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Causal Attributions for Teen Problem Drinking

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THESIS APPROVAL

The abstract and thesis of Barbara J. Seatter for the Master of Science in Psychology were presented December 5, 1994, and accepted by the thesis committee and the department.

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ABSTRACT

An abstract of the thesis of Barbara J. Seatter for the Master of Science in Psychology presented December 5, 1994.

Title: Causal Attributions for Teen Problem Drinking

Teen problem-drinking is a pervasive problem in our society. Teens with drinking problems utilize treatment centers and then return to school attempting to stay sober. However, many return to affiliate with problem drinkers instead of with non-drinkers, and risk for relapse is high. One explanation may be that teens without drinking problems do not accept teen problem drinkers into their peer group due to negative reactions toward problem drinkers. One way to examine their attitudes is to examine differences between teen problem drinkers and non-drinkers regarding causal attributions. Attribution theory proposes that various attributions will elicit different emotional reactions and will motivate teens to behave in certain ways.

The purpose of this study was to determine if teens with prior experience in treatment (problem drinkers) and teens without that experience (non-problem drinkers) make different causal attributions for teen problem drinking. Furthermore, group differences in emotional reactions, beliefs about how to offset the problem, and help-giving behaviors were also examined. This study also sought to determine whether there was a predictable link between attributions and emotional reactions, and between emotional reactions and help-giving behaviors.

One hundred twenty-one teenagers aged 13 to 20 were recruited as subjects, 79 from Portland area schools and 42 from treatment centers. Subjects completed a written survey measuring causal attributions for teen problem drinking, emotional reactions toward teen problem drinkers, beliefs regarding how to offset the problem, and help-giving behaviors.

Four MANOVAs were used to determine group differences. Results revealed group differences on causal attributions, emotional reactions, and offset controllability, but not on help-giving behaviors. Two multiple regressions were used to determine whether attributions predicted emotional reactions and whether emotional reactions predicted help-giving behaviors; results revealed no link.

Although results revealed group differences, these were found not to be consistent with the hypothesis based on attribution theory. Results did reveal positive outcomes regarding attitudes toward teen problem drinkers by non-problem drinkers, which is important as it suggests that teens without prior experience in treatment may be more accepting of teen problem drinkers than was expected.

CAUSAL ATTRIBUTIONS FOR TEEN PROBLEM DRINKING

by

BARBARA J. SEATTER

A thesis submitted in partial fulfillment of the
requirements for the degree of

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Teenage alcohol and drug abuse is an enormous social problem in this country today. In the past decade, efforts have been made to deal with this issue through alcohol and drug prevention programs, education programs, media campaigns and alcohol and drug rehabilitation programs for youth. Although there has been empirical research conducted to determine the frequency of alcohol and drug use among teens and the demographic characteristics of teen problem drinkers, little research exists about the attitudes of teenagers toward teen problem drinkers. The following study was conducted to examine factors that influence emotional reactions and attitudes of help-giving toward teenage problem drinkers by both teen problem drinkers and non-problem drinkers.

Previous research by attribution theorists points to factors such as perceived controllability, stability and locus of causality of drinking problems as predictors of either negative or positive affective reactions, and of subsequent willingness or unwillingness to provide help to the affected teenager. It is hypothesized that a teen problem drinker who has had experience in an alcohol treatment program will have a different causal attribution for teen problem drinking than a non-problem drinker who has not had experience in treatment. Consequently, the affective reactions and attitudes toward help giving will also be different for these individuals.

The History of Attribution Theory

Early attribution theorists such as Fritz Heider (1958) proposed that people classify the causes of events into either internal attributions such as ability and effort, or to external attributions such as chance and task difficulty. Heider believed that attribution is a phenomenon of every day life which people use to

search for meaning in what is happening around them. Heider also proposed the idea of causal responsibility. Not only are people concerned with causal attributions for an event, but also with determining who is responsible for an event. Attributing causal ascriptions to events provides people with a sense of mastery over their environment and with a way to manage themselves in that environment.

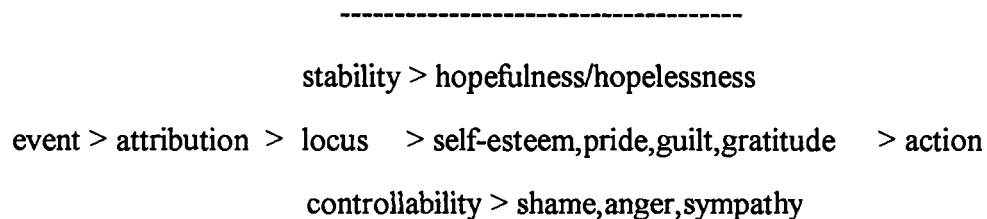
Heider laid the groundwork for future theories by Jones & Davis (1965) and Kelley (1967). Jones and Davis created a theory called correspondent inference; the way an observer makes inferences about other people's behavior. They propose that people make stable (unchanging) dispositional (internal) attributions about people because these attributions are most informative about the person. Making judgments that will change across situations will not lead to a better understanding of the individual. Behavior and intention (actions and motivation) which produce an event corresponds to some underlying disposition of the person. A correspondent inference depends on whether the behavior is freely chosen, socially desirable, and consistent with social norms.

Kelley's covariation model states that people assess information across three dimensions, consensus, consistency and distinctiveness. According to Kelly, individuals make a stimulus attribution if distinctiveness, consensus, and consistency are high. If consistency is high, but distinctiveness and consensus are low, a person attribution is made. A person attribution is comparable to a correspondent inference in that the behavior is attributed to something about the person.

Weiner's Attribution Theory of Motivation and Emotion

Drawing from these pioneers in attribution theory, Weiner proposed a model of motivation and emotion which integrates the three dimensions of locus, stability (Weiner et al; 1972) and controllability (Weiner, 1980). Weiner's theory was first explored in achievement settings, and has since been examined in helping-behavior situations, and in studies on reactions to social stigmas. His attribution theory of motivation hypothesizes that it is not the specific causes of behavior, but the underlying properties of locus, controllability and stability that are important in determining emotional reactions and future behavior. Figure 1 depicts the theoretical relationships among the dimensions, and the affective, cognitive and behavioral consequences of each.

Figure 1. The complete attribution-emotion-action theory of motivation.



Locus dimension. As Heider and others have shown, people use the locus of causality dimension to explain the events that happen around them. The actor attributes an event to either him/herself, or to an external cause. According to Weiner (1972), the importance of the locus dimension is that it affects the actor's self-esteem. Weiner (1979) found that subjects felt proud after an internal attribution for success and guilty after an internal attribution for failure, while

external attributions elicited gratitude after success, and anger after failure. The emotions elicited from these different attributions will motivate the actor in distinct ways (Weiner, 1980). For example, if success on a test is attributed to another person's help, the gratitude which the actor feels will lead to a desire to continue the relationship. On the other hand, if failure on the test is attributed to the actor's effort, the individual may avoid a subsequent failure by studying harder the next time.

Stability dimension. Weiner (1972) argues that while the locus and stability dimensions are linked in interpreting present outcomes, the stability dimension will have more effect on future expectations of success and failure than determining whether the cause of an event was internal or external. Effort, which is internal, can change across time, while ability, which is also internal, is generally stable across time (Weiner et al., 1976). As for external attributions, the difficulty of a task remains the same, while luck can vary.

In achievement setting studies, Weiner et al. (1976) found that if success or failure is attributed to stable causes, then the expectancy of future behavior will be consistent with the present outcome. However, if the outcome is attributed to unstable causes, then a shift in attribution is possible in the future. For example, if a student attributes failure on a task to lack of ability (stable), she will be more likely to believe she will fail on the same task in the future. But, if she attributes the failure to lack of effort (unstable), then a different outcome is possible in the future. Expectancy of change in outcomes leads to feelings of hopefulness, while no expectancy of change can lead to hopelessness.

Controllability dimension. An attribution for an outcome is perceived by the actor and by others as either controllable or uncontrollable. For example, a person may be able to change her level of effort to do better on a test, but may not be able to control her mood or fatigue levels. Likewise, external attributions for failing may be controllable, such as not getting tutored, while others are not, such as taking a difficult test.

Early studies showed that the controllability dimension is most responsible for affective reactions of observers. Jones and DeCharms (1957) found that failure due to insufficient effort (controllable) was evaluated lower than failure due to lack of ability (uncontrollable). Weiner & Kukla (1970) found that students high in effort and low in ability were rewarded, while students high in ability and low in effort were punished. In later studies, Weiner theorized that anger and guilt were emotions associated with people who have control over a bad outcome, while sympathy and shame were associated with uncontrollable bad outcomes. He found that attributions of failure due to lack of effort (controllable) maximized punishment, while success due to effort maximized rewards (Weiner, 1979).

Attribution and Help-Giving

Recent research has been conducted to investigate how the emotional reactions to attributions affect observers' actions. In the last decade, much of the research in attribution theory has studied help giving actions. Weiner hypothesized that observer's attributions for people's successes, failures, or problems will have important implications for whether the person in need of help will in fact receive it.

In a classic study by Weiner (1980), subjects were given two hypothetical scenarios in which a student asked to borrow class notes. The two scenarios

included 16 different situations with all combinations of the locus, stability and controllability dimensions. Subjects reported that they would be less likely to help the student by lending class notes if the lack of having class notes was attributed to internal and controllable causes.

Similar results were found in a second study using two different scenarios depicting either a drunk or an ill person needing help in the subway (Weiner, 1980). In this study, subjects were asked to report their attributions and feelings about the drunk and ill persons, and whether or not they would assist either of them. Subjects attributed being ill to uncontrollable causes and were more likely to feel sympathy and help the ill person. Subjects attributed being drunk to controllable causes, and were more likely to feel anger and not help the drunk person.

A study by Meyer & Mulherin (1980) supports Weiner's model of an attribution-affect-action link. The authors hypothesized that helping judgments would be mediated by affect and expectancy of future need. Hypothetical money-lending scenarios were used and the stability, locus and control dimensions were manipulated. Subjects were asked to rate their own emotional reactions, the expectancy of future need of the person borrowing money, and whether or not they would lend the money. Results revealed that the controllability of the cause for needing money most influenced helping judgments. Emotions such as concern and sympathy were greatest when the need was uncontrollable, but expectancy of future need did not influence help giving. Path analysis showed that controllability had an indirect influence on helping judgments by its effect on subjects' emotional reactions.

To further evaluate the model, Schmidt and Weiner (1988) conducted a study in which they investigated the relationship between controllability and judgments of help giving, as well as the strength of the controllability-affect, the affect-behavior, and the controllability-behavior paths. Results showed a significant path between emotions and help-giving. Adding the path of controllability to help-giving did not contribute to the significance of the model.

Perceptions of Responsibility for the Solution to a Problem and Help-Giving

Brickman and his colleagues (1982) wrote a theoretical paper to distinguish between four different models of helping and coping using attribution theory. They argue that the attribution of responsibility for the onset (cause) of a problem is different than responsibility for the offset (solution), and that each of these models will produce unique helping responses.

According to Brickman, observers will have different reactions to the outcomes of others depending on their orientations to a model of responsibility (1982). The moral model espouses that people are held responsible for both their problems and the solutions to their problems. The medical model is one in which people are neither responsible for their problems nor the solutions. In the enlightenment model, people are responsible for their problems, but are not responsible for the solutions. Finally, in the compensatory model, people are not responsible for their problems, but are responsible for the solutions. The models suggest that the perceptions for responsibility of the cause and solution for a problem can vary for different people.

For example, attribution studies on alcoholism show varying attributions for the cause of alcoholism. McHugh et al. (1979) report that some people believe

that alcoholism is an internal and controllable moral problem, while others believe it is an internal and uncontrollable medical problem. Still others believe that alcoholism is influenced by external factors such as family background or peer pressure (external and controllable). And finally, societal influences such as social class and economics have also been implicated as a cause (external, uncontrollable).

The various causal theories for the onset of the alcoholism will have implications on the emotional reactions to alcoholism, attributions for the solution to the alcohol problem, and expectations for recovery from alcoholism. Mulford and Miller (1964) found that people who thought of alcoholism as a disease were more likely to approve of treatment for alcoholics than those who believed it was a moral weakness. They also proposed that when people attribute alcoholism to dispositional factors it contributes to the negative reactions and the stigma of alcoholism as a moral weakness. The negative reactions may in turn contribute to the alcoholics' self-blame and may hinder their recovery.

Stigma Research

Current research in attribution theory further investigates the connection among observers' perceptions of the controllability of a problem, their emotional reactions, their attitudes toward help-giving, and their perceptions of responsibility for the solution. Within attribution research, the study of affective reactions and help-giving judgments toward people experiencing stigmatizing events is receiving important attention.

In a study by Dejong (1980), the controllability dimension was manipulated to determine the influence of the subjects' perceived controllability of obesity on

their opinions about obese girls. Subjects were shown a picture of either an obese peer or a normal weight peer who had a problem with paleness and read a letter in which the target persons wrote about their conditions. Half of the target persons attributed their problem to a thyroid condition (uncontrollable) while the others did not have a thyroid condition (controllable). Subjects were asked to rate the target girl on traits including self-control, discipline, laziness, friendliness, and happiness, and how much the subject liked the target girl. Results showed that the obese girl was rated as less self disciplined than the normal weight girl in the controllable situation, but in the uncontrollable situation there was no difference between the ratings of the two girls. Overall, the obese girl in the uncontrollable condition was liked as much as the normal weight girl, but significantly more liked than the obese girl in the controllable condition.

Another stigma-related study was conducted on the effects of causal attributions on heterosexuals' attitudes toward gays. Whitley (1990) showed that heterosexuals who attributed homosexuality to controllable causes, such as lifestyle choice, had a more negative attitude toward gays than those who attributed homosexuality to uncontrollable causes, such as genetics. Triplet and Sugarman (1987) found similar reactions to homosexual AIDS victims based on attributions. The authors hypothesized that homosexuals with AIDS are held personally responsible for their disease, and therefore have more negative reactions toward them than heterosexuals with AIDS. The hypothesis was further tested by comparing subjects' reactions to homosexual vs. heterosexual individuals with AIDS, genital herpes, serum hepatitis, and Legionnaire's disease. Results revealed

that homosexuals were held more personally responsible for their disease, regardless of diagnosis, than heterosexuals.

Weiner, Perry, and Magnusson (1988) conducted a study which compared the onset and offset controllability for physical stigmas (Alzheimer's, blindness, cancer, heart disease, paraplegia) and mental-behavioral stigmas (AIDS, child abuse, drug abuse, obesity, and Vietnam War syndrome). Subjects rated these stigmas in terms of the victim's responsibility for the stigma and its changeability. The investigators compared the perceived controllability and stability for the causes of the stigmas, as well as the emotional reactions and judgments of help giving for each stigma. Results revealed that the physically based stigmas were perceived as onset uncontrollable, which led to reactions of pity, and judgments to help. However, the mental-behavioral stigmas were perceived as onset controllable, which led to reactions of anger, and judgments of neglect. The stability of the problem was significantly related to the changeability of the problem and the efficacy of treatment. Subjects were more likely to give assistance and charitable donations to individuals with an uncontrollable problem than those with a controllable problem. Subjects chose medical treatment as the most likely treatment for increased life satisfaction for the individuals with physical stigmas and AIDS patients, and psychotherapy for increased life satisfaction for the individuals with the remaining mental-behavioral stigmas.

Recently, Schwarzer and Weiner (1991) proposed that the coping ability of the individual with a problem as well as the controllability of the onset of the problem will have an influence on other people's emotional reactions and willingness to give help. In a simulation experiment, onset controllability of eight

disease related social stigmas and the coping ability of the target person was manipulated. Subjects described as responsible for the onset of the stigma were blamed more for their condition than those described as a victim of circumstance. However, it was also found that actively coping individuals were blamed less and received more sympathy and support from others than individuals who were not actively coping.

Further analysis showed that helping behavior was mediated by different affective reactions. For example, pity was the best predictor for support for such life-threatening diseases as AIDS and cancer. Anger was the best predictor of unwillingness to help for behavioral-mental stigmas such as depression and obesity. Perceived social stress in relationships with the affected individual was linked with the unwillingness to provide help to those with socially deviant stigmas such as drug and child abuse.

Weiner (1985) states a word of caution when analyzing his model saying that the theoretically linked emotions do not always follow an attribution. The relations are not invariant across people, but do hold in general. Other cognitive processes are also going on such as weighing the costs of helping in some situations and the influence of past experience on judgments to give help.

The influence of Past Experience on judgments of help giving

Although variables such as coping ability and onset controllability have been found to influence affective reactions and judgments of help, it is unclear why different attributions are sometimes made for the same event. Skokan (1990) examined whether or not past experience was another variable influencing attributions and help-giving. In her unpublished dissertation, she used eight

hypothetical situations with varying combinations of controllability, negative life event, and coping ability. Subjects read two scenarios and evaluated their emotional reactions and the amount of social support they would be willing to give. In addition, subjects were asked questions regarding their personal experiences with negative life events, such as cancer, drug abuse, eating disorders, and bereavement. Results confirmed the hypothesis that people who had more overall contact with others who had experienced negative life events were more sympathetic and were more likely to give support to individuals in need of help.

A lack of experience with a negative life event may increase the likelihood of making the fundamental attribution error. The fundamental attribution error occurs when people attribute the cause of events to internal dispositions and disregard the external situation (Heider, 1958). Jones and Nisbitt (1972) found that in general people tend to attribute other people's failures to internal dispositions more than to external situations. The fundamental attribution error can have implications for how people perceive the causes of others' success and failures, and their subsequent feelings about them.

Current Study

Students with alcohol and drug problems are discovered as they show signs such as decline in school work, attendance, and coming to school under the influence. Many students who show these problems will be sent to alcohol and drug counseling and possibly treatment centers for either inpatient or outpatient help. While in treatment, these problem drinkers learn many things about the causes of alcohol and drug abuse. Although external circumstances such as dysfunctional families are addressed in treatment as contributing to the problem

drinking, most treatment programs teach that alcoholism is caused by a predisposed genetic condition. In other words, alcoholism is an uncontrollable disease (Finney, Moos & Chan, 1981).

The majority of the high school population does not get the same education about alcoholism as the teens who have been in treatment. It is possible that the teenagers who have not had experience with treatment have a different attribution for alcoholism. Students who don't understand the disease concept of alcoholism may attribute problem drinking to a controllable condition, or a weakness in character.

As prior studies of attribution have shown, perceiving the cause of problem drinking as controllable will elicit anger and an unwillingness to help. On the other hand, perceiving the cause of problem drinking as an uncontrollable condition will elicit sympathy and willingness to help. These differences in causal attributions contribute to problem drinking teenagers' lack of social support before they get help, and also to the lack of support they will receive after they return from treatment (Finney, Moos & Mewborn, 1980). To the extent that these different attributions reflect differences in experience or education levels, these attributions can be modified and used to provide a more supportive environment for alcoholic teens.

The current research compared the attributions for teen problem drinking by teenagers who have had personal experience in an alcohol rehabilitation program or knew someone who had experience in treatment with those teenagers who have not had any prior experience with treatment. Weiner's three dimensions of locus, causality, and stability were used in evaluating attributions for teenage

problem drinking. Relationships between these dimensions and their impact on affective reactions and judgments of help giving were investigated. In addition, possible reasons for the differences in attributions, to the extent that such differences exist, will be explored.

Hypotheses

- 1) The attributions of individuals who have personal prior experience with treatment (a lot of prior experience) or have prior experience in the case of knowing someone in treatment (some prior experience) will differ from those who have not been in treatment and have no past experience of knowing someone in treatment (no prior experience) on the locus, controllability, and stability dimensions. Those with prior experience will be more likely to attribute problem drinking to external, uncontrollable, and unstable causes. Those with no prior experience will be more likely to attribute problem drinking to internal, controllable, and stable causes.
- 2) Affective reactions, offset controllability, and help-giving will vary as a function of group membership. The groups with prior experience will feel more sympathy, less fear, more liking toward teen problem drinkers, will be more likely to believe that some form of help is needed to deal with the problem, and will be more willing to give help than the group with no experience. The group with no experience will feel more anger, more fear, less liking toward teen problem drinkers, will be more likely to believe that the problem drinker can offset the problem without outside assistance, and will be less willing to give help than the groups with prior experience.

3) Those individuals who attribute problem drinking to controllable causes will feel more anger toward the problem drinkers than those who attribute drinking to uncontrollable causes. Those individuals who attribute problem drinking to uncontrollable causes will feel more sympathy for the problem drinkers than those who attribute drinking to controllable causes.

4) Those individuals who feel anger toward the problem drinker will be less willing to give help to the problem drinker than those who feel sympathy. Those individuals who feel sympathy for the problem drinker will be more willing to provide help than those who feel anger.

Method

Subjects

Sixty-one male and 60 female teenagers between the ages of 13-20 were recruited for this study. Seventy-nine subjects were from Portland area high schools and 42 subjects were from Portland area alcohol treatment centers. All but 26 participants were from the city of Portland and attended public schools. Twenty-six subjects were from a suburb of Portland and attended a private school. Seventy-six percent of the subjects were Caucasian, 7% were Asian, 4% were Hispanic, 1% were African-American, and 12% reported a racial identity other than what was listed. Only 3% of the subjects reported not having a mother living in the home and 11% reported not having a father living in the home. The mean education level of parents was slightly higher for the subjects from the schools than subjects from the treatment program. However, the mean education level of parents for the entire population was some college or a two year degree.

Subjects were categorized into the following groups, based on the extent of their prior experience with treatment. Group 1 consisted of 8 subjects who were currently in school but had personal prior experience in treatment. Group 2 consisted of 44 subjects who were in school and had neither personal prior experience nor knew anyone with past experience in treatment. Group 3 consisted of 27 subjects who were in school and knew someone with past experience in treatment. Group 4 were 42 subjects who were currently in treatment.

Materials

A questionnaire (see Appendix A) was used to measure the three dimensions of Weiner's attribution theory: locus of causality, stability, and controllability. In addition, offset controllability, affective reactions, help-giving judgments, and prior experience with alcoholism were assessed.

The questionnaire consisted of the following subcategories: specific examples of causal attributions, the Causal Dimension Scale (Russell, 1982), measures of offset controllability, measures of affective reactions including sympathy, anger, fear, compassion and liking, measures of helping judgments, and measures of prior experience with alcoholism.

The specific examples of causal attributions were for descriptive purposes to identify the causes of problem drinking from the teen's perspective. The 19 closed-ended items which identified specific attributions were anchored by "not at all" the cause and "very much" the cause. Although the items were not combined for analyses, they were designed to be examples of combinations of internal/external, stable/unstable, and controllable/uncontrollable causes of

alcoholism. One open-ended item was designed to ask if there were any other potential causes of problem drinking that have not been given.

The items were examples of the typical reasons adults gave for alcoholism taken from the McHugh, Beckman & Frieze (1979) study of attributions for alcoholism. McHugh found that the most frequently cited cause of alcoholism was an interaction between external and personal factors, and that disease and addiction factors were cited less often.

The Causal Dimension Scale (Russell, 1982) consisted of nine semantic differential scales with three items measuring locus of causality, three items measuring stability, and three items measuring controllability of the causes listed in the causal attribution scale above. Responses to these items were on 9-point Likert-type scales anchored at the extremes. Russell found coefficient alphas ranging from .73 to .87, suggesting that the subscales were internally consistent. Research by Russell and McAuley (1986), Russell, Lenel, Spicer, Miller & Rose (1985), and McAuley, Russell and Gross (1983) supported the construct validity of the scale.

The measure of offset controllability consisted of six items which assessed the offset controllability for problem drinking (Brickman, Rabinowitz, Karuza, Coates, Cohn & Kidder, 1982). One item measured internal controllability for offset, "How much can a teen stop drinking on his/her own?" Four questions assessed external controllability for offset. For example, "How much can medical treatment help the teen stop drinking?" Responses to the items were on a 9-point Likert-type scale anchored by "not at all" and "very much."

The measure of affective reactions consisted of five closed-ended items and one open-ended item which assessed how subjects felt about the teen problem drinker (Weiner, Perry & Magnusson, 1988). The items were on 9-point Likert-type scales anchored by "none at all" and "a lot." The affective reactions evaluated on this scale were liking, anger, fear, sympathy, and compassion. One open-ended question asked for any other feelings toward the teen problem drinker.

The measure of helping judgments consisted of five items which assessed judgments toward help-giving (Weiner et al, 1988). The 9-point Likert-type scale items asked about the likelihood that the subject would give various forms of help and were anchored by "not at all likely" and "extremely likely." Two items assessed personal help-giving and three items assessed drinking-related help-giving.

The measure of prior experience with alcoholism adopted from Skokan (1990) consisted of twelve items including the number of family members and friends who have been to alcohol treatment, personal drinking frequency, delinquent history, and personal chemical dependency treatment experience.

Procedure

Data were collected at five separate times throughout the school year. Subjects completed the questionnaire as a group in a classroom setting at each collection site. Subjects were told by the experimenter that the questionnaires were anonymous, and that no one would know what their personal answers were. The experimenter explained that the questionnaire was not developed or administered by the school district or the treatment center and no teachers or counselors were present while students completed the questionnaire. The

experimenter passed out consent forms for those subjects who wished to participate and read the consent forms aloud. The experimenter administered the questionnaires in all cases except the private school where the teacher administered the survey, and read the directions at the beginning of each subscale to the subjects. The subjects were asked to raise their hands if they had any questions and the experimenter would come to their desks.

The questionnaires took about 25 minutes to complete. To ensure anonymity, subjects placed their completed questionnaires and consent forms in separate envelopes placed in the back of the room. Debriefing was conducted after the questionnaire was completed and the subjects were told the purpose of the research. The subjects were asked if there were any questions. The subjects were told that the results of the study would be made available to them when the research was complete. The subjects were thanked for their contributions.

Results

Because the Causal Dimension Scale (CDS) has been used only with adults, it was not clear whether adolescents would understand the directions and the response categories. Since the CDS has not been previously used with adolescents, reliability analysis was completed to determine if the CDS was internally consistent with teenage subjects. Results revealed poor reliability for each of the subscales ($\alpha = .19$ for stability, $\alpha = -.04$ for locus of control, and $\alpha = .06$ for controllability). This suggests that the respondents did not answer the subscale questions consistently throughout the survey.

Because the lack of reliability was unexpected, follow-up reliability analyses were conducted to determine whether reliability differed across schools

and ages of the respondents. While there were no significant differences in reliability scores across age groups, reliability of the scales was higher in the private school ($\alpha = .46$ for locus of control, $\alpha = .45$ for controllability, and $\alpha = .40$ for stability). Because the Cronbach alphas were low even in these subgroups, aggregate scores were not used in the analyses. The nine individual item scores were used as indicators of the locus, controllability, and stability constructs.

Hypothesis 1

A multivariate analysis of variance (MANOVA) was used to analyze the difference among attributions for teen problem drinking in the four groups on the stability, locus of control and controllability scores, and the discriminant function was used to determine which construct contributed most to the group differences. The school group with prior personal experience (Grp 1), the school group with no prior experience (Grp 2), the school group with some prior experience (Grp 3), and the treatment group (Grp 4), served as independent variables. Three items measuring locus of control, three items measuring controllability, and three items measuring stability from the Causal Dimension Scale constituted the dependent variables. All nine items were entered into the model simultaneously and in no specified order.

The overall Wilks Lambda revealed that the four groups were significantly different, $F(27, 301.46) = 2.35, p = .000$. Two discriminant functions were found to be significant. The second function was chosen to analyze due to overall greater standard coefficients in this function.

Of the nine items in the function, one item from each construct revealed standard coefficients showing significant contributions to the differences among the groups. The standard coefficient for how "changeable" the attribution was (.658) revealed that this stability variable contributed the most to the difference among the groups. The standard coefficient for how "intended" the attributions were (.546), and whether the attribution was located "inside or outside" the person (.478), showed that these controllability and locus of control variables contributed less to the differences among the groups.

Post hoc tests were performed to examine the mean controllability, stability and locus of control scores for each group (see Table 1). The Student-Newman-Keuls (SNK) test revealed the mean of the stability score for Grp 2 was significantly less than that of Grp 4 and that the mean of the controllability score for Grp 1 was significantly less than the mean for Grp 4. Therefore, the school group with no prior experience felt that the reasons for drinking were more "changeable" (unstable) than the treatment group did, and the school group with personal prior experience felt that the reasons for drinking were more "intended" (controllable) than the treatment group did. The mean locus of control scores for Grp 2 and Grp 3 were significantly greater than for Grp 4, revealing that the groups from school with either none or some prior experience felt that reasons for drinking were more "outside" (external) the person than the treatment group did.

Insert Table 1 about here

Hypothesis 2

A multivariate analysis of variance (MANOVA) was used to analyze the difference among the four groups on affective reactions toward teen problem drinker scores and the discriminant function was used to determine which affective reaction contributed most to the group differences. The school group with personal prior experience (Grp 1), the school group with no prior experience (Grp 2), the school group with some prior experience (Grp 3), and the treatment group (Grp 4) were independent variables, and the affective reaction items measuring "liking", "anger", "sympathy", "compassion", and "fear" were dependent variables. All five items were entered into the model simultaneously and in no specific order.

The overall Wilks lambda revealed the four groups were significantly different on the affective reaction scores, $F(15, 301.30) = 2.29, p = .004$. Only one discriminant function was found to be significant. The standard coefficient for the "liking" variable (-.835), revealed that this affect variable contributed most to the difference among the groups. The standard coefficient for the "compassion" variable (-.485), and the "fear" variable (.407), also contributed to the difference among the groups.

Post hoc tests were performed to examine the mean liking, compassion and fear scores for each group (see Table 2). The Student Newman Keuls (SNK) revealed the means of the "liking" variable for Grps 4, 3 and 1 were significantly greater than the mean of Grp 2, and the mean of the "fear" variable for Grp 2 was significantly greater than the mean of Grp 4. These results show that the treatment group and the school groups with some experience and personal experience, all

reported "liking" the teen problem drinkers more than the group from school with no experience, and the group from school with no experience reported feeling more "fear" toward teen problem drinkers than the treatment group. The SNK showed no significant differences among groups on the "compassion" variable.

 Insert Table 2 about here

A MANOVA was used to analyze the difference among the groups on the extent to which external resources can help teen problem drinkers stop drinking and the discriminant function was used to determine which resource contributed most to the group differences. The external offset controllability scores of how much "medical treatment", "higher power", "psychological counseling", "friends", and "family" can help offset the teens' drinking problem served as dependent variables, and the four groups were independent variables. All five items were entered into the model simultaneously and in no specific order.

The overall Wilks Lambda revealed the four groups were significantly different on the external offset controllability scores $F(15, 312.34) = 2.61, p = .001$. Only one discriminant function was found to be significant. The standard coefficient for the "higher power" variable (-.764), showed that this variable contributed most to the group differences. The "friends" variable standard coefficient (.644), and the "psychological counseling" variable standard coefficient (.491), also contributed to the group differences.

Post hoc tests were performed to examine the mean "higher power" and "friends" scores for each group (see Table 3). The Student Newman Keuls (SNK) revealed that the mean of the "higher power" variable for Grp 4 was significantly greater than for Grp 2 and Grp 3, indicating that the treatment group, more than the school groups, felt that a "higher power" can help in offsetting the problem. In addition, the means of the "friends" variable for Grp 2 and Grp 3 were significantly greater than the mean for Grp 4. This result indicated that the school groups, as opposed to the treatment group, believed that "friends" can help in offsetting the problem. There were no significant differences among the groups on the "psychological counseling" scores.

 Insert Table 3 about here

An ANOVA was conducted to analyze group differences with respect to what extent internal resources can help teen problem drinkers stop drinking. The internal offset controllability score measuring whether or not teens can offset their problem "on their own" was the dependent variable, and the four groups were independent variables. The internal offset controllability score was found not to be significant with respect to group membership.

A multivariate analysis of variance (MANOVA) was used to analyze group differences on how likely it would be for each group to provide help to teen problem drinkers. The help giving scores of "overall help", "helping get home", "helping with school work", "giving advice", and "emotional support", were dependent variables, and the four groups were independent variables. All items

were entered into the model simultaneously and in no specific order. The help-giving scores were found not to be significantly different by group.

Hypothesis 3

Multiple linear regressions were conducted to determine to what extent the locus of control, controllability, and stability of the attributions predict affective reactions. All nine items of the Causal Dimension Scale (three items measuring locus of control, three items measuring stability, and three items measuring controllability), were the independent variables. The affective reaction scores measuring "anger", "sympathy", "compassion", "fear", and "liking" were dependent variables. All items were entered into the model simultaneously. The overall R^2 was not significant for any of the models, $p > .05$.

Hypothesis 4

Multiple linear regressions were conducted to determine to what extent group membership and affective reactions predict help-giving behaviors. The school group with personal prior experience (Grp 1), the school group with no experience (Grp 2), the school group with some prior experience (Grp 3), and the treatment group (Grp 4), as well as the affective reaction scores of "anger", "sympathy", "compassion", "fear", and "liking" were independent variables. The help-giving scores of "overall help", "helping get home", "helping with school work", "giving advice", and "emotional support" were the dependent variables. All items were entered into the model simultaneously. The overall R^2 was not significant for any of the models, $p > .05$.

Discussion

Hypotheses 1 - Do teens with prior experience with treatment differ from those without prior experience on attributions for teen problem drinking, and are teens with no prior experience more likely to attribute problem drinking to internal, controllable, and stable causes than teens with prior experience?

Results show that the teens with prior experience do differ from teens without prior experience on attributions for teen problem drinking. However, the hypothesis that teens with no prior experience will be more likely to attribute the problem to internal, controllable, and stable causes than the teens with prior experience was not confirmed.

Stability

While the treatment group attributed teen problem drinking to unstable causes as expected, the group with no prior experience attributed problem drinking to more unstable causes than the treatment group. This finding is significant because it reveals that even teens with no prior experience with teen problem drinking believe that those with problems can change.

Controllability

Another unexpected finding was the difference between the school group with personal prior experience and the treatment group on the controllability scores. As hypothesized, the treatment group attributed problem drinking to uncontrollable causes. However, the school group with prior experience attributed drinking more to controllable causes. Since we would expect these groups to answer similarly because of their mutual prior experience, the hypothesis was not confirmed. Further more, the group with no prior experience was not significantly different

than the groups with prior experience on the controllability scores. This finding also does not confirm the hypothesis that these groups would be significantly different from each other. This finding suggests that the group with no prior experience may believe that teen problem drinking is out of the teen problem drinker's control which may positively affect how they feel about the teen problem drinker.

Locus of Control

Another difference in an unexpected direction was that the treatment group attributed problem drinking more to internal causes and the groups with no and some prior experience attributed more to external causes. This result is the opposite of the hypothesis that teens with prior experience would attribute problem drinking to external causes and teens with no prior experience to internal causes. The fact that the group with no or some prior experience attributed teen problem drinking to external causes is again a favorable finding for teen problem drinkers. Teen problem drinkers may obtain more support and sympathy from this population because of their perceived lack of personal responsibility. The response from the treatment group that problem drinking is due to internal causes may be explained by the fact that treatment centers teach that addiction is a disease within the individual. Respondents from the treatment center may have confused "internal causes" with internal disease.

Although results showed significant findings on these three constructs, it is unclear why all of the items measuring locus of control, controllability, and stability did not reveal significant differences. To be certain that the above results

are true, we would have liked to have similar patterns of group differences on each of the measures.

Hypotheses 2 - Do affective reactions, offset controllability, and help-giving behaviors vary as a function of group membership?

Results confirmed group differences on affective reactions toward teen problem drinkers, as well as beliefs regarding what types of resources may be required by teens to offset their problem. While the hypothesis that individuals with no prior experience would feel less sympathy, less compassion and more anger toward teen problem drinkers than individuals with prior experience was not confirmed, the hypothesis that individuals with no prior experience would not like, and be more afraid of teen problem drinkers was confirmed.

These results are partially consistent with Skokan's (1990) idea that individuals with prior experience and knowledge about a problem will have more positive affective reactions toward that person. The teens with prior experience may like the teen problem drinker more than a teen without personal experience because they are from the same peer group. Teens with experience of knowing someone in treatment may feel more liking because they have had a positive experience with the person they know. Also significant was that individuals with less prior experience will be more afraid of teen problem drinkers. These two findings may be related in that fear of teen problem drinkers may prevent an individual from knowing teen problem drinkers enough to like them. However, comparison of the means of these groups revealed that although those with no experience were more afraid of teen problem drinkers than those with experience, they were not much more afraid.

Speculation regarding the lack of significant differences between the groups on the anger, sympathy and compassion scales includes the possibility that teens may have no reason to be angry at teen problem drinkers. This may be due to the lack of teens experiencing anything done to them by teen problem drinkers to warrant them being angry. The same can be argued for the reactions of sympathy and compassion. Teen problem drinkers may not be sick or needy enough to warrant sympathy. Adult alcoholics have a reputation for hurting family members and being irresponsible, as well as possibly being physically sick or having lost everything. A survey of parents' and teachers' affective reactions toward teen problem drinkers may be more likely to reveal the affective reactions of sympathy and anger because they may have been hurt or disappointed by the teen problem drinker.

The hypothesis that the groups with prior experience were more likely to believe, than the group with no prior experience, that some form of help was needed to offset teen problem drinking was unconfirmed. Results showed no significant group differences on whether or not teen problem drinkers could offset the problem on their own.

However, results did reveal significant group differences on what types of help would be most useful for the teen problem drinker to offset their problem. Individuals with prior experience believed that a "higher power" was more necessary to offset the problem than those with no or with some prior experience. This finding is consistent with what is usually taught in treatment programs, and not what teens without personal experience would be expected to know. On the other hand, individuals with no or some prior experience believed more than the

individuals with prior experience that friends could help to offset problem drinking. An explanation for this finding may be that teens who have had problems with drinking could not turn to their friends for help because their friends may also be problem drinkers. However, teens without drinking problems may be likely to call on their friends to help with any problems.

An interesting note was that there were no group differences on whether or not medical professionals, psychiatrists or family members could be of help. The individuals with personal experience would be expected to report professionals being more helpful than the group with no experience because they had been treated by these professionals. Conversely, the individuals with no prior experience may be expected to believe that family could be of more help than the individuals with prior experience because they have not learned that family alone cannot offset the problem. Individuals with prior experience may have learned that the family alone cannot eliminate the problem or they may even have been estranged from their family during treatment.

The hypothesis that individuals with no prior experience would be less likely than individuals with prior experience to give help to teen problem drinkers was unconfirmed. Results revealed no group differences on willingness to give help to teen problem drinkers. Reasons for this finding include the possibility that teenagers may not be affected by stigmas such as problem drinking, and due to being non-judgmental, are willing to help teen problem drinkers.

Hypotheses 3 & 4 - Do causal attributions for teen problem drinking predict affective reactions and help-giving behaviors?

The hypotheses that prior experience and causal attributions for teen problem drinking will predict affective reactions, and affective reactions will, in turn, predict willingness to give help to teen problem drinkers was not confirmed. Therefore, the results are not consistent with the expectations based on Weiner's model of motivation and emotion (1979) which proposes that there is a sequence of emotional responses and actions that occur after a causal attribution is made about an event. Weiner (1980) confirmed this sequence with a research design using vignettes and hypothetical situations. The results of this study may show that the model of attribution does not stand out so clearly when using a real life situation and retrospective questions.

Conclusion

In summary, results of this study show significant group differences on the Causal Dimensions Scale constructs of locus, controllability and stability. However, these differences were not in polar opposites with regard to group membership as hypothesized, but were significantly different in degree of controllability and stability in the same direction. Both teens with prior experience and no prior experience thought teen problem drinking was attributed to unstable and uncontrollable causes. And teens with no prior experience attributed teen problem drinking to external causes while those with prior experience attributed the problem to internal causes. These findings are positive for teen problem drinkers since teens with no prior experience believe that teen problem drinkers are

not responsible for the onset of their problem, the problem is caused by outside influences, and that teen problem drinkers can change.

On the other hand, results also revealed group differences on the affective reactions of "liking" and "fear." Teens with no prior experience liked teen problem drinkers less, and were more afraid of them than teens with prior experience. These findings point to negative feelings toward teen problem drinkers and may affect how they are treated by non problem drinkers.

Another positive result for teen problem drinkers is that teens with no prior experience believe that some form of help is needed to offset the problem. Teens with prior experience believed that a "higher power" was helpful to offset the problem while those without experience believed "friends" would be most helpful. Interestingly, there were no significant differences between the groups on whether professionals and family could help offset the problem.

Results do not confirm a number of expected group differences including differences on help-giving behaviors. It appears that teens with no prior experience do not differ from those with experience in willingness to give help. All groups were equally willing to give help to teen problem drinkers. These findings would logically follow based on the positive outcomes on the locus, stability and controllability findings. However, results did not reveal the predicted link between attributions for teen problem drinking, affective reactions and help-giving behaviors.

Although this study shows group differences in many of the measures, the hypothesis that these responses would predict reactions as illustrated in Weiner's model of attribution (1980), was not confirmed. But because some differences

among the groups were found to exist, and because Weiner (1980) and his colleagues have shown the attribution model does work in hypothetical situations, it is difficult to determine that these group differences do not have an influence on attitudes and behaviors toward teen problem drinkers. In fact, Weiner (1985) cautioned that the theoretically based emotions do not always follow an attribution. He stated that other processes may be going on such as the costs and benefits of helping and the influence of past experience. It may be that help-giving is not affected by these reactions, but some other behavior is. While teens may not have different attitudes toward help-giving, they may have different responses to teen problem drinkers that were not measured.

Limitations

A number of research limitations are necessary to discuss. First, the low reliability may mean that the teens did not understand the questions on the Causal Dimension Scale (CDS). It is possible that the questions were too difficult, or this age group may not be able to translate their reported causes to the dimensions of locus, controllability and stability. Nonetheless, one conclusion may be that Russell's CDS cannot be used in future studies with adolescents without undergoing changes to the Causal Dimension Scale.

However, the improved reliability scores from the private school respondents suggest there may be other reasons teens answered inconsistently on the CDS. One reason was that they may not be thinking of only one cause for teen problem drinking. Because they were given 19 causal examples prior to answering the CDS, they may be thinking of various causes when answering the CDS questions instead of just the one cause they feel is most important. It is also possible that

lack of concentration was a factor. The time when these surveys were given was near the end of the school year and near a vacation time. The experimenter observed many respondents finishing the surveys quickly and in some instances laughing and talking during them. Various age levels and classrooms seemed to take the research more or less seriously than others. The survey given at the private school was the only one administered by the regular teacher in the classroom. An explanation for these students understanding the CDS better than the other students could be that they paid better attention and tried harder because their teacher was conducting the survey. The education level of the private school students may also have been a factor.

Another limitation was the number of students who had prior experience with teen problem drinking. We cannot get clear group differences when the groups may not be that different. Because problem drinking is so pervasive in our society, it was difficult to obtain many subjects who have had no prior experience with problem drinkers. On the other hand, it was assumed that the treatment group and the school group with past personal prior experience were similar. This study did not determine whether the students with past prior experience in treatment were currently using alcohol again, or if they were in recovery. Therefore, it is difficult to determine whether these subjects continued to believe what they learned in the treatment center or not.

These limitations reveal that the conclusions drawn from this study should not be generalized to any population, and we cannot say that Weiner's attribution model is not valid. Changes must be made to the subject pool, measurement tool, and the administration of the survey procedure before replicating the study.

Future research

Future research would require changes to the subject pool, including recruiting subjects who fall into two clear groups of treatment experience and non-experience. There is also a need to develop a Causal Dimension Scale (CDS) that teenagers understand and to make directions clear prior to beginning the survey. The new CDS should include less causal examples, and simpler words that will measure the locus, controllability, and stability constructs. This new scale should also be pre-tested. Survey's should be administered at approximately the same time and in a very structured setting to lessen confounding variables.

Because there were no group differences in the present study on the anger and sympathy variables, one interesting future study could be to use teachers, counselors and parents with either prior experience or no prior experience with teens in treatment, as subjects instead of teens. Since the Causal Dimension Scale has been shown (Russell, 1986) to be reliable for adult subjects, replicating the present study with adults may reveal group differences in causal attributions. Further, as discussed earlier, adults may also be more inclined to be either angry or sympathetic toward teen problem drinkers depending on their attributions.

Finally, future research should also involve redesigning this study using written vignettes describing hypothetical situations with various differences in attributions for locus of control, stability and controllability. Subjects would continue to be grouped by level of prior experience and affective reactions, as well as behaviors such as friendship, and attitudes, such as possibility for future success, could be measured. This design may reveal Weiner's attribution model due to fewer confounding variables.

It is clear that the prevalence of alcohol use among teenagers highlights the importance of continuing this work. Future research may help to more clearly identify the relationships among attributions, emotions, and behaviors that may influence the interactions of teen problem drinkers with others so effective interventions can be developed.

Table 1. Means and standard deviations of stability, controllability and stability scores by group.

	Grp 1 school/exp n = 8		Grp 2 school/noexp n = 43		Grp 3 school/soexp n = 26		Grp 4 trxt n = 40	
	M	S.D.	M	S.D.	M	S.D.	M	S.D.
Stability	4.00	3.5	*2.86	1.9	2.60	1.4	*3.87	2.5
Ctrlability	*4.00	2.4	5.30	2.0	5.60	2.3	*6.40	2.2
Locus	4.00	2.5	*5.84	2.1	*5.52	2.0	*4.15	1.7

Table 2. Means and standard deviations of the affect scores by group.

	Grp 1 school/exp n = 8		Grp 2 school/noexp n = 43		Grp 3 school/soexp n = 26		Grp 4 trx/exp n = 40	
	M	S.D.	M	S.D.	M	S.D.	M	S.D.
like	*5.62	1.8	*3.33	1.9	*4.35	1.9	*5.17	2.1
anger	4.50	1.8	4.93	2.4	4.61	2.3	3.92	2.4
sympathy	6.12	2.3	5.12	2.6	4.92	2.7	5.32	2.7
compassion	6.87	1.5	4.95	2.5	4.70	2.2	5.37	2.2
fear	2.12	1.3	*4.18	2.5	3.11	2.1	*3.27	2.3

Table 3. Means and standard deviations of the offset-controllability scores by group.

	Grp 1 school/exp n = 8		Grp 2 school/noexp n = 43		Grp 3 school/soexp n = 26		Grp 4 trx/exp n = 40	
	M	S.D.	M	S.D.	M	S.D.	M	S.D.
medical	7.37	1.8	5.95	1.7	5.81	1.8	5.66	2.4
high pwr	5.00	4.0	*4.90	2.6	*4.66	2.5	*6.78	2.2
psychiatric	6.00	2.9	5.36	1.9	5.10	2.3	4.43	1.8
friends	6.12	2.3	*6.75	2.1	*6.85	1.9	*5.33	2.5
family	6.37	1.8	5.70	2.2	6.18	1.9	5.23	2.4
on own	6.75	2.4	5.20	2.0	5.00	2.1	4.52	2.18

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Appendix A

Attitudes Toward Teen Problem Drinking

The following is a questionnaire which is designed to find out how you feel about teenagers who have a drinking problem. Participation is totally voluntary; if you don't want to complete the questionnaire you don't have to. If you do want to participate, the answers you give will be completely anonymous. That is, no one will know who filled out the questionnaire or what your personal answers were. Please do not put your name on the questionnaire.

Please place a check in the space which applies to you.

- 1) **Name of school:** Lincoln __, Jefferson __, Grant __, Franklin __
- 2) **Your age:** 14 __, 15 __, 16 __, 17 __, other _____
- 3) **Sex:** Female __ Male __

Family Background:

4) **Mother** (or mother figure):

a. The mother figure in our family is my:

__ mother __ stepmother __ grandmother other ____

b. There is no mother figure in our home due to:

__ death __ divorce __ separation other cause _____

c. Mother's highest level of education is:

- | | |
|--|--|
| <input type="checkbox"/> completed elementary school | <input type="checkbox"/> completed 2 year college |
| <input type="checkbox"/> completed middle school | <input type="checkbox"/> completed 4 year college |
| <input type="checkbox"/> completed high school | <input type="checkbox"/> completed Master's degree |
| <input type="checkbox"/> completed some college | <input type="checkbox"/> completed some higher degree (Ph.D., Ed.D., etc.) |

d. Mother's occupation (including working in the home) is: _____

5) **Father** (or father figure):

a. The father figure in our family is my:

- father stepfather grandfather other _____

b. There is no father figure in the home due to:

- death divorce separation other cause _____

c. Father's highest level of education is:

- | | |
|--|--|
| <input type="checkbox"/> completed elementary school | <input type="checkbox"/> completed 2 year college |
| <input type="checkbox"/> completed middle school | <input type="checkbox"/> completed 4 year college |
| <input type="checkbox"/> completed high school | <input type="checkbox"/> completed Master's degree |
| <input type="checkbox"/> completed some college | <input type="checkbox"/> completed some higher degree (Ph.D., Ed.D., etc.) |

d. Father's occupation (including working in the home) is: _____

6) The total number of people who live in our household is _____.

7) My family's racial background(s) is/are:

- Caucasian Afro-American Hispanic Asian other _____

Teenagers who have drinking problems are the ones who got in trouble for drinking, who have gone into treatment for alcohol problems, or who come to school drunk. Some people believe that there are many causes for alcoholism among teens, while others think there are only one or two. I want to find out what you think are the causes for alcohol abuse among teenagers, and how you feel toward teenagers who have drinking problems. Please answer honestly and accurately. There are no "correct" answers, only your feelings and opinions.

For the following questions, please circle the number that best expresses your opinions about why teenagers become problem drinkers. Number 1 means that the reason stated is "not at all a cause," and number 9 means that it is "very much the cause" for why teenagers become problem drinkers. You can also choose any number between 1 and 9.

Teenagers become problem drinkers because:

1. they are unhappy with their life.

1	2	3	4	5	6	7	8	9
not at all								very much

2. they come from lower income families.

1	2	3	4	5	6	7	8	9
not at all								very much

17. they are unlucky.

1	2	3	4	5	6	7	8	9
not at								very
all								much

18. they think life is too difficult.

1	2	3	4	5	6	7	8	9
not at								very
all								much

19. they have low self-esteem.

1	2	3	4	5	6	7	8	9
not at								very
all								much

20. Please list other causes of teenage problem drinking which you think are important but were not listed above.

PLEASE CONTINUE TO THE NEXT PAGE

6. Are the causes something that are:

1	2	3	4	5	6	7	8	9
variable over time								Stable over time

7. Are the causes:

1	2	3	4	5	6	7	8	9
Something about the person								Something about others

8. Are the cause something that are:

1	2	3	4	5	6	7	8	9
Changeable								not changeable

9. Are the causes something for which:

1	2	3	4	5	6	7	8	9
No one is responsible								Someone is responsible

PLEASE CONTINUE TO THE NEXT PAGE

Please circle the number from "none at all" to "a lot" that best represents how you feel about teenagers who have drinking problems.

1. How much do you like teen problem drinkers?

1 2 3 4 5 6 7 8 9
not at all a lot

2. How much anger do you feel toward teen problem drinkers?

1 2 3 4 5 6 7 8 9
none at all a lot

3. How much do you feel sympathy for teen problem drinkers?

1 2 3 4 5 6 7 8 9
not at all a lot

4. How much compassion do you feel toward teen problem drinkers?

1 2 3 4 5 6 7 8 9
none at all a lot

5. How much are you afraid of teen problem drinkers?

1 2 3 4 5 6 7 8 9
not at all a lot

6. How else do you feel toward teen problem drinkers?

PLEASE CONTINUE TO THE NEXT PAGE

11. Have you ever attended chemical dependency treatment (either outpatient or inpatient)? ___ yes ___ no

12. If yes, how many times? 1 2 3 4 5+

For how long total? ___ 1 month ___ 2 months ___ 3+ months

The end. Thank you.

Please place your survey in the envelope in the back of room.