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Psychotherapists' Perceptions of Adjustment and Attraction Toward Children Described as in Therapy[1]

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A consideration of the job requirements, training, and role of therapists and other service professionals led to the formulation of two hypotheses: that therapists will perceive more maladjustment than laymen in persons supposedly undergoing therapy, and that therapists will like these "clients" less than will laymen because maladjustment is socially undesirable. A group of professional therapists and a matched group of lay persons were asked to describe two children portrayed in films. One child was actually in therapy; the other was not, but was described as such. Content analyses of the descriptions revealed greater attribution of maladjustment to the normal child by therapists and a tendency (but not significant) to like him less. Therapists also showed less attraction to the actually disturbed child. These data were viewed as having implications for clients' prognoses.

Some recent theorizing (Rosenthal and Jacobson, 1968), suggests that a person whose job is to help or guide others will best succeed if he does not underestimate the potential of his charges. Under ideal conditions, he would recognize the strengths of those dependent upon him. The more favorable a benefactor's evaluation, the more positive the self-concept of the person should be (cf. Hastorf, Schneider, & Polefka, 1970; Jones & Gerard, 1967) and presumably, the better his chances for improvement. However, it is often the benefactor's job to look for weaknesses so as to help. If so, and if he has been trained to do so, these same weaknesses would become salient and the client would be perceived as less well-adjusted and possibly less "likeable" than if his problems were less salient.

Teachers (Coleman, 1966; Beez, 1970), management (McGregor, 1957; Likert, 1968), and psychotherapists (Laing, 1965; Mischel, 1968) are among the service professionals whose occupation demands that they examine others' problems. With respect to therapists, who were the focus of this study, their training, and role are two additional factors which might lead to their client's positive qualities being relatively less salient to them, than to, for example, laymen. Since the training emphasizes how to deal with psychological difficulties, they may graduate with a distorted view of how the normal individual reacts in different situations (cf. Cronbach, 1955), an overestimate of the number of people with serious problems, and a readiness to perceive problems in others.

[1] The data reported were collected as part of a senior Honors Thesis by the first author (now at Yeshiva University), supervised by the second author, and partly supported by an NSF grant to the second author (GS-1611). The authors are indebted to the parents of Scott and Eric, The Connecticut College Nursery School, and The Child Guidance Clinic of Southeastern Connecticut for giving permission to film the children. We are also grateful to our *Ss* for volunteering their valuable time without remuneration.

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justment in a child actually in therapy and also a normal child misleadingly described as in therapy than would laymen. Since the latter child was known to be normal, and in fact, unusually bright and well-adjusted, obtaining the predicted difference between therapists and laymen in attribution of maladjustment could be attributed to the therapists' perceptions rather than to the behavior itself. The second prediction was that both children would be liked less by the therapists.

Two related hypotheses were tested at the same time.

1. Therapists will perceive a greater difference between the two children than will laymen. The training of professional therapists emphasizes the individuality of others. Therapists in training are taught to use tests and other diagnostic techniques in order to differentiate among individuals. As experts, they should find those differences. (A previous study is suggestive. Crow (1957) found that medical students trained in "interpersonal judging accuracy" failed to increase their accuracy—in fact, decreased it—because they predicted too much variability among others.)

2. Therapists will be more confident of their assessments than will laymen. Their training and professional role would lead them to assume that they are more expert than others at judging people.

Method

Subjects

Two groups of subjects, therapists and lay persons, participated in the experiment. All subjects were approached individually, and asked to participate in a study investigating possible correlations between children's behavior patterns and their socioeconomic background. No subjects were paid.

Of 25 professional therapists, 9 had Ph.D. degrees, 14 had M.A. degrees, and 2 had M.S.W. degrees. Eight were solely in private practice; the rest were associated with institutions. Thirteen were females, 12 were males. All were located in New York or Connecticut. Since it could be argued that our sample was unduly loaded with non-Ph.D.'s, their data were compared on all dependent measures to those of the Ph.D.'s. There were no significant or near-significant differences between these two groups; in fact, the Ph.D.'s tended to be more different from laymen in the directions predicted than were the non-Ph.D.'s.

The major control group was a sample of 25 adult lay persons, matched to the therapists on sex, age (mean = 42.8 years), educational level, and number of children (mean = 2.02). As with the therapist group, there were 9 Ph.D.'s and 16 with 2-year graduate degrees.

Procedure

The *S*s participated in the experiment individually, or with one to two other *S*s in the room (14 therapists, 12 laymen). At the start, a female *E* explained that they would be observers in a study attempting to correlate children's behavior with their socioeconomic background. She said, "A large group of all kinds of 4-year-old male children has been filmed. Each child is shown in situations as similar as possible to every other child. Children have been filmed in nursery schools, in child guidance clinics, in playgrounds. . . ." The *E* then looked over a list, acted as if to find the children assigned to the *S*(s), and told him their names. The *S*s were then asked to observe the films closely so they would be able to record their observations afterwards. A "Guide for Recording" was distributed to "give you an idea of the kinds of things . . . to watch for." The Guide given the *S*s was a general outline of behaviors and characteristics (e.g., motility, body function, expression) adapted from one used in clinical diagnosis (Beller, 1962). This was used to lend credence for the request to record the children's behavior, and to encourage all the *S*s to pay close attention to their task.

Once the *S*s had perused the Guide, two 9-min silent color films were shown to them: one was a film of Eric, age 4, a severely disturbed child, actually undergoing treatment; the other was Scott, age 4, an unusually bright, well-adjusted child (according to his nursery school records and parents) with no previous record of emotional disturbance. Both films placed the children in several situations: playing alone and with other children on a playground, eating cookies and juice, painting in a schoolroom with a teacher present, playing with a large box and some gourds. The major difference in actual behavior was that Scott sought out other children and acted energetically, whereas Eric always played alone and his movements were unusually slow. The film order was counterbalanced so that half of the *S*s in each group saw Eric first, and half saw Scott first.

After each film, a four-page questionnaire was

given to the *Ss*. Space was provided for writing a description of the child. The questionnaire also included an adjective check list and a psychiatric classification check list. When the *Ss* had viewed both films, and completed the questionnaires, they were apprised of the real nature and purpose of the experiment. While all showed surprise (none had previously indicated suspicion), no *Ss* seemed resentful, perhaps because all had correctly surmised that Eric was much more disturbed than Scott. Every *S* said he had believed that Scott was in therapy, though some said he should not be.

Dependent Measures

The first part of the questionnaires consisted of four open-ended items asking the subjects to describe the filmed child. These were: "Please describe the child as completely as you can," "Would you comment specifically on the social development and the emotional health of the child." "Did the child do anything in any situation which you consider of particular importance," "Do you have any feelings about what the child's background might be." The answer to these four questions were combined for analysis (most *Ss* responded with a number of statements to the first question, and answered the others with one or two sentences).

The adjective check list, adapted from LaForge's (1963) Interpersonal Check List, consisted of 72 socially desirable and undesirable adjectives (e.g., intelligent, likeable, helpful, disagreeable, etc.). The adjectives used were only those which a pretest group of 50 *Ss* had rated as unambiguously positive or negative, and which were rated as not being a clinical label by two clinical psychologists. The *Ss* were asked to check the adjectives which best described the child. Another check list, constructed for this study, was presented as a list of "descriptive categories or classes of behavior sometimes used for psychiatric evaluation." The *Ss* were told that, "if you feel it appropriate, check the relevant categories." Thirteen types of disorders were listed, under three general rubrics, "transient situational personality disorders," "psychoneurotic disorders (neuroses)," and "psychotic disorders (functional psychoses)." Some of the categories listed were conduct disturbance, anxiety reaction, depressive reaction, schizophrenic reactions.

Each *S* in the present study was assigned scores based on his responses to the questionnaires. The adjective check list was scored by simply counting the number of adjectives checked, and then by computing the proportion of these adjectives which were socially undesirable. The psychiatric check list was scored by counting the number of categories checked.

A content analysis was executed on the answers to the open-ended questions. First, for each questionnaire, all assertions were counted. Then, every assertion was scored on 10 measures. These were: (1) affect toward the child, using a 5-point scale where 1 = very favorable and 5 = very unfavorable (with the restriction that assertions stating a degree of maladjustment or adjustment could not be also rated for affect toward the child), (2) whether the assertion concerned the child's mental health, (3) if so, whether the assertion stated that the child was healthy or maladjusted, (4) whether the assertion assigned the child a psychiatric disorder label, (5) whether the assertion attempted to explain the child's behavior psychologically, (6) whether the assertion implied a therapeutic goal (e.g., stated a need for therapy or made a prognosis), (7) use of psychological or psychiatric jargon, (8) whether the child's name was used, (9) whether the assertion distorted film content, (10) confidence of the assertion (where 1 = very confident and 3 = uncertain). Ratings on all assertions were then summed to obtain a score for each dependent measure.

Identifying information was removed from questionnaires before they were judged. One judge scored all of the questionnaires. A second judge scored a third of the open-ended questions, to check on reliability. There were only two disagreements for any of the measures, except for the two (confidence and affect) where scales were used. On these measures, one judge consistently used slightly more extreme scores, but not more than 1 scale point more and not differentially across conditions.

Results

Analyses of variance were performed on the data from the 14 dependent measures. To test the major hypotheses, 2 × 2 analyses were performed, for each stimulus child, with therapists and laymen on one dimension and film order on the other. Other analyses assessed the differences in perception of the two children, and the differences between therapists and students.

Effects of the Experimental Procedure

As described earlier, the procedure was apparently successful in creating a set whereby *Ss* thought they were describing two children at present undergoing treat-

ment for emotional disturbance. However, the *Ss* did perceive a great difference between the children's behavior, and attributed much more disturbance to the child who actually was disturbed. For example, on the three measures of maladjustment (to be described below), therapists and laymen together attributed significantly more abnormalities to the actually disturbed child ($p < .01$). The films, then, were informative to some extent.

For all groups, film order also had systematic effects. Generally, showing the disturbed child first made the normal child seem more normal and more likeable. When the disturbed child was viewed first, both therapists and laymen were less likely to assert that the normal child was maladjusted ($F(1,46) = 7.71$; $p < .01$), to check socially undesirable adjectives about him ($F(1,46) = 8.66$; $p < .01$), and to express negative affect for him ($F(1,46) = 8.68$; $p < .01$). These results could be attributed to a perceptual contrast, where seeing a very disturbed person makes others seem quite normal by comparison. Another effect of seeing the disturbed child first was to increase the use of psychological jargon in describing him and the normal child ($F = 18.36,\ 8.37$; $p < .01$). Perhaps a "psychologizing" response disposition was aroused by his portrayal.

All the *Ss* seemed to take their instructions equally seriously. There were no significant differences among therapists and adult laymen in either the total number of adjectives checked on the list, or in the total number of assertions made on the open-ended items, as one would expect if there were no group differences in involvement or perception of the *E*'s requests.

Major Hypotheses

Two predictions were made. The first was that therapists would be more likely than laymen to perceive maladjustment in a disturbed child and a normal child when both were described as being in psychotherapy.

The results of the content analysis for maladjustment assertions should be the primary dependent measure used to test this hypothesis. It will be recalled that such assertions were counted independently of desirability assertions, and only when jargon or psychiatric terminology was not employed.

Table 1 (I) presents the data for this measure of perceived maladjustment.

The hypothesis was confirmed for assertions about the normal child. Therapists alleged greater maladjustment than did laymen ($F(1,46) = 5.20$; $p < .05$). Assertions about the disturbed child were in

TABLE 1

MALADJUSTMENT PERCEIVED IN CHILDREN "UNDERGOING THERAPY" BY PROFESSIONAL THERAPISTS AND ADULT LAYMEN: MEAN SCORES ON ITEMS REQUIRING DESCRIPTION OF A NORMAL AND DISTURBED CHILD

	Child observed			
	Normal		Disturbed	
	Group[a]			
Dependent measures	Therapists	Laymen	Therapists	Laymen
I. Content analysis: Proportion maladjustment assertions	.26[b]	.12	.64	.54
II. Content analysis: Number psychiatric classifications	.21	.04	1.54[b]	.44
III. Psychiatric check list: Number categories checked	.60[b]	.16	1.12	.76

[a] $N = 25$ in each group.

[b] Therapists vs laymen, $p < .05$.

TABLE 2

LIKING OF CHILDREN "UNDERGOING THERAPY" BY PROFESSIONAL THERAPISTS AND ADULT LAYMEN: MEAN SCORES ON ITEMS REQUIRING DESCRIPTION OF A NORMAL AND DISTURBED CHILD

Dependent measures	Child observed			
	Normal		Disturbed	
	Group[a]			
	Therapists	Laymen	Therapists	Laymen
I. Content analysis of open-ended items:				
Rated affect toward child[b]	2.68	2.30	3.96[c]	3.47
II. Adjective check list:				
Proportion undesirable adjectives	.23	.14	.90[c]	.73

[a] $N = 25$ in each group.

[b] The higher the score, the lower the positive affect.

[c] Therapists vs laymen, $p < .05$.

the same direction, but not significantly different.

The two other measures described in Table 1 indicate that therapists attributed more disturbance in psychiatric terms to the disturbed child (II; $F(1,46) = 6.65$; $p < .05$) and checked more disorders on the Psychiatric Check List (III; $F(1,46) = 5.89$; $p < .05$) when describing the normal child. In addition, other comparisons were in the same direction. One would expect therapists to use psychiatric classification to a greater extent, so these latter data must be considered of minor interest. However, they did parallel the data from the content analysis.

The second major hypothesis was that therapists would like the stimulus children less than laymen would. Again, the best measure is from the content analysis, where desirability was scored independently of maladjustment and jargon. This measure is the mean rating of affect for all assertions but those concerned with maladjustment or using jargon (see Table 2 (I)). The hypothesis was confirmed for the disturbed child, therapists' assertions being more negative ($F(1,46) = 4.92$; $p < .05$); it was not confirmed for the normal child, but the difference was in the predicted direction.

Another measure described in Table 2 is the proportion of undesirable adjectives checked on the adjective check list (II). For the disturbed child, therapists used undesirable adjectives relatively more often than laymen did ($F(1,46) = 4.78$; $p < .05$), and for the normal child the difference was in the same direction but not significant. These data replicate those derived from the content analyses.[2]

Other Findings

There was only slight evidence that the therapists perceived a greater difference between the two children than did the laymen. On the adjective check list, therapists were not more likely to use different adjectives to describe the two children. Otherwise, on the measure of using psychiatric classifications (Table 1), there was a significant interaction of group by child, whereby the therapists attributed a greater difference in psychiatric disorder between the two children than did laymen ($F(1,48) = 6.6$; $p < .05$). However, their relatively greater use of classification for the disturbed child primarily accounts for the interaction. No other interactions were obtained. It should be noted, however, that the measures used in this study were not appropriate for a strong test of the hy-

[2] This measure must be interpreted with caution because undesirability in the ICL check list is not independent of extremity, which in turn should be correlated with maladjustment.

pothesis that therapists overdifferentiate among individuals.

A corollary hypothesis was that the therapists would be more confident of their assertions than would laymen. This hypothesis was not confirmed. Confidence was measured by judges' ratings of each assertion on a 3-point scale, where, for example, statements saying, "I am sure that . . ." were judged as more confident than, "I think . . ." or "Perhaps . . ." . No differences were obtained on this measure. Given the limited information they were, then, therapists were no more confident of their assessments than were laymen.

Therapists vs students

A small sample of undergraduate freshmen who were completing a year's introductory psychology course at Connecticut College and who intended to major in psychology were also tested. All, but one, were female. This group was originally intended as a control for therapist's familiarity with psychological labels and interest in psychology. That is, perhaps the study of psychology leads one to be more attuned to maladjustment. However, the data indicated that interest in psychology or familiarity with it did not, of itself, lead to increased perceived maladjustment in others or decreased liking for them. On every measure testing the major hypotheses (Tables 1 and 2), there were no differences between students and laymen (Table 3). However, student responses were closer to therapists' than laymen's were when describing maladjustment in the normal child, indicating at least a minimal effect of interest or familiarity. In addition, students, like therapists, were more prone to use psychological jargon and explanations than were laymen. Their average mention of therapy fell somewhere between the other two groups. Since the student sample was mostly female (all but one), the student females were also compared to female therapists and laymen with substantially the same results. These data, however, are only suggestive since the students differed in a number of ways from therapists i.e., they were an unmatched sample.

TABLE 3
MEAN SCORES FOR PSYCHOLOGY STUDENTS (N = 16) ON DEPENDENT MEASURES PRESENTED IN TABLES 1 AND 2

Dependent measures	Child observed	
	Normal	Disturbed
Proportion maladjustment assertions	.16	.56
Affect toward child	2.25[a]	3.60[a]
Number categories checked on psychiatric list	.31	.94
Psychiatric classifications	.12	.31[a]
Proportion undesirable adjectives	.13	.78[a]

[a] Therapists vs students, $p < .05$ or better.

DISCUSSION

The major results obtained in the present experiment were that (1) therapists perceived greater maladjustment in a normal child than did lay persons, and (2) therapists liked a disturbed child less than did the laymen. With some reservations, then, we suggest that therapists will be more likely than laymen to perceive maladjustment in "normal" persons who enter therapy, and will be less attracted to those with obvious emotional disturbance. The first finding is not particularly surprising and merely confirms that therapists do what they are supposed to do, i.e., look for problems. Given no reason to doubt the *E*, both children were perceived as in need of help. The disturbed child, whose problems were readily apparent to anyone, was perceived as equally maladjusted by both laymen and therapists. But therapists "read" more into the film of the normal child.

The maladjustment data may point to a necessity for more caution by therapists. The misleading label for the normal child used in the present study did have a significant effect on therapists; the same situation could occur in real life. Given that the therapists did perceive the normal child as relatively maladjusted, perhaps therapists' diagnoses are sometimes worse than they should be. One cannot conclude from the data that therapists perceive everyone as more maladjusted than laymen do (since

there was no child described as "normal"), but one can tentatively propose that clients referred by other professionals or by experts in other fields, or people diagnosed as disturbed, may have a poor chance of being dismissed as normal. In the case of children, this may have severe implications for their futures.

The second finding, of relatively little attraction to the disturbed child by therapists, was predicted from the assumption that maladjustment has negative implications for a person's likeability. Since therapists were predicted to see more maladjustment, they should like the child less, too. This finding also has implications for therapists' behavior in real therapy situations. Perceiving the client as less likeable may hinder the client's progress. A person who is not liked should be less attracted to the therapist, conform less, and would be more likely to "escape" the relationship, or pay less attention (cf. Kiesler and Kiesler, 1969). One might note that commitment to the therapist would be important. If the client were highly committed to therapy, lack of attraction to the therapist might make him more likely to cooperate and conform to therapist suggestions in the hopes of increasing acceptance (Kiesler and Corbin, 1965). Many clients are not so self-committed, however. Perhaps therapists might obtain better treatment outcomes if their skill at detecting maladjustment were deemphasized. Perceiving a client as more like others should indirectly enhance the client's self-concept and make him appear more likeable. At the least, therapists ought to be aware that the perception of maladjustment has implications for other attributions and evaluations which are made. The present data, for example, suggest that "positive regard" for obviously disturbed clients may be difficult to attain.

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