tests. SPSS was used to conduct t-tests, correlations and ANOVAs to generate results. Effect sizes range from .00 to 1.00, with higher values indicating a greater amount of variability accounted for by the independent variable.

## RESULTS

### *Comfort Level*

For the pretest of comfort level student participants reported a mean score of 3.2 out of a 4.0 maximum (SD=.631). Range of scores included 1.00-4.00. Proximately, 72% of participants reported a moderate to high comfort level of 3.00 or higher.

### *Mental Health Knowledge Quiz*

For the pretest of mental health knowledge participants scored an average of 9.69 out of 12 points possible (SD=1.63). The range of scores was 3.00-12.00. Out of the sample population 57% of participants scored a 10.00 or higher.

### *Health Locus of Control*

For the posttest of the Multidimensional Health locus of control survey (MHLC) descriptive statistical differences between conditions and dimensions were recorded (Table 1).

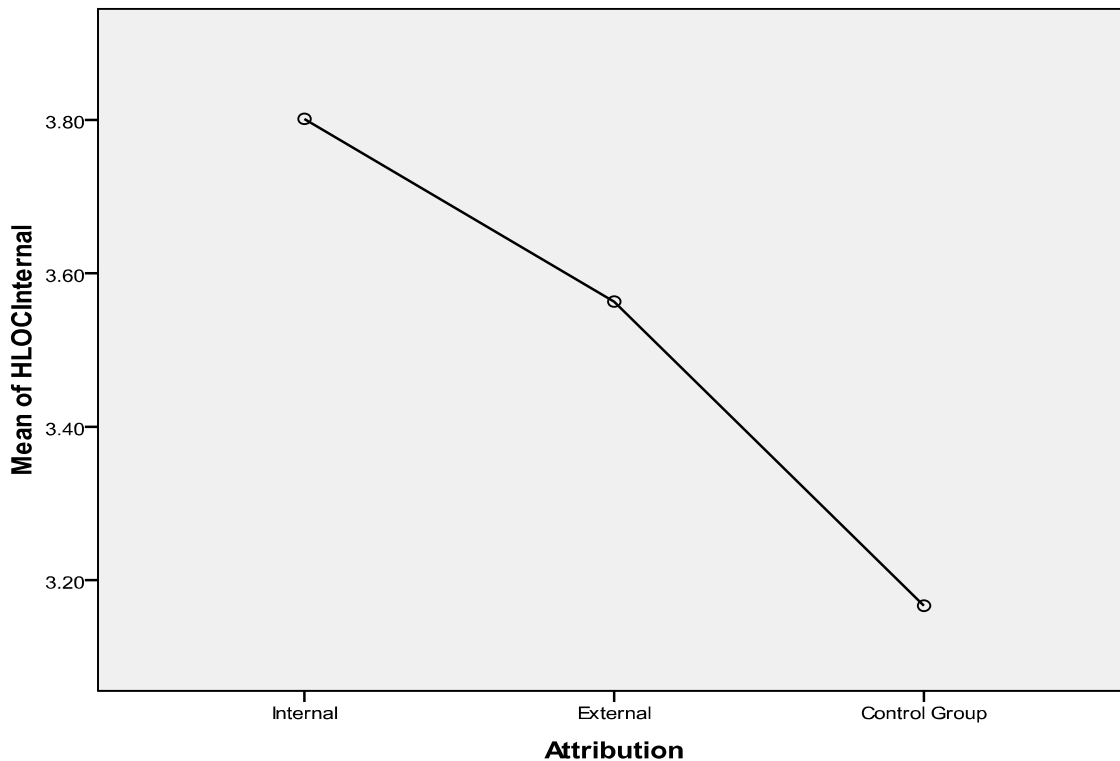
Table 1  
*Descriptive Statistics per Condition for each MHLC Dimension*

	Condition	N	Mean	Std. Deviation	Minimum	Maximum
HLOC Internal	Bipolar Disorder/Internal	29	3.9483	.92164	2.33	5.50
	Bipolar Disorder/External	37	3.5000	.92379	1.50	5.00
	Alcoholism/Internal	23	3.6159	.60184	2.67	5.33
	Alcoholism/External	29	3.6437	1.04912	1.67	5.83
	Control Group	13	3.1667	.64500	2.17	4.00
HLOC Others	Bipolar Disorder/Internal	29	3.7126	1.04549	1.00	5.67
	Bipolar Disorder/External	37	3.9640	.87059	2.00	5.00
	Alcoholism/Internal	23	4.0000	.65905	2.33	5.33
	Alcoholism/External	29	4.2414	.90806	1.67	6.00
	Control Group	13	3.5897	.73477	2.00	4.67
HLOC Chance	Bipolar Disorder/Internal	29	2.4828	.89570	1.00	4.17
	Bipolar Disorder/External	37	2.6937	.92506	1.00	4.50
	Alcoholism/Internal	23	3.0507	.99676	1.00	4.67
	Alcoholism/External	29	2.1954	.97800	1.00	4.17
	Control Group	13	2.6667	.72329	1.67	4.00
HLOC Doctors	Bipolar Disorder/Internal	29	4.333	.91721	2.33	6.00
	Bipolar Disorder/External	37	4.2793	1.03194	2.00	6.00
	Alcoholism/Internal	23	4.1014	.97667	1.67	5.67
	Alcoholism/External	29	4.5517	1.05513	2.00	6.00
	Control Group	13	4.4103	.61092	3.33	5.33

For each dimension a maximum score is 6.0.

Based on the descriptive statistics of the survey, participants felt that health could be controlled more internally (i.e., the person), by others (e.g., family, friends) and by doctors, compared to chance (e.g., fate or luck).

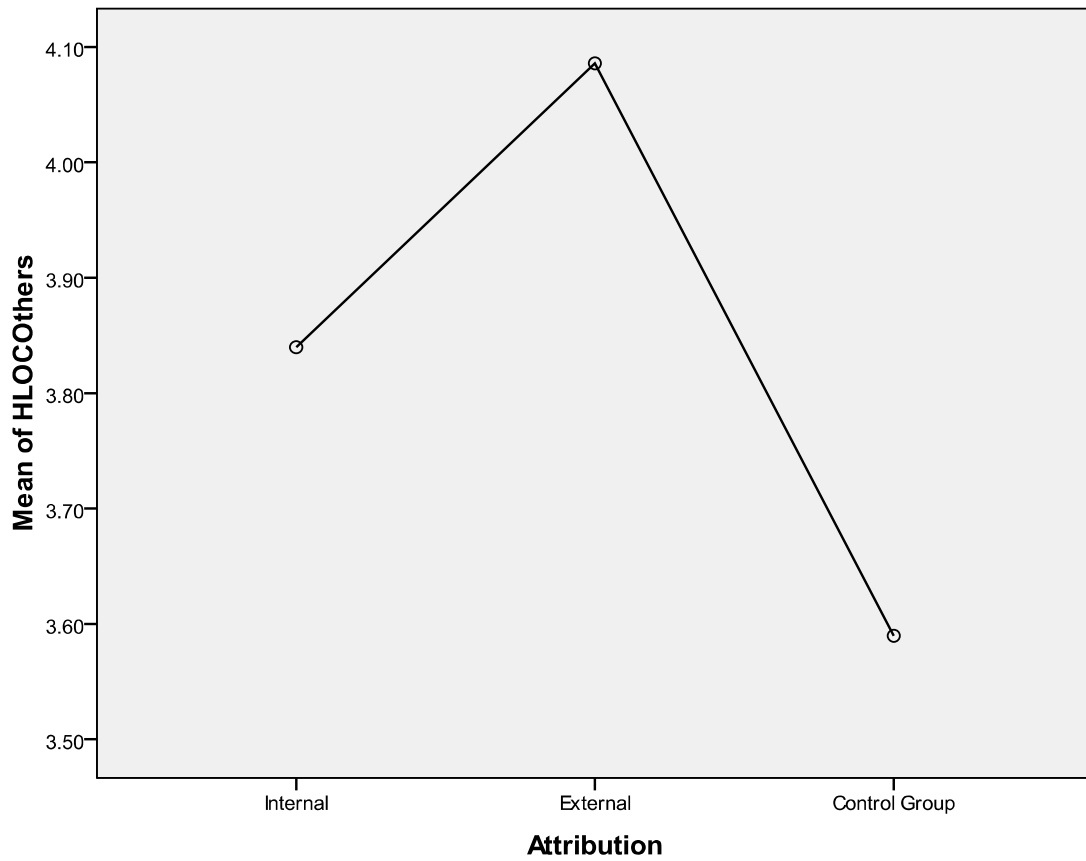
**Figure 1: Manipulated Attribution vs. Mean Scores of HLOC Internal**



**Figure 1:** The figure is an illustration of collapsing across illness, and comparing the manipulated attribution (i.e. internal and external) versus scores of HLOC *Internal*.

Notice, internal attribution yielded a higher internal rating compared to both the external attribution and the control group (Figure 1). The trend supports the intended manipulation of implied attribution within each stimulus condition.

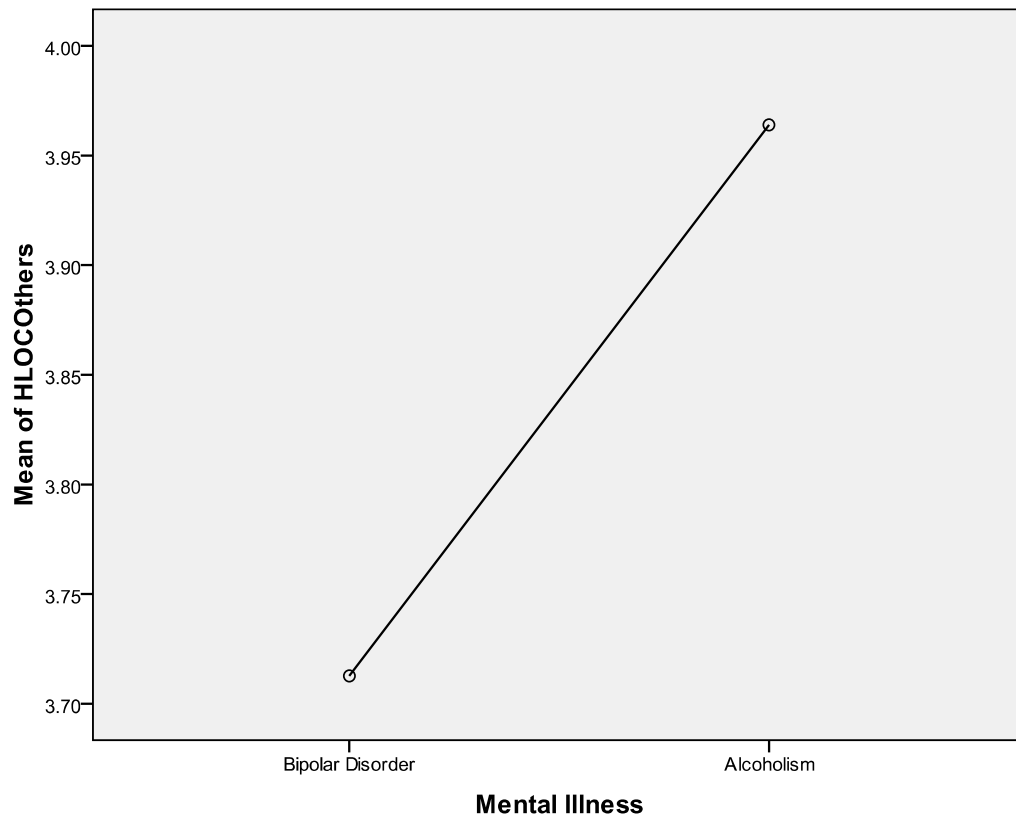
**Figure 2: Manipulated Attribution vs. Mean Scores of HLOC Others**



**Figure 2:** The figure is an illustration of collapsing across illness, and comparing the manipulated attribution versus scores of HLOC Others.

The mean scores of HLOC Others supported the stimulus manipulation, in that the external condition elicited a higher control rating for others compared to both the internal attribution and the control group (Figure 2).

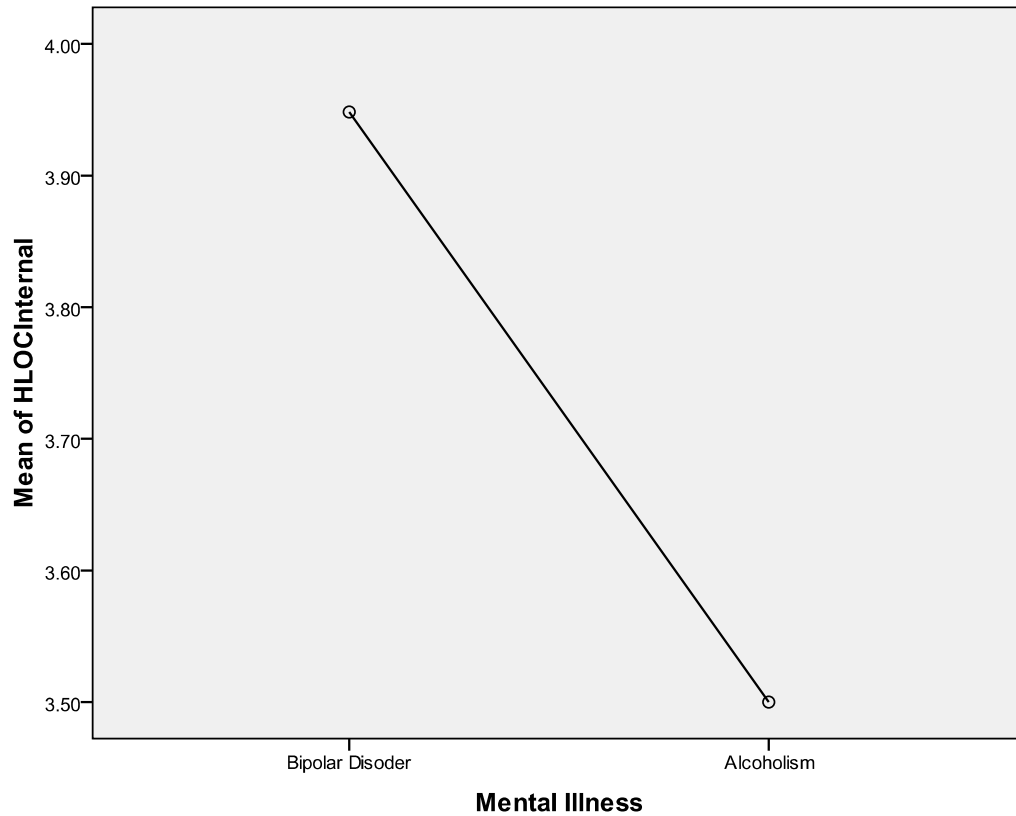
**Figure 3: Mental Illness vs. Mean Scores of HLOC Others**



**Figure 3:** The figure is an illustration of collapsing across attribution and comparing the conditions of Bipolar Disorder and Alcoholism and the variable of HLOC Others.

Although not statistically significant, ( $F(1, 64) = 1.13, p < .05$ ), the illustration shows a trend of Bipolar Disorder eliciting a lower HLOC Others score compared to Alcoholism (Figure 3). The trend means that participants felt that the control of others on a person's health is more salient in the case of Alcoholism than Bipolar Disorder.

**Figure 4: Mental Illness vs. Mean Scores of HLOC Internal**

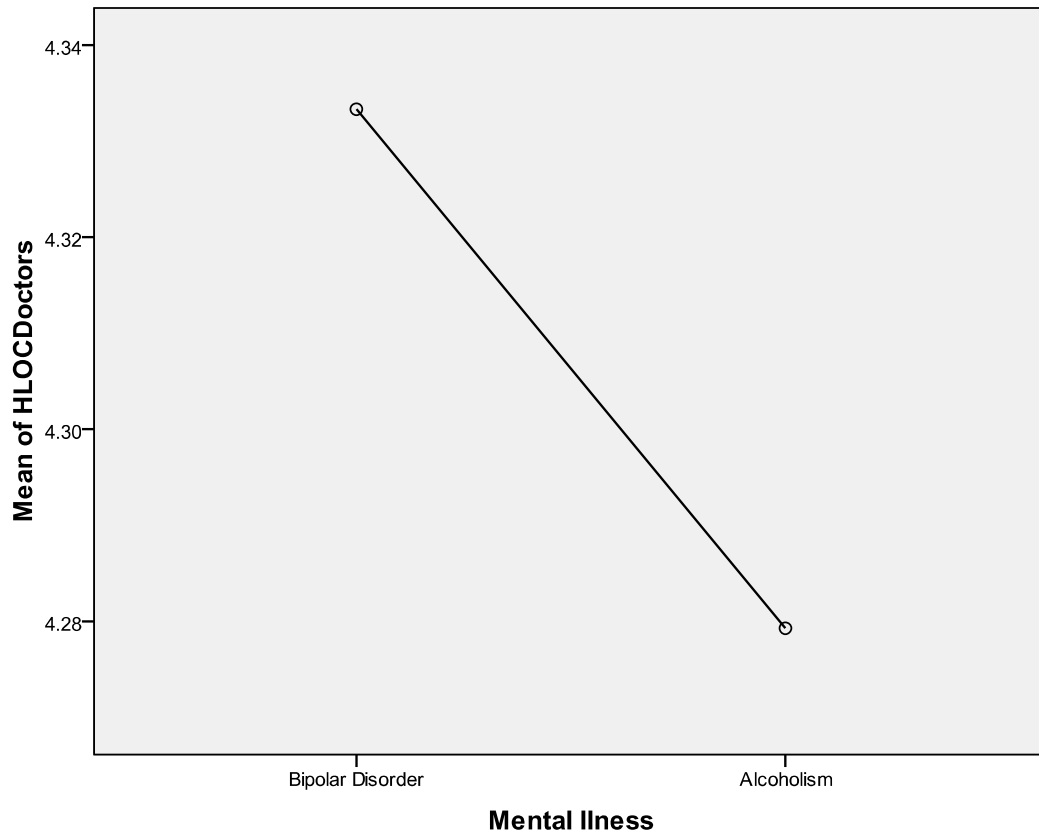


**Figure 4:** The figure is an illustration of collapsing across attribution and comparing the conditions of Bipolar Disorder and Alcoholism and the variable of HLOC Internal.

Although not significant, ( $F(1, 64) = 3.26, p < .05$ ), the figure shows a leaning of Bipolar Disorder eliciting a greater HLOC Internal rating than that of Alcoholism (Figure 4). Thus, the differences in means indicate that participants felt that internal control is higher for the condition of Bipolar Disorder than that of Alcoholism.



**Figure 5: Mental Illness vs. Mean Scores of HLOC Doctors**



**Figure 5:** is an illustration of collapsing across attribution and comparing the conditions of Bipolar Disorder and Alcoholism and the variable of HLOC Doctors.

Despite the fact the results were not statistically significant, ( $F(1, 64) = .049$ ,  $p > .05$ ), figure shows a leaning of Bipolar Disorder eliciting a greater HLOC Doctors rating than that of Alcoholism (Figure 5). The differences in means demonstrate that the participants felt doctors and medical professionals had more control in treatment of the condition of Bipolar Disorder than Alcoholism. Across all conditions, a two-tailed Pearson Correlation test indicated a significant correlation between HLOC Internal and perceived controllability  $r(114) = .29$ ,  $p < .01$ . The correlation suggested as HLOC Internal ratings go up, perceived controllability also increases.

### *Emotional Support*

In examination of the posttest for willingness to lend emotional support, across conditions participants reported an  $M=3.03$  out of a 4.00 maximum score, indicating an overall high level of willingness to lend emotional support. The range of scores were from 1.90-4.00,  $SD=.491$ . However, the quiz was reflective, and that each pair of questions asked both for the participant's ability compared to their potential partner's ability to lend emotional support. Scores indicated that participants thought they had the greater ability to lend emotional support compared to their potentially "ill" partner. Table 2 is the descriptive statistics across all conditions for the emotional support scale, also illustrating the differences between the participants' ability to lend emotional support and what they perceive to be their partner's ability to lend emotional support.

Table 2

#### *Descriptive Statistics per Dimension for the Emotional Support Scale*

Dimension	N	Mean	Std. Deviation	Minimum	Maximum
Participant	117	3.38	.48506	1.80	4.00
Partner	117	2.68	.63860	1.40	4.00

*Note.* Maximum score = 4.00.

### *Hypotheses*

Hypothesis 1 predicted that participants who perceived their partner's condition as controllable would be less willing to lend emotional support than those who believe the illness is uncontrollable. Based on conducted statistical analysis the hypothesis was partially supported. A descriptive statistical analysis of the independent measures of controllability and willingness to lend emotional support were first employed to address

this hypothesis. Scores of perceived controllability were computed out of a maximum score of 6.0. Table 3 is the mean scores of perceived controllability for each condition.

Table 3

*Mean Scores per Condition for the Measure of Perceived Controllability*

Condition	N	Mean	Std. Deviation	Minimum	Maximum
Bipolar Disorder/Internal	28	4.8214	.89974	3.25	6.00
Bipolar Disorder/External	37	4.6351	.93094	2.25	6.00
Alcoholism/Internal	22	4.4545	.84739	2.50	5.75
Alcoholism/External	29	4.5948	.85412	2.75	6.00
Control Group	--	-----	-----	-----	-----

*Note.* The control group did not complete the posttest of Perceived Controllability.

Using an ANOVA scores indicated no significance difference between condition as it applies to perceived controllability,  $F(3, 112) = .732, p < .05$ . Table 4 is the ANOVA results comparing between groups the variable of perceived controllability.

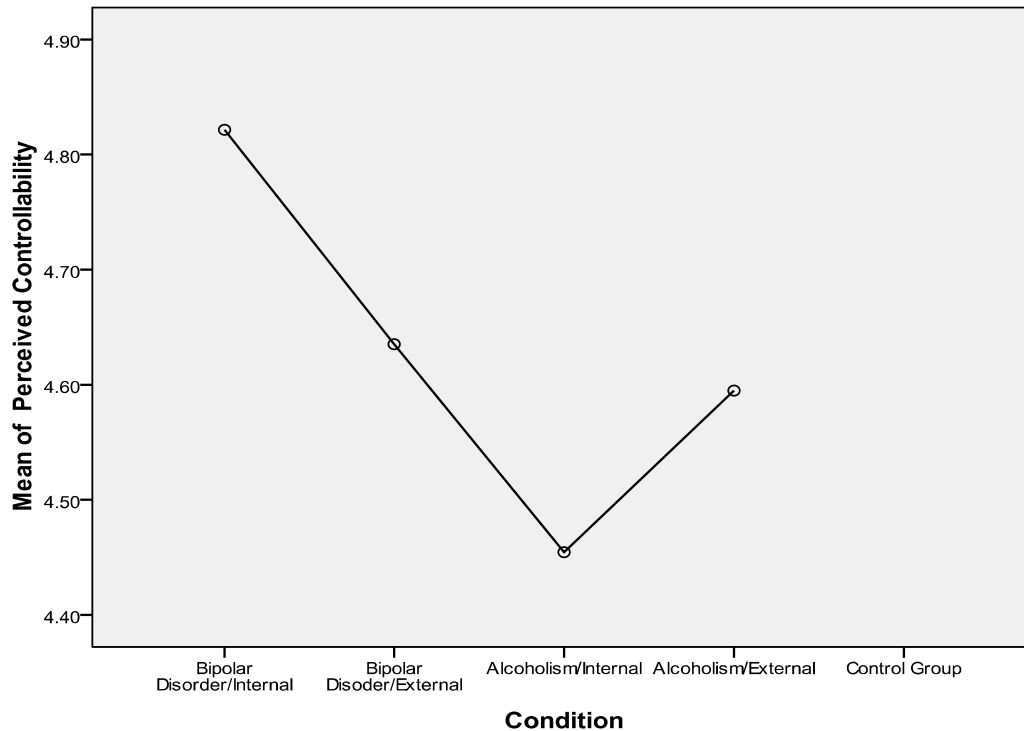
Table 4

*ANOVA Results Comparing Between Groups and the Variable of Controllability*

Test	Sum of Squares	df	Mean Square	F	Sig.
Controllability (Combined)	1.736	3	.579	.732	.535
Linear Term Unweighted	1.051	1	1.051	1.329	.251
Weighted	.937	1	.937	1.184	.279
Deviation	.800	2	.400	.506	.604
Quadratic term Unweighted	.747	1	.747	.945	.333
Weighted	.662	1	.662	.837	.362
Deviation	.137	1	.137	1.740	.678
With Groups	88.663	112	.791		
Total	90.299	115			

*Note.* Equal variance is assumed.

**Figure 6: Condition vs. Mean Scores of Perceived Controllability**



**Figure 6:** The figure demonstrates the differences between conditions and perceived controllability. Note the control group did not receive the perceived controllability measure.

As previously stated, no significant differences were calculated between groups; however, note the trends within the graph (Figure 6). Bipolar Disorder with the manipulated internal attribution elicited a greater controllability rating compared to Bipolar Disorder with the manipulated external attribution. However, Alcoholism with manipulated internal attribution elicited a lower controllability rating compared to Alcoholism with the manipulated external controllability. The mean scores also indicated that participants viewed the mental illnesses presented as moderately to highly controllable. Next within the analysis of understanding attribution and control, the HLOC dimension of internal was compared across conditions.

Independent sample t-tests were conducted to compare each condition for differences in perceived controllability. Only specific condition comparisons demonstrated statistically significant differences for variables concerning control. In comparing Condition 1 and Condition 3 an independent sample t-test indicated a significant difference between the posttest of MHLOC Internal,  $t(50)=1.49$ ,  $p<.023$ , demonstrating that the condition of Bipolar Disorder/Internal had a significantly higher rating of internal controllability than Alcoholism/Internal. Table 5 is the pre and posttest descriptive statistics comparison of Condition 1 (i.e., Bipolar Disorder/Internal) and Condition 3 (i.e., Alcoholism/Internal).

Table 5

*Pre and Posttest Descriptive Statistics for Condition 1 and Condition 3*

Test	Condition	N	Mean	Std. Deviation
Comfort Level	Bipolar Disorder/Internal	30	3.2286	.77214
	Alcoholism/Internal	23	3.2738	.65927
Emotional Support	Bipolar Disorder/Internal	28	2.9571	.60579
	Alcoholism/Internal	23	3.1087	.44611
HLOC Internal	Bipolar Disorder/Internal	29	3.9483	.92164
	Alcoholism/Internal	23	3.6159	.60184
HLOC Others	Bipolar Disorder/Internal	29	3.7126	1.0454
	Alcoholism/Internal	23	4.0000	.65905
HLOC Chance	Bipolar Disorder/Internal	29	2.4828	.89570
	Alcoholism/Internal	23	3.0507	.99676
Controllability	Bipolar Disorder/Internal	28	4.8214	.88974
	Alcoholism/Internal	22	4.5455	.84739

Table 6 is the results of each independent samples test for Condition 1 and Condition 3.

Table 6

*Independent Samples Tests for Condition 1 and Condition 3*

Test	F	Sig.	<i>t</i>	df	Mean difference	Std. Error difference
Comfort Level	.045	.833	-.228	52	-.04524	.19838
Emotional Support	2.863	.097	-.997	49	-.15155	.15195
HLOC Internal	5.515	.023	1.494	50	.33233	.22251
HLOC Others	2.392	.128	1.148	50	-.28736	.25024
HLOC Chance	.179	.674	2.161	50	.56797	.26288
HLOC Doctors	.006	.940	.880	50	.23188	.26353
Controllability	.296	.589	1.468	48	.36688	.24992

*Note.* Equal variances assumed.

In comparing Condition 3 and Condition 4 an independent sample t-test indicated a significant difference between the posttest of HLOC Internal,  $t(50)=-.113$ ,  $p<.043$ , suggesting that the condition of Alcoholism/Internal had a higher internal controllability rating than that of Alcoholism/External. Table 7 is the descriptive statistics per variable for Condition 3 and Condition 4.

Table 7

*Descriptive Statistics per Variable for Condition 3 and Condition 4*

Test	Condition	N	Mean	Std. Deviation
Comfort Level	Alcoholism/Internal	24	3.2738	.65927
	Alcoholism/External	31	3.4765	.63023
Emotional Support	Alcoholism/Internal	23	3.1087	.44611
	Alcoholism/External	29	2.9276	.43498
HLOC Internal	Alcoholism/Internal	23	3.6159	.60184
	Alcoholism/External	29	3.6437	1.04912
HLOC Others	Alcoholism/Internal	23	4.00	.65905
	Alcoholism/External	29	4.2414	.90806
HLOC Doctors	Alcoholism/Internal	23	4.1014	.97667
	Alcoholism/External	29	4.5517	1.05513
Controllability	Alcoholism/Internal	22	4.4545	.84739
	Alcoholism/External	29	4.5948	.85412

Table 8 is the results of each independent samples test for Condition 3 and Condition 4.

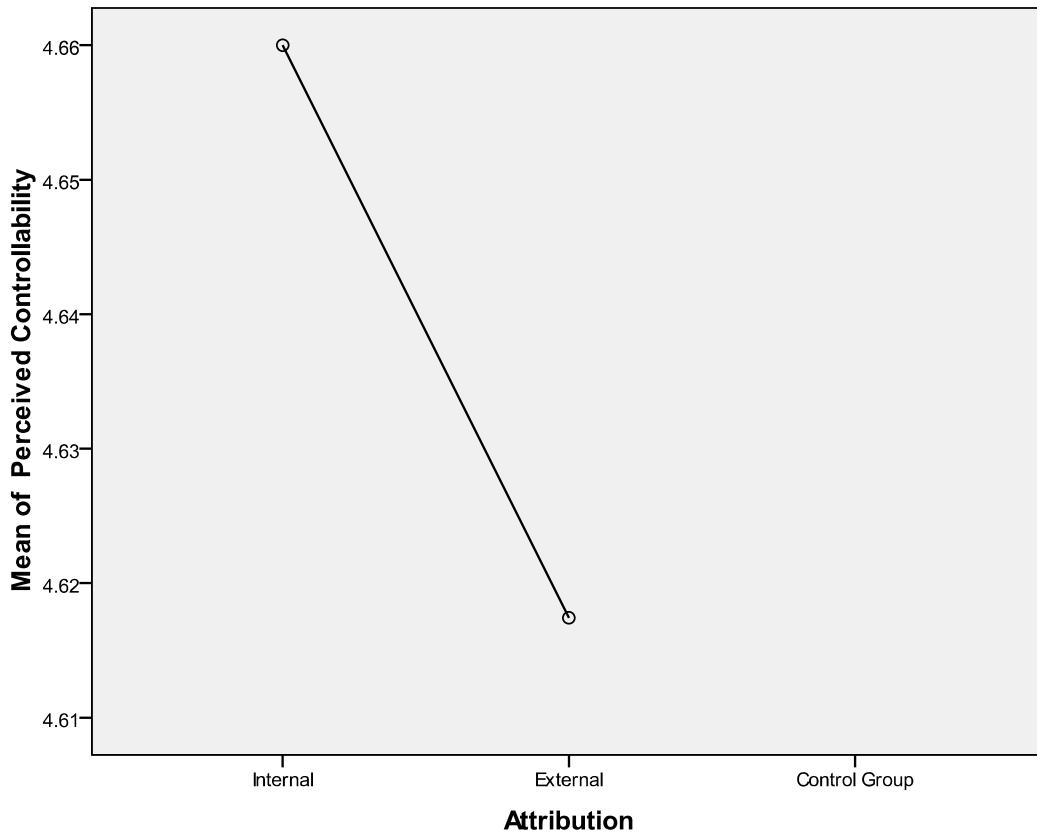
Table 8

*Independent Samples Tests for Condition 3 and Condition 4*

Test	F	Sig.	t	df	Mean difference	Std. Error difference
Comfort Level	.354	.554	-.015	53	-.00269	.17482
Emotional Support	.029	.866	1.474	50	.1811	.12283
HLOC Internal	4.294	.043	-.113	50	-.02774	.24592
HLOC Others	1.502	.226	1.110	50	-.24138	.22561
HLOC Chance	.135	.715	3.106	50	.84432	.27539
HLOC Doctors	.439	.511	1.579	50	-.45027	.28518
Controllability	.032	.858	-.583	49	-.14028	.24067

Considering statistical significant results were limited between conditions for perceived controllability, the analysis then collapsed the data across illness, comparing the manipulated attribution (i.e., internal and external).

**Figure 7: Manipulated Attribution vs. Mean Scores of Perceived Controllability**

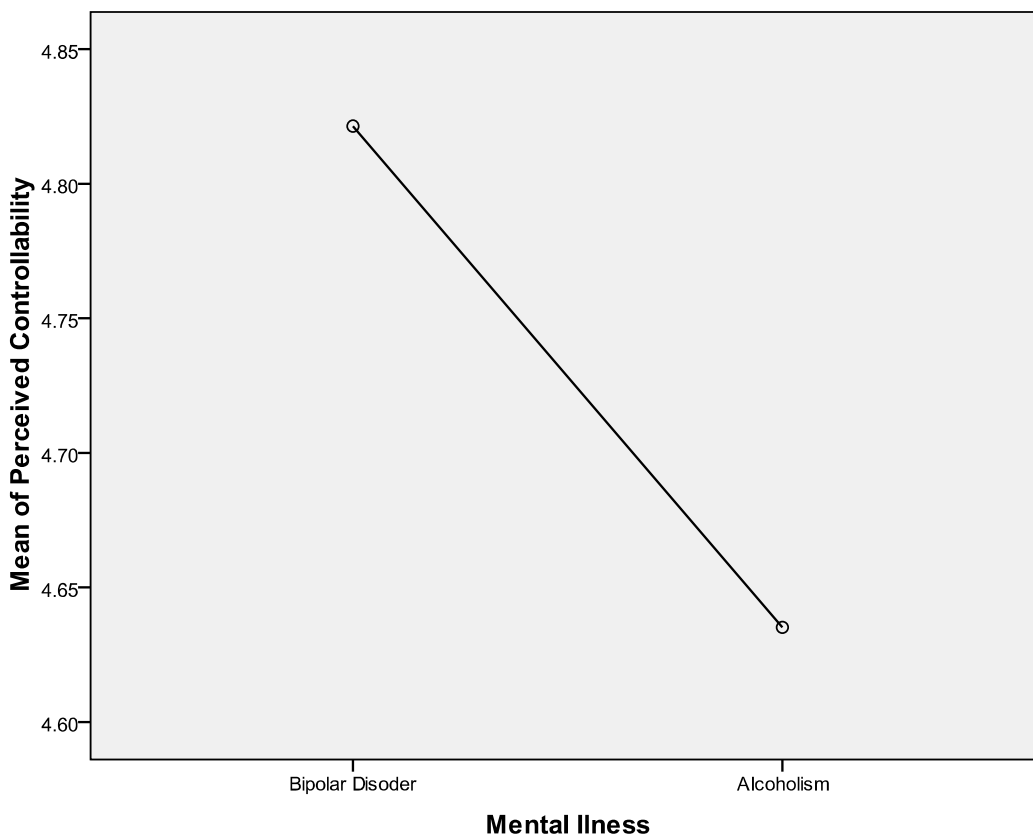


**Figure 7:** The figure is an illustration of collapsing across illness, and comparing the manipulated attribution versus mean scores of perceived controllability.

Notice that the internal condition produced a slightly higher rating of controllability than that of external (Figure 7). Though non significant, the trend does support the intended manipulation, in that internal attributes should be perceived as more controllable than external attributes. In addition to comparing internal and external attribution, the analysis examined differences between the two mental illnesses as it applies to perceived controllability.



**Figure 8: Mental Illness vs. Mean Scores of Perceived Controllability**



**Figure 8:** The figure is an illustration of collapsing across attribution and comparing the conditions of Bipolar Disorder and Alcoholism and their perceived controllability.

Thought not statistical significant, ( $r(114) = .964, p < .05$ ), Bipolar Disorder elicited a greater controllability rating than that of Alcoholism (Figure 8). In continuing the analysis of controllability and emotional support, across all conditions, a two-tailed Pearson Correlation test indicated a significant correlation between controllability and emotional support level  $r(114) = .19, p < .05$ . The correlation signifies that as ratings of perceived controllability go up, willingness to lend emotional support is lowered, thus partially supporting H 1.

Hypothesis 2 predicted participants who could accurately attribute certain behaviors to sign/symptoms of the illness would be more likely to lend emotional support than those who attribute the actions as internal and or dispositional. An analysis of both the attribution style assessment and emotional support were employed to address this hypothesis. In comparing emotional support and the dimension of diagnostic attribution, a one-sample test indicated a significance  $t(116) = 66.74, p > .00$ , and  $t(115) = 47.825, p > .00$ . Therefore, across conditions, there is a significance difference in participants' ability to label (i.e., attribute) the presented signs/symptoms to the diagnosis. A closer examination of attributing behaviors to the diagnosis indicates that participants were more willing to attribute certain signs and symptoms to the diagnosis of Alcoholism than that of the signs and symptoms of Bipolar Disorder. Also the test indicates a difference between groups in willingness to lend emotional support. Participants indicated that they were more willing to support a partner with the condition of than Alcoholism than Bipolar Disorder.

## SUMMARY

The purpose of the research was to investigate the effects of both attributional style and health locus of control on emotional support within potential partnerships that are affected by mental illness. The research focused on the young adult population due to the prevalence of mental illness. It was important to examine the young adult partnerships because of the relationship dynamics of disclosing and seeking emotional support. Based on previous scholarship, the research posed two central research questions.

RQ 1: How does the perceived controllability of a mental illness influence people's willingness to give emotional support to a partner living with a mental illness?

RQ 2: How does the attribution of the mentally ill partner's actions affect the supporter partner's willingness to lend emotional support?

Using an experimental design with participants reviewing and answering based on hypothetical scenarios, the research manipulated the mental disorder presented (i.e., Bipolar Disorder or Substance Abuse Disorder), and the how the potential actions associated with the illness could be attributed (i.e., internal or external).

### *Hypotheses: Results and Implications*

Hypothesis 1 predicted that participants who perceived their partner's condition as controllable would be less willing to lend emotional support than those who believe the illness is uncontrollable. The hypothesis was partially supported. First, the descriptive statistics results demonstrated that the student participants viewed both

conditions as moderately to highly controllable. Their perceived controllability rating was formulated based on the presented symptoms, actions and behaviors that could be exhibited if their potential partner was diagnosed. Though no significant differences were calculated between conditions for perceived controllability there were trends within the data. For example, Bipolar Disorder with the manipulated internal attribution elicited a greater controllability rating compared to Bipolar Disorder with the manipulated external attribution. There are several implications if this trend continued. Not only did participants rate Bipolar Disorder as controllable, but also felt that it is best controlled internal (i.e., by the person) rather than controlled or influenced by their partner's environment. However, Alcoholism with manipulated internal attribution elicited a lower controllability rating compared to Alcoholism with the manipulated external controllability. Thus, participants felt that Alcoholism could be controlled more by a person's environment rather than personally (i.e., internally).

The differences in how participants viewed Alcoholism and Bipolar Disorder are significant in understanding how the young adult population socializes and understands certain mental illnesses. Considering the results were just based on trends and not statistical significant results, the hope is that with future replication of the study, participants would view external and internal attributions equally.

As previously noted, research suggests that Bipolar Disorder is likely caused by multiple factors that interact with each other to produce a chemical imbalance affecting certain parts of the brain (NAMI, 2009). Bipolar Disorder is also seen to have a hereditary/genetic component. In addition, a stressful environment or negative life events may interact with the underlying "biological vulnerability" to produce the disorder

(NAMI, 2009). Therefore, participants viewing Bipolar Disorder as both highly controllable and internally controlled are wrongly conceptualizing the causes of the illness. With Alcoholism the onset occurs gradually. Over a period of time, drinking alcohol alters the balance of some of the chemicals in your brain, including gamma-aminobutyric acid (GABA), which inhibits impulsiveness, and glutamate, which over excites the nervous system (Mayo Clinic, 2009). Alcohol also raises the levels of dopamine in the brain, which is associated with the pleasurable aspects of drinking. Other factors that can lead to excessive drinking and the addiction process include: genetics, emotional state, psychological factors/other mental illnesses, and social/cultural factors. Participants felt that environment and other people played a greater role in controlling Alcoholism than the person diagnosed. Though the environment of an alcoholic plays a significant role in their maintaining a healthy lifestyle, participants downplayed the role of personal control and choices.

Next within the analysis of understanding attribution and control, the Multidimensional Health Locus of Control dimension of internal control was compared across conditions. In review of the MHLOC, the dimension of internal control is a measure of how much a person's behaviors (i.e., positive or negative) influence their health/condition. It also comments on how personal responsibility influences a person's health/condition. Independent sample t-tests were conducted to compare each condition for differences in perceived controllability. Only certain condition comparisons demonstrated statistically significant differences. In comparing Condition 1 and Condition 3 there was a significant difference between the posttest of MHLOC Internal, demonstrating that the condition of Bipolar Disorder/Internal had a significantly higher

rating of internal controllability than Alcoholism/Internal. The results reinforce that participants viewed Bipolar Disorder as having more internal control than that of Alcoholism. However, the HLOC dimension of internal gives us more information than that of just perceiving the condition as controllable. For example, high internal LOC suggests that people's actions and choices directly influence their health and condition. Thus, participants view the signs/symptoms of Bipolar Disorder as influenced by personal choices.

In continuing the analysis of controllability and emotional support, across all conditions, a two-tailed Pearson Correlation test indicated a significant correlation between controllability and emotional support level. The correlation signifies that as ratings of perceived controllability go up, willingness to lend emotional support is lowered, thus partially supporting H1. The correlation is supported by previous research. The relationship between perception of controllability and the actual act of helping is not direct, but mediated through emotions (Forst€rling, 2001, p. 157). Weiner extends that attributions lead to emotions and that these guide behavior (p. 157). Piliavin et al. (1969) studies revealed high correlations between controllability judgments and emotions. For example, anger correlated with actions that were seen as controllable, while pity and sympathy correlated to actions that were viewed as uncontrollable (Piliavin et al, 1969). Further, these studies support the idea that there is a motivational sequence in which cognitions lead to emotions and these affects, as a result, guide behavioral intentions (Forst€rling, 2001, p. 159).

Figure 3 is an illustration of collapsing across attribution and comparing the conditions of Bipolar Disorder and Alcoholism and the variable of HLOC Others.

Although not statistically significant, the illustration shows a trend of Bipolar Disorder eliciting a lower HLOC Others score compared to Alcoholism. The trend means that participants felt that the control of others on a person's health is more salient in the case of Alcoholism than Bipolar Disorder. Figure 5 is an illustration of collapsing across attribution and comparing the conditions of Bipolar Disorder and Alcoholism and the variable of HLOC Doctors. Despite the fact the results were not statistically significant, the figure shows a leaning of Bipolar Disorder eliciting a greater HLOC Doctors rating than that of Alcoholism. The differences in means demonstrate that the participants felt doctors and medical professionals had more control in treatment of the condition of Bipolar Disorder than Alcoholism. In review, hypothesis 1 was partially supported based on the trends established with the data. The results also supported the connection between controllability and emotional support.

Hypothesis 2 predicted that participants who could accurately attribute the behaviors presented as signs/symptoms of the illness would be more likely to lend emotional support. An analysis of both the attribution style assessment and emotional support were employed to address this hypothesis. Based on results, H2 was fully supported. In comparing emotional support and the dimension of diagnostic attribution, a one-sample test indicated significant difference. Therefore, across conditions, there is a significance difference in participants' ability to label (i.e., attribute) the presented signs/symptoms to the diagnosis. In a closer examination, it was easier for participants to view the signs/symptoms for Alcoholism as linked to the diagnosis, compared to the signs/symptoms of Bipolar Disorder. Also, the test indicates a difference between groups in willingness to lend emotional support. Participants reported higher emotional

support ratings for the condition of Alcoholism than that of Bipolar Disorder. Previous research supports that people's attributions depends on the perceptions of others' ability to control their own behavior. Frequently, people are more sympathetic or less angry towards those who demonstrate disturbing behavior through no fault of their own. Therefore, if the behaviors accurately reflect what are known symptoms of the disease, then the caregiver/supporter can attribute such a behavior to the illness (Williamson, 2005, p. 216). However, in the present case participants were only able to identify certain behaviors as signs or symptoms.

The research gathered several other measures that were not directly addressed within the research questions. For the pretest of comfort level student participants reported a mean score of 3.2 out of a 4.0 maximum. Proximately 72% of participants reported a moderate to high comfort level of 3.00 or higher. For the pretest of mental health knowledge participants scored an average of 9.69 out of 12 points possible. Out of the sample population, 57% of participants scored a 10.00 or higher. Therefore, students were both moderately knowledgeable about mental health and felt comfortable discussing it. For the posttest of the Multidimensional Health locus of control survey descriptive statistical differences between conditions and dimensions were recorded. Based on the descriptive statistics of the survey, participants felt that mental health could be controlled more internally (i.e., the person), by others (e.g., family, friends) and by doctors, compared to chance (e.g., fate or luck).

In examination of the posttest for willingness to lend emotional support across conditions participants reported an  $M= 3.03$  out of a 4.00 maximum score, indicating an overall high level of willingness to lend emotional support. However, the quiz was



reflective, and that each pair of questions asked both for the participant's ability compared to their potential partner's ability to lend emotional support. Scores indicated that participants thought they had the greater ability to lend emotional support compared to their potentially "ill" partner. These results could lead to two inferences. First, the lower ability of the "ill" partner could be a judgment based both on the diagnosis and the narrative presented. Also the differences in ability could be an implication of a self-serving reporter bias, in that participants would always indicate a higher ability than the other person.

### *Strengths in Research*

In comparing Condition 3 and Condition 4 an independent sample t-test indicated a significant difference between the posttest of MHLOC Internal, suggesting that the condition of Alcoholism/Internal had a higher internal controllability rating than that of Alcoholism/External. The results indicate that the manipulation between the condition as strong enough to elicit a trend in the data. The results also indicate that participants felt that Alcoholism does have a degree of internal control. Considering statistical significant results were limited between conditions for perceived controllability, the analysis then collapsed the data across illness, comparing the manipulated attribution (i.e., internal and external). Figure 7 is an illustration of collapsing across illness, and comparing the manipulated attribution versus mean scores of perceived controllability. Notice that the internal condition produced a slightly higher rating of controllability than that of external. Though, not significant, the trend does support the intended manipulation, in that internal attributes should be perceived as more controllable than external attributes. Figure 1 is an illustration of collapsing across illness, and comparing

the manipulated attribution (i.e. internal and external) versus scores of HLOC Internal. Notice, internal attribution yielded a higher MHLOC Internal rating compared to both the external attribution and the control group. The trend supports the intended manipulation of implied attribution within each stimulus condition. Figure 2 is an illustration of collapsing across illness, and comparing the manipulated attribution versus scores of HLOC Others. The mean scores of HLOC Others supported the stimulus manipulation, in that the external condition elicited a higher control rating for others compared to both the internal attribution and the control group. Across all conditions, a two-tailed Pearson Correlation test indicated a significant correlation between HLOC Internal and perceived controllability. The correlation suggested as HLOC Internal ratings go up, perceived controllability also increases supporting the connection of attribution theory and locus of control within the conceptual framework.

### *Limitations*

In understanding the strengths and implications of the present research it is critical to examine limitations within theoretical framework and methodology. First attribution theory, the study of attributions, is important for understanding interpersonal communication, in that the causes we give for behaviors are part of the meaning we derive from them (Galvin & Cooper, 2006, p. 85). The meaning created is then a fundamental part of what is communicated in an interpersonal interaction, thus influencing actions within our relationship. Considering attribution theory is a social cognitive theory, its application and results are limited in a hypothetical-experimental design. In addition, attribution research points out that people use attributions to help explain unexpected behavior and make sense of the world. However, people's

attributions are often biased for several reasons. The present research did examine attribution style. However, the link between measures did not uncover or discover bias. In future research, measures need to be developed to help aid in understanding how attributions can be biased. In addition, attribution theory's use in explaining the behaviors of others, along with its application in health communication, is still in its beginning application stage. The field of attribution theory is large, rather than a theory it is developing into a field of study with the application and implementation differing among subject areas (Weiner, 2008). There are also assumptions made within attribution theory. Understanding the implications of forming attributions assumes that the causal descriptions that people make for other individuals' outcomes directly influences the reactions toward these individuals with regard to these outcomes (Forst€erling, 2001, p. 149); meaning that with the application of the theory the assumption is made that attribution will always effect action. Lastly, in understanding the implications of the findings of the research more distinctions between attribution theory and locus of control are needed. Besides theoretically, there are some limitations within the research's methodological approach.

Although the information gained in experimental designs can be vast and replicated successfully, it is imperative to understand flaws and bias within measures, along with potential confounding variables. The current research used a mixture of both established measures and researcher-created measures. Additional pretesting in newly created measures would help increase the studies validity and reliability. Also the measures of comfort level and emotional support need larger scales to increase variability in participant ratings. The other issue within the methodology to be

addressed in future research is the limitation of comparing across two completely different mental illnesses. Experimental design is best used to compare variations within one variable, thus comparing internal and external attribution was acceptable. However, comparing Bipolar Disorder and Alcoholism creates flaws, in that there are several confounding variables unable to be addressed when examining the perceived differences between the illnesses. Lastly, the research recognizes the limitations and implications of the sample. For example, the sample population is from a southern university, having certain cultural implications on how mental illness is socialized. Future replication of the study would strive to test differing population samples. Also the population's diversity is limited, in that the majority of the population is both female and Caucasian.

#### *Future Goals*

The intention of the present research was to understand how mental illness could affect the daily communication process of emotional support. However, due to the nature of the experimental design and the use of hypothetical scenarios only certain results and implications could be reached. As the principal investigator, my future research hopes include to continue working with attribution theory within the inquiry of interpersonal relationships dealing with mental illness. The ultimate goal is to investigate actual relationships in which one or both partners are living with a mental illness. It is important to note that often mental illness is not experienced by one partner, but both people within the relationship. Other goals include using a qualitative approach with the addition of problematic integration theory to understand how the dialectic tension of certainty and uncertainty affects emotional support. As the principal

researcher, I view social science research as the best method of linking research and theory to practice and implementation. The ultimate goal within my research is not only to provide new information and prospective, but to be able to enhance the quality of life of others.

### *Conclusion*

The research used both attribution theory and the concept of locus of control in guiding the investigative inquiry. The goal of using attribution theory was to gain understanding of when emotional support is given or not given based on how a person attributes their partner's mental illness. The research is important because of the lack of understanding of how daily attribution affects emotional support in interpersonal relationships dealing with a partner's mental illness. The intended use locus of control (LOC) was to gain a deeper understanding of the act of asserting judgments of controllability when it applies to another person's health. The results suggested several important implications. In review, the participants reported that the mental illnesses presented were moderately to highly controllable. The results also inferred that the participants' willingness to lend emotional support is effect by the perceived controllability of the illness. Lastly, the research suggested that being able to attribute certain behaviors to the diagnosis is a factor in the participants' willingness to lend emotional support.

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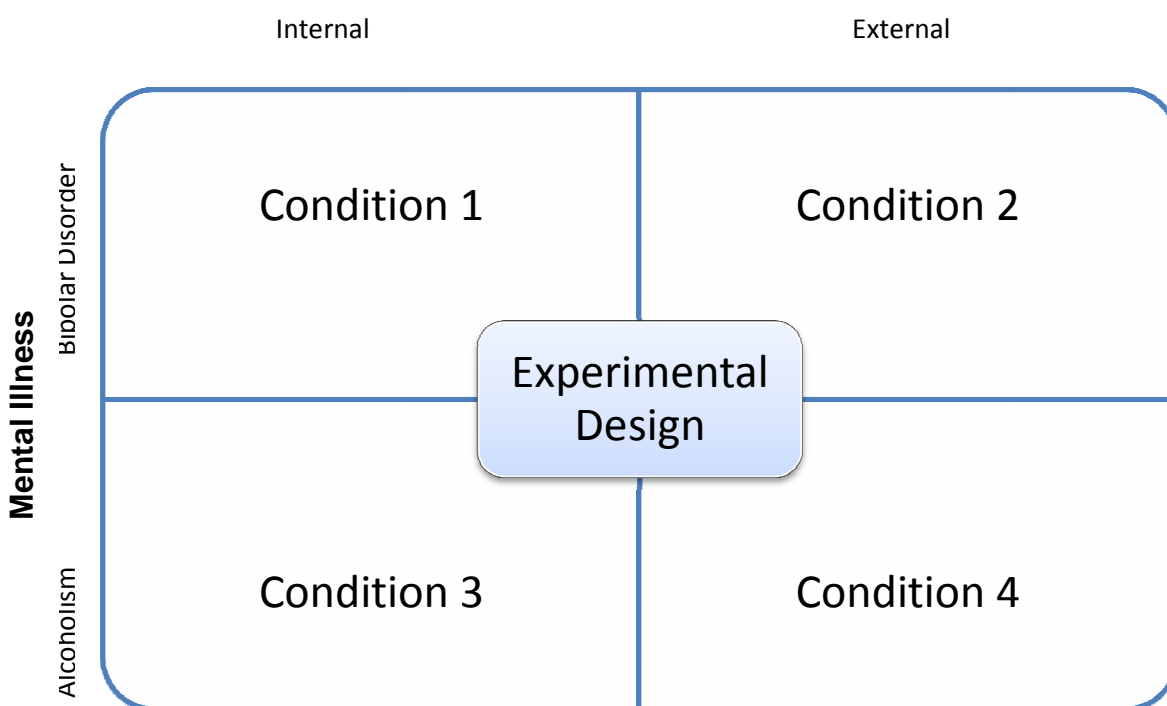
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# APPENDIX

## Appendix A

### Attribution



## Appendix B

### Narrative Stimulus per Condition

Instructions: The following is a journal narrative. Read the journal narrative completely. Throughout the narrative, imagine as if the person writing the journal entry is your current or potential relationship partner. Following the reading of the narrative, you will be asked to respond to the actions/behaviors of “your partner.”

Note: The participant will only read one of the following four narratives – to be randomly assigned.

#### Condition 1: Bipolar Disorder/Internal Attribution

*\*Two weeks prior to the writing of this journal entry, your partner was diagnosed with Bipolar Disorder, a mental health condition.*

After a lengthy struggle with financial aid, disability services, the counseling center, and every other system on campus with a pulse. I finally returned to classes, or at least the ones that I decided not to drop. Attendance policies bite ass anyways, even if I wasn't “sick.” Who wants to learn about U.S History at 8:00 am?! For the past couple of months, I could have slept for days upon days and well, my courses were just in the way of my sleep schedule...so I skipped them. I remember sitting on the couch only taking time out to eat, and watch mindless TV, while the other 18 hours of the day were spent sleeping. Well, after taking the advice of my partner, I decided to go to the health center. This led to several doctor visits, and one to the “crazy person” specialist – they finally put me on medication and diagnosed me with Bipolar Disorder. However, I have postponed starting the medicine prescribed to me for fear of side effects, and well, what it will do to me...and to avoid what others might think. And because I don't believe anything is really wrong, that I can't work out by myself.

I actually started feeling better recently, but research papers, labs and homework just isn't on my to-do list this week. I got to make up for all the living I didn't do last month! It was actually great this week. I decided to go out with a group of friends to the bar on Thursday night for \$.25 beer, because you know me I love to party! I don't remember exactly how much I had to drink, but the tab on my dad's credit card said it was \$65.50 night. I suppose I bought a few too many rounds, but we were celebrating and having fun. Like I said, I don't remember how much I had to drink that night, or even how I got home. But I awoke the next morning to a friend's sofa, so it was all good. My friends let me in on the night's events. Apparently, I was close to sealing the deal with a person in the bar when my friends pulled me a way to leave. I don't think my partner should know... I will probably go out again tonight – I have too much energy to sit home and waste on school.

#### Condition 2: Bipolar Disorder/External Attribution

After a lengthy struggle with financial aid, disability services, the counseling center, and every other system on campus with a pulse. I finally returned to classes, or at least the ones that I decided not to drop. Attendance policies bite ass anyways, even if I wasn't "sick." Who wants to learn about U.S history at 8:00 am?! For the past couple of months, I could have slept for days, upon days and well, my courses were just in the way of my sleep schedule...so I skipped them, but my friends skip too sometimes. I remember sitting on the couch only taking time out to eat, and watch mindless TV, while the other 18 hours of the day were spent sleeping. Well, after taking the advice of my partner, I decided to go to the health center. This led to several doctor visits, and

one to the “crazy person” specialist – they finally put me on medication and diagnosed me with Bipolar Disorder. However, I have postponed the starting of the medicine prescribed to me for fear of side effects, and well, what it will do to me...and to avoid what others might think. And because I don’t believe anything is really wrong, that I can’t work out by myself. I mean it’s not like I’m like my grandmother, or that cousin my family speaks of. I don’t believe for one second that shit can be hereditary.

I actually started feeling better recently, but research papers, labs and homework just isn’t on my to-do list this week. I got to make up for all the living I didn’t do last month! It was actually great this week. I decided to go out with a group of friends to the bar on Thursday night for \$.25 beer. My friends begged me into going with them, and well I can’t let them down. I don’t remember exactly how much I had to drink, but the tab on my dad’s credit card said it was \$65.50 night. I suppose I bought a few too many rounds, but we were celebrating and having fun. Like I said, I don’t remember how much I had to drink that night, or even how I got home. But I awoke the next morning to a friend’s sofa, so it was all good. My friends let me in on the night’s events. Apparently, I was close to sealing the deal with a person in the bar when my friends pulled me a way to leave. I don’t think my partner should know... I will probably go out again tonight, my friends want to go out too – I have too much energy to sit home.

### Condition 3: Alcoholism/Internal Attribution

*\*Two weeks prior to the writing of this journal entry, your partner was diagnosed with the Substance Abuse Disorder of Alcoholism, a mental health condition.*

Is it just the winter blahs? I'm feeling better (I guess), but I cannot make myself do anything. I have NO ENERGY or INCENTIVE to do anything. I don't "feel" depressed, but I can hardly move around. Last night, I laid down on my bed at 9:00 PM and covered myself with a blanket and slept until 10:00 AM this morning. I didn't even get undressed...which was great because I didn't have to get ready...I kept the same clothes on that I wore yesterday. I almost thought about going to class, but decided against it. I know after my initial visits with both the health center and the counseling center I need to take my meds and go to the support group recommended, along with my regular check-ups. But I still feel the need to drink. I'm so nauseated...

It was just three weeks ago in which I decided to go out with a group of friends to the bar on Thursday night. I don't remember exactly how much I had to drink, but the tab on my dad's credit card said it was \$85.00 night. Like I said, I don't remember how much I had to drink that night, or even how I got home. But I awoke the next morning to a friend's couch. My friends often tell me that I consume multiple shots, and drinks. Sometimes without a person drinking with me. I often blackout...

I'm irritated that now I can't drink when I normally did. I used to start drinking in the early afternoon before my late classes. I would always have a drink with dinner, and then a drink or so before bedtime. That's normal right? A few days ago, I rummaged through the cabinets for a bottle of wine...When I couldn't find it I smashed a plate to the floor in frustration. Then I remembered my flask in the bottom of my laptop bag...

#### Condition 4: Alcoholism/External Attribution

Is it just the winter blahs? I'm feeling better (I guess), but I cannot make myself do anything. I have NO ENERGY or INCENTIVE to do anything. I don't "feel"

depressed, but I can hardly move around. Last night I laid down on my bed at 9:00 PM and covered myself with a blanket and slept until 10:00 AM this morning. I didn't even get undressed...which was great because I didn't have to get dressed... I kept the same clothes on that I wore yesterday. I almost thought about going to class, but decided against it. I know after my initial visits with both the health center and the counseling center I need to take my meds and go to the support group recommended, along with my regular check-ups. But I still feel the need to drink. And it's a daily struggle. I know others in my family have struggled with Alcoholism, but I don't think my problem is that deep. I'm a college student.

I'm so nauseated...

I t was just three weeks ago in which I decided to go out with a group of friends to the bar on Thursday night. I mean I am in college, and that's what college students do-- go drink on a week night. I don't remember exactly how much I had to drink, but the tab on my dad's credit card said it was \$85.00 night. Like I said, I don't remember how much I had to drink that night, or even how I got home. But I awoke the next morning to a friend's couch. My friends often tell me that I consume multiple shots, and drinks. Sometimes without a person drinking with me. I often blackout...

I'm irritated that now I can't drink when I normally did. I used to start drinking in the early afternoon before my late classes. I would always have a drink with dinner, and then a drink or so before bedtime. That's normal right? A few days ago, I rummaged through the cabinets for a bottle of wine...When I couldn't find it I smashed a plate to the floor in frustration. Then I remembered my flask in the bottom of my laptop bag...

## Appendix C

### Pretest: Comfort Level

*Note: Throughout the survey, the term “partner” is used to describe a significant other within a close/intimate relationship. Please answer the questions based on a previous or current relationship, and or on a potential future relationship. Circle one appropriate answer for each question.*

1. My current comfort level **with my personal health** is...

1

2

3

4

(Very Uncomfortable) (A little Uncomfortable) (Somewhat Comfortable) (Very Comfortable)

2. My current comfort level with **discussing** my personal health is...

1

2

3

4

(Very Uncomfortable) (A little Uncomfortable) (Somewhat Comfortable) (Very Comfortable)

3. In relationships (past, present or future) my level of comfort with **my partner’s health** is...

1

2

3

4

(Very Uncomfortable) (A little Uncomfortable) (Somewhat Comfortable) (Very Comfortable)

4. In relationships (past, present or future) my level of comfort in **discussing my partner’s health** is....

1

2

3

4

(Very Uncomfortable) (A little Uncomfortable) (Somewhat Comfortable) (Very Comfortable)

5. My current comfort level with **discussing mental health in general** is...

1

2

3

4

(Very Uncomfortable) (A little Uncomfortable) (Somewhat Comfortable) (Very Comfortable)



6. My current comfort level with **discussing my mental health is...**

1

2

3

4

(Very Uncomfortable) (A little Uncomfortable) (Somewhat Comfortable) (Very Comfortable)

7. My current comfort level with discussing **a partner's mental health is...**

1

2

3

4

(Very Uncomfortable) (A little Uncomfortable) (Somewhat Comfortable) (Very Comfortable)

## Appendix D

### Pretest: Relational Attribution Measure (RAM)

**II. Instructions:** This questionnaire describes several things that your significant other might do. Imagine your significant other performing each behavior and then read the statements that follow it. Please circle the number that indicates how much you agree or disagree with each statement, using the rate scale below:

1	2	3	4	5	6
DISAGREE STRONGLY	DISAGREE	DISAGREE SOMEWHAT	AGREE SOMEWHAT	AGREE	AGREE STRONGLY

**1. YOUR SIGNIFICANT OTHER CRITICIZES SOMETHING YOU SAY:**

- |   |   |   |   |   |   |  |
|---|---|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other's behavior was due to something about him/her (e.g., the type of person they are, the mood she was in). |
| 1 | 2 | 3 | 4 | 5 | 6 | The reason my significant other criticized me is <u>not</u> likely to change.  |
| 1 | 2 | 3 | 4 | 5 | 6 | The reason my significant other criticized me is something that affects other areas of our relationship.                     |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other criticized me on purpose rather than unintentionally  |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other's behavior was motivated by selfish rather than unselfish concerns.                                     |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other deserves to be blamed for criticizing me.   |

**2. YOUR SIGNIFICANT OTHER DOES NOT PAY ATTENTION TO WHAT YOU ARE SAYING:**

- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | The reason my significant other did not pay attention is something that affects other areas of our relationship.                |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other's behavior was motivated by selfish rather than unselfish concerns.  |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other's behavior was due to something about him/her (e.g., the type of person they are, the mood he/she was in). |
| 1 | 2 | 3 | 4 | 5 | 6 | The reason my significant other did not pay attention is NOT likely to change.  |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other did not pay attention on purpose rather than unintentionally.  |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other deserves to be blamed for what he/she did.   |

**3. YOUR SIGNIFICANT OTHER BEGINS TO SPEND LESS TIME WITH YOU:**

- |   |   |   |   |   |   |  |
|---|---|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 | 6 | The reason my significant other began to spend less time with me is not likely to change.  |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other's behavior was due to something about him/her (e.g., the type of person he/she is, the mood he/she was in). |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other's behavior was motivated by selfish rather than unselfish concerns.   |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other deserves to be blamed for what he/she did.  |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other spent less time with me on purpose rather than unintentionally  |
| 1 | 2 | 3 | 4 | 5 | 6 | The reason my significant other spent less time with me is something that affects other areas of our relationship.               |

**4. OUR SIGNIFICANT OTHER IS COLD AND DISTANT:**

- |   |   |   |   |   |   |  |
|---|---|---|---|---|---|--|
| 1 | 2 | 3 | 4 | 5 | 6 | The reason my significant other was distant is not likely to change.   |
| 1 | 2 | 3 | 4 | 5 | 6 | The reason my significant other was distant is something that affects other areas of our relationship.                           |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other was distant on purpose rather than unintentionally.   |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other's behavior was due to something about him/her (e.g., the type of person he/she is, the mood he/she was in). |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other deserves to be blamed for what he/she did.  |
| 1 | 2 | 3 | 4 | 5 | 6 | My significant other's behavior was motivated by selfish rather than unselfish concerns.   |

## Appendix E

### Pretest: Mental Health Knowledge Quiz

**III. Instructions:** The following is a brief quiz to determine the basic knowledge level college students have about mental health. Answer each question by circling what you believe is the best answer.

Answer each question to the best of your ability. There are no penalties for incorrect answers.

**1) Mental health is defined as:**

- a) A constant feeling of contentment
- b) Striking a balance in all aspects of your life - social, physical, spiritual, economic, mental
- c) Achieving a period of 12-18 months without a psychotic episode

**2) Mental illness is:**

- a) a single, rare disorder
- b) a broad classification for many disorders.

**3) Who is most likely to get a mental illness?**

- a) Poor, uneducated people
- b) People with stressful jobs
- c) Mental illness can affect anyone, regardless of intelligence, social class or income level.

**4) Mental illness is caused by:**

- a) Personal weakness or frailty
- b) It is hereditary
- c) Mental illness can affect anyone, regardless of intelligence, social class or income level.

**5) Violence is often associated with mental illness - true or false?**

- a) True: the general public is more often at risk
- b) False: people with mental illness are more likely to be the victims, rather than the perpetrators of violence

**6) Depression and bipolar disease are collectively known as:**

- a) Anxiety disorders
- b) Mood disorders
- c) Personality disorders

**7) Panic attacks and phobias are collectively known as:**

- a) Pan-phobic disorders
- b) Anxiety disorders
- c) Fear-based conditions

**8) Eating disorders only affect women – true or false?**

- a) True: women are more vulnerable to media images of thin females
- b) False: men develop eating disorders, too, though in smaller numbers than women

**9) Clinical depression is:**

- a) sadness or disappointment
- b) depression brought on by frequent trips to a hospital or dental clinic
- c) severe feelings of worthlessness, sadness and emptiness that last for several weeks and begin to interfere with a person's work and social life

**10) "Manic" depression is also known as:**

- a) the highs and lows
- b) bipolar affective disorder
- c) the blues

**11) Stigma refers to:**

- a) a plan of treatment agreed to by patient and doctor
- b) societal prejudice that can prevent people in need from speaking out or seeking help

**12) There is very limited treatment for mental illness - true or false?**

- a) True: mental illness is always a life sentence.
- b) False: a person's quality of life can be improved with treatments such as psychotherapy, cognitive behavioral therapy, medication, occupational therapy and social supports.

## Appendix F

### Posttest: An adaption of the Multidimensional Health Locus of Control Scale

**I. Instructions:** The next set of questions will ask you to respond based on a hypothetical diagnosis. To answer the following questions, please respond as if your significant other has been diagnosed with to ***be randomly Assigned (Bipolar Disorder or Alcoholism)***. Please read the directions prior to answering the questions.

**Directions:** Each item below is a belief statement about your partner’s medical condition with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher will be the number you circle. The more you disagree with a statement; the lower will be the number you circle. Please make sure that you answer **EVERY ITEM** and that you circle **ONLY ONE** number per item. This is a measure of your personal beliefs; obviously, there is no right or wrong answers.

1=STRONGLY DISAGREE ( <b>SD</b> )	4=SLIGHTLY AGREE ( <b>A</b> )
2=MODERATELY DISAGREE ( <b>MD</b> )	5=MODERATELY AGREE ( <b>MA</b> )
3=SLIGHTLY DISAGREE ( <b>D</b> )	6=STRONGLY AGREE ( <b>SA</b> )

1	If my partner’s condition worsens, it is their behavior which determines how soon they will feel better again.	1	2	3	4	5	6
2	As to their condition, what will be will be.	1	2	3	4	5	6
3	If they see the doctor regularly, they are less likely to have problems with their condition.	1	2	3	4	5	6
4	Most things that affect their condition happen to them by chance.	1	2	3	4	5	6
5	Whenever their condition worsens, they should consult a medically trained professional.	1	2	3	4	5	6
6	They are directly responsible for their condition getting better or worse.	1	2	3	4	5	6

7	Other people play a big role in whether my partner's condition improves, stays the same, or gets worse.	1	2	3	4	5	6
8	Whatever goes wrong with my partner's condition is their own fault.	1	2	3	4	5	6
9	Luck plays a big part in determining how their condition improves.	1	2	3	4	5	6
10	In order for my partner's condition to improve, it is up to other people to see that the right things happen.	1	2	3	4	5	6
11	Whatever improvement occurs with my partner's condition is largely a matter of good fortune.	1	2	3	4	5	6
12	The main thing which affects their condition is what they do for themselves.	1	2	3	4	5	6
13	They deserve the credit when their condition improves and the blame when it gets worse.	1	2	3	4	5	6
14	Following doctor's orders to the letter is the best way to keep their condition from getting any worse.	1	2	3	4	5	6
15	If their condition worsens, it's a matter of fate.	1	2	3	4	5	6
16	If they are lucky, their condition will get better.	1	2	3	4	5	6
17	If their condition takes a turn for the worse, it is because they have not been taking proper care of themselves.	1	2	3	4	5	6

18	The type of help they receive from other people determines how soon their condition improves.	1	2	3	4	5	6
----	---	---	---	---	---	---	---

*Note.* The dimension of *internal*, questions 1, 6, 8, 12, 13, 17; the dimension of *chance*, questions 2, 4, 9, 11, 15, 16; the dimension of *doctors*, questions 3, 5, 14; the dimension of *others*, questions 7, 10, 18.



## Appendix G

### Posttest: Willingness to Lend Emotional Support Survey

**II. Instructions:** The next set of questions will ask you to respond based both on a hypothetical diagnosis and the narrative presented. To answer the following questions, please respond as if your significant other has been diagnosed with the condition described within the narrative. Please answer each question to the best of your ability.

1. How much could you understand the problem and worries associated with your partner's condition?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

2. How much love and affection could a partner living with this condition give to you?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

3. How much love and affection could you give to this partner?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

4. How much effort could a person living with this condition give you when needed?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

5. How much effort would you give to this person when needed?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

6. How much could you confide in your partner?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

7. How much could you potentially care about your partner with this condition?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

8. How much could you rely on your partner if you had a serious problem?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

9. How much could your partner rely on you if they had a serious problem?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

10. How much could you open up to them if you needed to talk about your worries?

1 (Not at all)            2 (Very little)            3(Some)            4 (A lot)

## Appendix H

### Posttest: Attributional Style Survey for Condition 1 and Condition 2

**III. Instructions:** This questionnaire describes several things that the significant other did within the narrative. Imagine your significant other performing each behavior and then read the statements that follow it. Please circle the number that indicates how much you agree or disagree with each statement, using the rate scale below:

1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY		SOMEWHAT	SOMEWHAT		STRONGLY

**1. “I have postponed starting the medicine prescribed to me.”**

**I believe the following action’s *cause* is best classified as...**

1	2	3	4	5	6	Expressive: A consequence of your partner’s emotional & physical state
1	2	3	4	5	6	Accidental: Not aware of the consequences on you or others
1	2	3	4	5	6	Trait-oriented: A result of your partner’s enduring traits or characteristics
1	2	3	4	5	6	Self-Centered: To fulfill the needs or wants of your partner
1	2	3	4	5	6	Diagnostic Impact: A symptom/behavior as a result of their condition

**The controllability of the action is best described as....**

1	2	3	4	5	6	The action could be controlled in the future
1	2	3	4	5	6	The action could be controlled by your partner in the future
1	2	3	4	5	6	The action could be controlled by your actions in the future
1	2	3	4	5	6	The action is best controlled by only your partner
1	2	3	4	5	6	The action is best controlled by others for your partner

1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY		SOMEWHAT	SOMEWHAT		STRONGLY

2. "I don't remember exactly how much I had to drink, but the tab on my Dad's credit card said it was a \$65.00 night."

I believe the following action's *cause* is best classified as...

1	2	3	4	5	6	Expressive: A consequence of your partner's emotional & physical state
1	2	3	4	5	6	Accidental: Not aware of the consequences on you or others
1	2	3	4	5	6	Trait-oriented: A result of your partner's enduring traits or characteristics
1	2	3	4	5	6	Self-Centered: To fulfill the needs or wants of your partner
1	2	3	4	5	6	Diagnostic Impact: A symptom/behavior as a result of their condition

The controllability of the action is best described as....

1	2	3	4	5	6	The action could be controlled in the future
1	2	3	4	5	6	The action could be controlled by your partner in the future
1	2	3	4	5	6	The action could be controlled by your actions in the future
1	2	3	4	5	6	The action is best controlled by only your partner
1	2	3	4	5	6	The action is best controlled by others for your partner

1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY		SOMEWHAT	SOMEWHAT		STRONGLY

**3. “Well, my courses were just in the way of my sleep schedule... so I skipped them.”**

**I believe the following action’s *cause* is best classified as...**

1	2	3	4	5	6	Expressive: A consequence of your partner’s emotional & physical state
1	2	3	4	5	6	Accidental: Not aware of the consequences on you or others
1	2	3	4	5	6	Trait-oriented: A result of your partner’s enduring traits or characteristics
1	2	3	4	5	6	Self-Centered: To fulfill the needs or wants of your partner
1	2	3	4	5	6	Diagnostic Impact: A symptom/behavior as a result of their condition

**The controllability of the action is best described as....**

1	2	3	4	5	6	The action could be controlled in the future
1	2	3	4	5	6	The action could be controlled by your partner in the future
1	2	3	4	5	6	The action could be controlled by your actions in the future
1	2	3	4	5	6	The action is best controlled by only your partner
1	2	3	4	5	6	The action is best controlled by others for your partner

1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY		SOMEWHAT	SOMEWHAT		STRONGLY

**4. My friends let me in on the night. Apparently, I was close to sealing the deal with a person in the bar, when my friends pulled me away to leave. I don't think my partner should know..”**

**I believe the following action's *cause* is best classified as...**

1	2	3	4	5	6	Expressive: A consequence of your partner's emotional & physical state
1	2	3	4	5	6	Accidental: Not aware of the consequences on you or others
1	2	3	4	5	6	Trait-oriented: A result of your partner's enduring traits or characteristics
1	2	3	4	5	6	Self-Centered: To fulfill the needs or wants of your partner
1	2	3	4	5	6	Diagnostic Impact: A symptom/behavior as a result of their condition

**The controllability of the action is best described as....**

1	2	3	4	5	6	The action could be controlled in the future
1	2	3	4	5	6	The action could be controlled by your partner in the future
1	2	3	4	5	6	The action could be controlled by your actions in the future
1	2	3	4	5	6	The action is best controlled by only your partner
1	2	3	4	5	6	The action is best controlled by others for your partner

## Appendix I

### Posttest: Attributional Style Survey for Condition 3 and Condition 4

**III. Instructions:** This questionnaire describes several things that the significant other did within the narrative. Imagine your significant other performing each behavior and then read the statements that follow it. Please circle the number that indicates how much you agree or disagree with each statement, using the rate scale below:

1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY		SOMEWHAT	SOMEWHAT		STRONGLY

1. "I don't remember exactly how much I had to drink, but the tab on my Dad's credit card said it was an \$85.00 night."

**I believe the following action's *cause* is best classified as...**

1	2	3	4	5	6	Expressive: A consequence of your partner's emotional & physical state
1	2	3	4	5	6	Accidental: Not aware of the consequences on you or others
1	2	3	4	5	6	Trait-oriented: A result of your partner's enduring traits or characteristics
1	2	3	4	5	6	Self-Centered: To fulfill the needs or wants of your partner
1	2	3	4	5	6	Diagnostic Impact: A symptom/behavior as a result of their condition

**The controllability of the action is best described as....**

1	2	3	4	5	6	The action could be controlled in the future
1	2	3	4	5	6	The action could be controlled by your partner in the future
1	2	3	4	5	6	The action could be controlled by your actions in the future
1	2	3	4	5	6	The action is best controlled by only your partner
1	2	3	4	5	6	The action is best controlled by others for your partner

1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY		SOMEWHAT	SOMEWHAT		STRONGLY

**2. “My friends often tell me that I consume multiple shots and drinks... sometimes without a person drinking with me. I often blackout...”**

**I believe the following action’s *cause* is best classified as...**

1	2	3	4	5	6	Expressive: A consequence of your partner’s emotional & physical state
1	2	3	4	5	6	Accidental: Not aware of the consequences on you or others
1	2	3	4	5	6	Trait-oriented: A result of your partner’s enduring traits or characteristics
1	2	3	4	5	6	Self-Centered: To fulfill the needs or wants of your partner
1	2	3	4	5	6	Diagnostic Impact: A symptom/behavior as a result of their condition

**The controllability of the action is best described as....**

1	2	3	4	5	6	The action could be controlled in the future
1	2	3	4	5	6	The action could be controlled by your partner in the future
1	2	3	4	5	6	The action could be controlled by your actions in the future
1	2	3	4	5	6	The action is best controlled by only your partner
1	2	3	4	5	6	The action is best controlled by others for your partner



1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY		SOMEWHAT	SOMEWHAT		STRONGLY

**3. “I would always have a drink with dinner, and then a drink or so before bedtime.”**

**I believe the following action’s *cause* is best classified as...**

1	2	3	4	5	6	Expressive: A consequence of your partner’s emotional & physical state
1	2	3	4	5	6	Accidental: Not aware of the consequences on you or others
1	2	3	4	5	6	Trait-oriented: A result of your partner’s enduring traits or characteristics
1	2	3	4	5	6	Self-Centered: To fulfill the needs or wants of your partner
1	2	3	4	5	6	Diagnostic Impact: A symptom/behavior as a result of their condition

**The controllability of the action is best described as....**

1	2	3	4	5	6	The action could be controlled in the future
1	2	3	4	5	6	The action could be controlled by your partner in the future
1	2	3	4	5	6	The action could be controlled by your actions in the future
1	2	3	4	5	6	The action is best controlled by only your partner
1	2	3	4	5	6	The action is best controlled by others for your partner

1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY		SOMEWHAT	SOMEWHAT		STRONGLY

**4. “A few days ago, I rummage through the cabinets for a bottle of wine...When I couldn’t find it I smashed a plate to the floor in frustration.**

**I believe the following action’s *cause* is best classified as...**

1	2	3	4	5	6	Expressive: A consequence of your partner’s emotional & physical state
1	2	3	4	5	6	Accidental: Not aware of the consequences on you or others
1	2	3	4	5	6	Trait-oriented: A result of your partner’s enduring traits or characteristics
1	2	3	4	5	6	Self-Centered: To fulfill the needs or wants of your partner
1	2	3	4	5	6	Diagnostic Impact: A symptom/behavior as a result of their condition

**The controllability of the action is best described as....**

1	2	3	4	5	6	The action could be controlled in the future
1	2	3	4	5	6	The action could be controlled by your partner in the future
1	2	3	4	5	6	The action could be controlled by your actions in the future
1	2	3	4	5	6	The action is best controlled by only your partner
1	2	3	4	5	6	The action is best controlled by others for your partner

## Footnotes

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<sup>i</sup> Mental Illness: medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning (NAMI, 2009).

<sup>ii</sup> The term partner will be used throughout the research to demonstrate a close/romantic relationship, and allow for discretion in regard to labeling the dynamics of the makeup of a couple.