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EFFECTS OF VIDEOTAPE PLAYBACK ON CAUSAL ATTRIBUTION  
IN DISTRESSED COUPLES

DISSERTATION

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Previous research indicates that actors in a situation tend to attribute causality to situational factors, while observers of that actor's behavior tend to attribute causality to personal dispositions of the actor. The literature also suggests that dispositional attribution can be promoted by changing the visual perspective of the actor to that of an observer of his or her own behavior through the use of videotape playback. A videotape playback treatment was investigated in the present study with regard to its effects on acceptance of responsibility for conflict in distressed couples. Fifteen couples who had come to the Southern Illinois University Counseling Center for marital therapy were randomly assigned to one of three conditions. In the first treatment condition, couples were seen in three 90-minute pretherapy sessions. The first 45 minutes were devoted to communications skills training in the context of couples attempting to resolve actual problems in the marriage. The last 45 minutes were devoted to a videotape playback of the initial 45 minutes. No training was done during the playback. In a second treatment condition,

couples were given three 90-minute sessions of communications skills training also in the context of the couples attempting to resolve actual marital difficulties. Sessions were videotaped but were not viewed by the couples. Five couples were also assigned to a control condition which received neither communications skills training nor videotape playback. Three major hypotheses were tested. The first hypothesis that subjects given videotape playback of their pretherapy sessions would show a significant increase in self-attribution was supported. However, self-attribution change scores for subjects in the videotape playback group were not significantly different from those of subjects in the comparison groups, thereby qualifying inferences, conclusions, and generalizations from the data. The second hypothesis that subjects who received videotape playback of their pretherapy sessions would show a significant increase in the frequency of self-attributional statements was also supported. Results of the present study did not support the final hypothesis that following a significant increase in self-attribution, subjects would show a significant increase in perceived "importance of self-change" and a significant decrease in perceived "importance of spouse change" for resolution of marital conflict. It was concluded that videotape playback may provide an effective

means of facilitating acceptance of responsibility for conflict in distressed couples. The implication for practitioners is that videotape playback could accelerate the marital therapy process through facilitation of the acceptance of responsibility.

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EFFECTS OF VIDEOTAPE PLAYBACK ON CAUSAL ATTRIBUTION  
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Gurin, Veroff, and Feld (1960) have reported that individuals seeking marital therapy typically attribute greater causality or responsibility for the difficulties in the marriage to the spouse than to themselves. For a marital relationship to improve, however, change on the part of both spouses is generally necessary. Further, change is not forthcoming until both partners become aware of, and accept responsibility for, conflict. Although the element of causal attribution in marital disturbance and therapy has yet to be examined (Wright & Fichten, 1976), it seems reasonable to assume that the marital therapy process could be accelerated by a pretherapy training procedure whereby this awareness and acceptance of responsibility could be facilitated. The present study is an investigation of the effects of causal attribution interventions upon the marital therapy process.

The purpose of the present study was to examine the effects of videotape playback of marital pretherapy sessions on spouses' causal attribution or attribution of blame for marital difficulties. Specifically, could videotape playback promote self-attribution of responsibility? Alger and Hogan (1967, 1969) have reported the only research pertinent

to this question. Although they maintained that videotape playback interrupted spouses' blame patterns and helped each spouse take more responsibility for his or her own behavior, their data were based solely on clinical inference and client self-report.

The rationale for the present study was suggested by Shaver's (1975) contention that self-observation is a prerequisite for self-attribution and by Storms' (1973) study in which he used videotape playback to change individuals' visual perspective of a social situation from that of actors to that of observers of their own behavior. As reoriented observers, subjects more often attributed causality to self than to the situation.

This review of the literature will focus attention on the social psychological research concerned with causal attributional differences between actors and observers and psychotherapy research investigating the use of videotape self-confrontation. This latter area was chosen for review rather than pretherapy training research employing videotape for two reasons. First, the crucial aspect of the proposed videotape procedure is the observation of the sessions--it is, in essence, a self-confrontation procedure. While it is true that the learning of (communication) skills in pretherapy sessions might facilitate or accelerate the therapy process, this skills learning has little or nothing to do with the crux of the proposed procedure--



changing causal attribution. The second reason for videotape self-confrontation in therapy being the preferred area of research for review is the paucity of research in the videotape pretherapy training area; the only studies found by this reviewer were reported in unpublished doctoral dissertations (e.g., Raque, 1973).

#### Actors and Observers: Attributional Differences

Jones and Nisbett (1971) have proposed that actors in a situation tend to attribute their behavior to situational causes, while observers of the same behavior are apt to attribute it to dispositional qualities of the actor. Explanations for this tendency include information availability and information processing. The availability explanation involves a difference in the nature and extent of information that each has available. The actor has more knowledge with respect to his or her past behavior and present experiences. This difference probably prevents the actor from attributing dispositionally while allowing the observer to make a dispositional attribution (Nisbett, Caputo, Legant & Maracek, 1973).

The information-processing explanation for the actor-observer difference is that actors cannot observe much of their own behavior. Instead, their attention is focused on situational cues with which their behavior is coordinated. As a result, it appears to the actor that his or her behavior is a response to these situational cues (Nisbett, Caputo,

Legant & Maracek, 1973). The observer, however, has the actor as part of the situation he or she is observing. In that he or she has the actor to watch, the observer probably sees less of the actor's situation. Therefore, the actor's behavior becomes more important than situational cues, and the observer is more likely to view the actor's behavior as resulting from a stable trait of the actor. It is this second explanation that has particular relevance for the present study.

An early study (Jones, Rock, Shaver, Goethals & Ward, 1968) lending support for Jones and Nisbett's (1971) proposition used problem-solving tasks to investigate the effects of varying distributions of success and failure on attribution of intellectual ability. Jones et al. found that when subjects were asked to predict another's performance, their predictions primarily reflected judgments of the other's intelligence--a dispositional attribute. However, when the subject's own future performance was being predicted, there was a tendency for the subjects to relate performance fluctuations to variations in item difficulty--a situational attribute.

Nisbett, Caputo, Legant, and Maracek (1973) reported that observers assumed actors would behave in the future in ways similar to those they observed; however, the experimenters found that the actors did not share this assumption. Subjects also tended to describe their own choices on such

matters as girlfriend or college major in terms of the properties of the chosen object, while describing similar choices of friends in terms referring to dispositional qualities of the friend. Finally, subjects ascribed more personality traits to others than to themselves. All of the previous findings support the contention that observers attribute causality to the actor's dispositions, while the actor attributes causality to the situation. Similarly, Lay, Ziegler, Hershfield, and Miller (1974) found that while subjects made more situational attributions about their own behavior, friends' and acquaintances' attributions about the behavior of the subjects were more often dispositional.

Although the aforementioned studies provide support for Jones and Nisbett's hypothesis, none of them directly test it. In addition, the results of these studies can probably be explained without benefit of the actor-observer proposition. A direct test would require changing the perspective of actors to that of observers. Storms (1973) was able to accomplish this through the use of videotape. He believed that the greatest difference between actors and observers is that they have different points of view and that if attributions are influenced by point of view, it should be possible to change the way actors and observers interpret behavior by changing their visual orientations. In his procedure, two actor subjects at a time engaged in a

conversation, while two observer subjects observed their matched actor. In one experimental condition, actors saw a videotape of themselves--a new orientation, while observers saw a videotape of the other participant with whom their target actor had been interacting--also a new orientation. On seeing the videotape replay of themselves, the actors' orientations were changed to those of observers. As a result of this reorientation, self-viewing actors attributed more to their own dispositions than did observers. It was concluded that self-observation can change the causal interpretation a person gives to his or her own behavior and that the self-viewing actor is more likely to accept personal responsibility for his or her behavior than to attribute responsibility to the situation. Storms saw his study as having implications for marital therapy. He suggested that a spouse who sees himself or herself on videotape may realize for the first time his or her own role in marital difficulties and may be more willing to accept some elements of blame.

Regan and Totten (1975) conducted an experiment to test Jones and Nisbett's information-processing explanation that aspects of the situation are phenomenologically more salient for actors, while characteristics of the actor are more salient for the observer. The perspective of the observer was altered without making available any additional information. Half of the subjects were instructed

to empathize with the actor, while the other half were told simply to observe her. It was hypothesized that the adoption of an empathic set by observers would increase the likelihood that they would provide relatively more situational and less dispositional attributions for an actor's behavior. In empathizing with the actor, observers should be more likely to take the role of the actor and adopt his or her phenomenological perspective. Empathizing observers should as a result attribute more situationally as the actor would. Results indicated that subjects who witnessed the conversation after receiving empathy instructions provided relatively more situational and less dispositional attributions for the target person's behavior than did subjects receiving standard observer instructions.

The information-processing explanation was also investigated by Taylor and Fiske (1975). They maintained that whatever an individual focuses on in the environment should affect his or her perception of causality. If he or she attends to a single part of the environment to the exclusion of the rest, the information from that part becomes more salient. The information should then provide a basis for the explanation one adopts in determining causality in a situation. Although subjects were instructed to overattend to one of two persons conversing on videotape, the observed person's behavior was not perceived as dispositionally based, nor was the other person's behavior

perceived as situationally based. The experimenters, however, did find that subjects perceived the participant they focused on as causal in the situation. They concluded that where one attends in the environment influences what information is perceived as salient. This information is then given considerable weight or importance when one attributes causality.

Miller and Norman (1975) attempted to extend the basic actor-observer distinction to include active as well as passive observers. An active observer was defined as an individual who either influences or is influenced by the actor he or she is observing. Research had previously focused on the type of observer Jones and Nisbett had alluded to--the passive observer--an individual who does not influence nor is influenced by the actor he or she is observing. In a conflict situation, active observers were found to attribute more responsibility to the actor and less to the situation than did passive observers. Also, when comparing the actors' own perceptions with those of passive observers, the experimenters found that the actors saw more disposition in their own behavior. As a result, they attributed more responsibility to themselves than did passive observers. Results suggested a relationship between causal perceptions and the need to perceive oneself as exercising effective control.

Taylor and Koivumaki (1976) attempted to extend the information availability explanation for the actor-observer

difference in causal attribution. They believed that the fact that actors regard themselves in situational terms may be mediated by their knowledge of their lack of consistency across situations. The experimenters reasoned that if this is true, then the better we know another person, the more we are apt to regard his or her behavior as situationally determined. In that increasing acquaintanceship did not result in an increasingly situational view of the other, it was concluded that a purely information-processing model of person perceptions may be inadequate, and motivational processes need to be taken into account. Nonetheless, in the investigation of acquaintanceship, subjects were found to view themselves more situationally or less dispositionally than they viewed their spouses--a relevant finding for the present study.

In addition to investigating the effect of acquaintanceship on actor-observer differences, Taylor and Koivumaki also looked at attributions regarding both favorable and unfavorable behavior to determine the effect of social desirability of the behavior on the kinds of attributions made about its causes. Results revealed that people are generally regarded as causing "good" behaviors and situational factors as causing "bad" behaviors. This valence factor all but eliminated the actor-observer effect. This is apparently a contradiction of an earlier finding by Jones and Davis (1965) who reported that undesirable or

socially inappropriate behavior is more apt to be attributed to disposition than is more desirable or socially appropriate behavior. Taylor and Koivumaki maintain, however, that the two findings are not necessarily contradictory in that in evaluating undesirable behavior, an observer looks for a situational cause. If the observer finds a situational cause cannot be found, the observer will attribute the negative behavior to dispositions of the actor with more assurance than he or she attributes positive behaviors dispositionally.

Harvey, Harris, and Barnes (1975) examined the effects of the behavioral consequence severity of a "negative" or "bad" behavior on the causal attributions of actors and observers. They predicted that an observer would show a greater tendency to make attributions to the actor the more severe the consequences of the actor's behavior, but that the actor would attribute less responsibility to himself/herself the more severe the consequences. In the procedure, the actor was to administer shock to another person for incorrect answers on a learning task. The "shocked" person was to exhibit either moderate or severe stress in conjunction with being shocked. Observers watched the actor administer the shock and the other person's reaction to it. Results showed that observers attributed more responsibility to the actors the more severe the consequences of their behavior, while the actors attributed less



to themselves the more severe the consequences of their behavior. It was concluded that actors and observers do not simply make attributions without consideration of the consequences of the behavior.

In summary, the research indicates support for Jones and Nisbett's (1971) hypothesis that actors are apt to attribute causality situationally, while observers tend to attribute dispositionally. Explanations for this tendency include differences in the information available about an event and differences in how the information is processed. Neither explanation taken solely appears capable of totally explaining the actor-observer difference in causal attribution. Storms (1973) maintains that the two are not mutually exclusive and used both explanations in discussing the results of his informative study. He believed that through his videotape reorientation procedure, actors received new information when reoriented to observers. At the same time, the salience of already available information changed. He also believed that reorientation may have produced new response sets, resulting in reoriented actors thinking more about their own personalities revealed in their behavior. With its videotape reorientation procedure, its results, and its implications for marital therapy, Storms' study is, of course, the crucial study in this section of the literature review; it provides the framework on which the present study is based.

### Videotape Self-Confrontation in Psychotherapy

This second major section of the review of the literature will be concerned only with the use of videotape playback in psychotherapy settings and will be divided with regard to the form of psychotherapy used--more specifically, individual, group, and marital and family. For a review of videotape playback in nontherapy situations, the reader is directed to an exhaustive review by Sanborn, Pyke, and Sanborn (1975).

Individual therapy. Many of the earlier attempts at videotape self-confrontation involved case studies. Geertsma and Reivich (1965) employed videotape replay in the treatment of a female patient who had been diagnosed as a mixed personality disturbance and described as a poor candidate for conventional psychotherapy. Seven weekly sessions were videotaped. The patient and her therapist viewed each tape one week after it was made. As a result, the patient's self-ratings substantially changed. The self-ratings were judged to be a more accurate assessment than previous self-ratings, as they were more in agreement with the ratings made by a group of student nurses who had had contact with the patient. The experimenters maintained that the videotape playback itself had been beneficial, in that it served as a stimulus for evoking strong affect.

Kagan and his associates (Kagan, Krathwohl & Miller, 1963; Resnikoff, Kagan & Schauble, 1970) have also reported

case studies employing videotape playback in what they have termed "interpersonal process recall" (IPR). In IPR, counselor and client are videotaped. Following videotaping, counselor and client, while separated from each other, are joined by two other counselors. As the tape is replayed, any of the counselors or the client can stop the tape and discuss recalled feelings. Of relevance for the present study is the contention of Kagan and his associates that their procedure accelerates the therapy process.

In treating a case of anorexia nervosa, Gottheil, Backup, and Cornelison (1969) exposed the patient to 54 self-image confrontations via sound motion picture film during the 16-month period she was hospitalized. Confrontation sessions which involved the patient watching herself respond in a brief interview were followed by questions regarding her feelings about viewing herself. The experimenters reported that the patient's weight increased, that she was able to recognize some of her problems, that her future plans became more realistic, and that her body image changed such that thinness was re-valued.

Lautch (1970) has described the treatment of an individual with a severe obsessive-compulsive disorder in which he used videotape confrontation as an adjunct to systematic desensitization. The patient was concerned about the intolerance of his image and, as a result, was phobic about seeing his own reflection, as well as being

seen by others. After numerous traditional desensitization sessions, he became able to look at his therapist. He was then persuaded to allow himself to be videotaped in an interview. The videotape was shown to him initially with his face out of focus and in dark contrast. Through the course of 18 videotape viewing sessions, focus was increased and the contrast lightened to the point that he could view his face in focus without experiencing anxiety. After this point, the patient was described as making rapid progress in the sense that he became more sociable, was discharged from the hospital, attended a rehabilitation course, and became fully employed.

Resnik, Davison, Schuyler, and Christopher (1973) reported on two individuals who had attempted suicide. When the patients were brought to the emergency room, their conditions, the measures used to save them, and the reactions of their families were recorded on videotape. After the patients were transferred from emergency to psychiatry, individual and group therapy were instituted. Following every two individual therapy sessions, the patients would watch a 10-minute segment of the videotape made at emergency. The videotape served two purposes; it stimulated material that helped engage the patients in therapy, and it also made it difficult for the patients to deny their despair and suicidal intent by confronting them with the consequences of their suicidal behavior. The experimenters

claimed that both patients came to assume responsibility for their suicidal behavior, as well as understanding its antecedents.

Moore, Chernell, and West (1965) were probably the first researchers to employ a sizeable sample and a control group to investigate the effects of videotape replay on therapeutic change. Their experimental group consisted of 40 neuropsychiatric patients who until discharge viewed daily five-minute interviews devoted to how the patients were progressing. A control group did not have the benefit of videotape replay. Overall, 80% of the experimental group were judged to be moderately to maximally improved as compared to 55% of the control group. It was concluded that the opportunity to view oneself could change a person's clinical course and that it has an effect on the degree of improvement.

Boyd and Sisney (1967) compared a psychiatric group having the advantage of videotape replay with a similar group which did not have videotape replay. With scores on the Leary Interpersonal Check List as the dependent measure, Boyd and Sisney found that with only one 10-minute exposure to themselves on videotape, the pathology level of the patients in the experimental group became "less extreme." The pathology level in the control group either did not change or became more severe.

Paredes, Ludwig, Hassenfeld, and Cornelison (1969) exposed 66 alcoholics to motion pictures of themselves while under the influence of alcohol. When confronted with their behavior on film, many patients used the material on film as a point of departure to discuss significant life events and the devices they had used to avoid dealing with their problems. Typical responses by the patients to themselves on film indicated dissatisfaction with their physical appearance and low self-esteem. It was concluded that videotape self-confrontation could be useful in the treatment of alcoholics.

As striking as the positive changes reported in the previously cited videotape self-confrontation studies appear to be, there have been studies reported which cast some doubt on its effectiveness and its advantages over the more traditional audiotape confrontation. Paredes, Gottheil, Tausig, and Cornelison (1969), for example, have reported a study finding negative results. In their study, one group of patients viewed videotapes of themselves in biweekly sessions. A second group viewed videotapes of another person, while a third group viewed no videotapes. Psychological test data used as dependent measures revealed no significant differences among the groups. The investigators concluded that their study offered no evidence that the videotape procedure was either helpful or harmful.

Feinstein and Tamerin (1972) have reported the use of videotape self-confrontation with an alcoholic--a case which can only be termed a treatment failure. Although the patient improved (i.e., became more open and communicative, developed better relationship with his therapist) during a five-week treatment period, his gains and improvements disappeared at termination of treatment. Griffiths and Hinkson (1973) have also reported a study which raises questions as to the duration or maintenance of videotape treatment effects. Although the experimenters were able to affect a change in psychiatric patients' self-assessment of social ease, this change disappeared within two weeks. Inferences or conclusions from this study should probably be tempered by the fact that the videotape treatment involved only one 20-minute exposure to the patients.

Geertsma and Reivich (1969) have offered the only direct comparison of audio- and videotape confrontation. Their results suggested that the self-relevant material channeled auditorally was more effective than visually channeled material in producing cognitive and affective change in psychiatric inpatients.

Group therapy. Stoller (1967, 1968a, 1968b, 1969) has written extensively on the use of videotape feedback in group therapy. He believed the advantages of videotape for therapy groups are that feedback (a) includes nonverbal as well as verbal responses to behavior, (b) is as close to

the unit of behavior as possible, and (c) comes from a neutral course, thereby making it less distorted than feedback characteristic of individual relationships. Stoller maintained that videotape feedback facilitates the change process in a patient by helping develop what he called a "reflective role-taking attitude" which involves role-taking toward oneself. He believed that change occurs after an individual can visualize and conceptualize the difference between what he or she intends to present to others and what is actually presented.

Berger, Sherman, Spalding, and Westlake (1968) have reported on the use of videotape with therapy groups in a community mental health service. They, like Stoller, contended that videotape confrontation gives the patient an opportunity to experience others more objectively--particularly the therapist--thereby reducing transference distortion. Berger (1971) saw the effects of videotape confrontation in groups as leading to awareness of pathological or self-defeating interaction and styles of relating.

Videotape has also been used to enhance the therapeutic value of psychodrama. Goldfield and Levy (1968) believed videotape enhances psychodrama in that it captures spontaneity, it helps the actor become aware of the inter-role patterns which occur, and it has therapeutic value for the people in the audience in that it aids them



in becoming aware of feelings and expressions. Gonen (1971) saw videotape in psychodrama as providing confrontations with reality which are stronger and more dramatic than those offered by therapists.

Marital and family therapy. Alger and Hogan (1967, 1969) have reported on the use of videotape playback with more than 75 couples and families. They maintained that it can be helpful to an individual in contacting and taking responsibility for his or her own feelings and behavior. More specifically, they contended that it can interrupt blame patterns which allows the marital partners to assume a more objective position, resulting in a lesser tendency to assign blame.

In his work with couples, Silk (1972) reported that of 25 couples who used his videotape procedure, 70% stated that they had gained considerably from the experience. Silk believed that videotape reveals the difficulty each spouse has listening to the other and seeking the other's point of view.

In perhaps the only study of an empirical nature in this section of the literature review, Kaswan and Love (1969) compared the effects of videotape confrontation, brief child psychotherapy, and parental counseling in the treatment of emotional and behavior problems of elementary school children. Videotapes of the families involved were obtained during their initial visit to a family clinic.

In the confrontation procedure, each family member viewed brief sections of the tape and rated each family member on the tape using an adjective rating scale. Family members then compared their ratings with those of trained observers. Comparisons of ratings in conjunction with videotape replay stimulated evaluation and exploration of the behaviors by the family members. With school grades and observers' ratings of classroom and playground behaviors as dependent measures, results indicated that the confrontation group showed more improvement than the cases employing the two other interventions.

Summary and critique. Videotape playback has been used in a variety of psychotherapeutic settings and apparently in many cases results in therapeutic gain or acceleration of the therapy process or both. Unfortunately, much of the research is of the clinical case study type or lacks experimental rigor. More specifically, many studies have employed small samples, no control groups, and inadequate dependent measures. For further critique of methodology in self-confrontation research, the reader is directed to a review of Bailey and Sowder (1970).

#### Hypotheses

Previous research (e.g., Lay, Ziegler, Hershfield & Miller, 1974; Nisbett, Caputo, Legant & Maracek, 1973) indicates that there is a tendency for actors to attribute their own actions to situational requirements, but for

observers of the same actions to explain them by the stable personal dispositions of the actor. Also, Storms (1973) found that when he changed a subject's visual orientation or perspective from actor to observer by using videotape, the subject tended to make more dispositional attributions about his or her own behavior than did observers. Therefore, it was hypothesized that:

1. Subjects who received pretherapy training plus videotape playback of that training would show an increase in change of blame attributed to self from pre- to post-test.

2. Subjects who received pretherapy training plus videotape playback of that training would show an increase in the frequency of self-attributional statements from pretherapy session one to session three.

The assumption was made that with a change in causal attribution there would be a concomitant change in the perceived "importance for change" for resolution of marital difficulties. It was further hypothesized that:

3. Following an increase in blame attributed to self, subjects would also show an increase in perceived "importance of self-change" and a decrease in perceived "importance of spouse change" for resolution of their marital difficulties.

## Method

### Subjects

The sample consisted of 15 couples who had come to the Southern Illinois University Counseling Center with poor communication as one of their presenting problems and who had volunteered to participate in the present study. Two other couples began but did not complete the study. Ages of subjects ranged from 21 to 42 years with a mean age of 30.82 years. The present marriage was the first for each subject. Couples had been married from 1.5 to 10 years with a mean of 7.00 years and none had any previous marital therapy experience.

### Criterion Measures

Marital Therapy Questionnaire. The Marital Therapy Questionnaire (MTQ) is an unpublished instrument designed by the experimenter solely for the purposes of the present study (see Appendix A for questionnaire). The questionnaire is divided into two parts. In the first part, the subject is to list the three most important problem areas in the marriage. For each problem area, the subject is to estimate the percentage of the responsibility or blame which can be attributed to self, spouse, or factors other than self or spouse. In the second part of the questionnaire, the subject is asked to specify three areas of desired change in both his or her own and spouse's behavior and to assess the importance of each of these changes

occurring for the resolution of their marital difficulties. The assessment of "importance for change" is made on a nine-point Likert scale labeled extremely unimportant (1) to extremely important (9).

To ensure that subjects in the present study rated the same problems at the posttest that they had specified at the pretest, problem statements were transferred verbatim from the pretest to the posttest questionnaire. The same procedure was also used with the "Desired Changes" section on the questionnaire.

To establish test-retest reliability for the MTQ, 10 married students from an undergraduate psychology class and their spouses completed the questionnaire on two occasions with a four-week interval between testings. For this sample, the instrument was found to have a test-retest reliability of .84. This reliability coefficient is actually an average of the correlations computed separately for each item on the questionnaire.

Self-attributional statements. In the present study, self-attributional statements (SAS) were defined as here-and-now statements, in which the subject accepted blame or responsibility for conflict while using the pronouns "my" (e.g., That is my fault) or "I" (e.g., I will accept responsibility for that). The frequency of SAS was recorded for the first 45 minutes of all first and third pretherapy sessions.

Marital Communication Inventory. Bienvenu (1968) developed the Marital Communication Inventory (MCI) to assess the communication process as an element of marital interaction. Specifically, it is a self-report inventory which measures communication patterns and styles rather than content. Subjects respond on a four-point Likert scale with regard to their agreement to each of 46 items. Responses are scored from zero to three with a favorable response given to the higher score. There are separate forms for husbands and wives, although item content is the same. The instrument is appropriate for any married individual who is living with his or her spouse.

In a validity study (Bienvenu, 1978), MCI scores for a group receiving marital counseling were compared with those of a group with no apparent marital difficulties. The latter group demonstrated a significantly higher level of communication on the MCI than the group receiving counseling. In terms of reliability, Bienvenu (1970) reports a split-half reliability coefficient of .93, while Rappaport (1976) reports a test-retest reliability of .94.

Although the present study was primarily concerned with how videotape playback affects causal attribution, its incorporation of communications training as part of the procedure allowed for the investigation of videotape playback effects on couples' communication. Of the few instruments designed to assess communication, the MCI's

more than adequate validity and reliability made it a logical choice.

Marriage Adjustment Inventory. The Marriage Adjustment Inventory (MAI), developed by Manson and Lerner (1962), is a self-report inventory presenting 157 statements representative of what its authors believe to be the 12 most common problem areas in a marriage: family relations, dominance, immaturity, neurotic traits, sociopathic traits, money management, children, interests, physical, sexual, abilities, and incompatibility. The subject indicates which of the statements apply to himself or herself, his or her spouse, or both.

The manual reports no validity or reliability data for the instrument. Nonetheless, the MAI was chosen as the adjustment measure for the present study because it allows each subject to rate not only his or her own adjustment but his or her spouse's adjustment as well.

#### Trainers

One white male aged 28 and one white female aged 29 served as trainers in the present study. Both were third-year doctoral students in counseling psychology at Southern Illinois University. Both had similar levels of training and experience, as they had completed the same practicum sequence together. The experimenter had served as a practicum supervisor for both students. The training for their roles in the present study focused on detecting

faulty and destructive communication patterns and promoting constructive change in those patterns. Specifically, trainers were to make couples aware of five common faulty communication patterns--incongruent communication, incomplete messages, generalizations, untested assumptions, and subject switches (see Appendix B for definitions and specific examples of these faulty communication patterns). In terms of detecting these patterns, they were trained to a 90% criterion as compared to the ratings of the experimenter, who was trained and experienced in the use of communications training with couples using videotaped interviews of couples in therapy.

Trainers were taught by the experimenter to use feedback, instruction, modeling, and behavioral rehearsal in order to facilitate more constructive communication patterns. They were also instructed to use a specific intervention for a specific communication pattern (see Appendix B for specific interventions).

As an ongoing check against a decrease in detection accuracy and intervention standardization, a counseling psychologist reviewed the videotape of each trainer's second session for each couple. Any significant departure from the 90% detection criterion (75% or less), or the implementation of more than one incorrectly chosen intervention in a session, was to result in further training sufficient to attain again the 90% detection criterion



and the intervention criterion of less than two incorrect interventions per session.

### Procedure

When potential subjects (couples) were seen on intake, they were asked by the experimenter if they would be interested in participating in a research project designed to shorten the marital therapy process. If they expressed a willingness to participate, they read a statement outlining the procedures and expectations of the research project (see Appendix C for statement).

All couples were seen on intake by the experimenter. On intake, couples filled out the MAI, the MCI, and the MTQ. Couples were randomly assigned to one of two experimental groups or a control group. Couples in the two experimental groups were then randomly assigned to one of two trainers who was blind to the actual purposes of the present study.

Experimental group 1. Each week for three weeks, couples in experimental group 1 (E1) received a 45-minute pretherapy session, immediately followed by the videotape replay of that session. The decision to use three sessions was an arbitrary one. The experimenter wanted to allow enough exposure time to permit the hypothesized observer effect to take place but not so much time that the procedure was not time effective--remembering that the rationale for the study was to accelerate the marital therapy process.

In the pretherapy sessions, couples were given conflict resolution tasks--tasks derived from the lists of desired changes compiled on intake. More specifically, a desired change from one spouse's list of desired changes for his or her spouse was chosen by the trainer and presented to the couple. These desired changes were chosen on the basis of importance, with the most important change chosen first from one spouse's list. When the conflict resolution task associated with that change was resolved, then the desired change designated as the most important on the other spouse's list was chosen. When the task associated with that change was resolved, then the second most important one on the first spouse's list was chosen and so on. The couple's task was to try to come to some sort of agreement as to how the desired change might be accomplished. For example, if a woman wanted her husband to be more affectionate, their task would be to try to agree as to a strategy which would lead to the husband becoming more affectionate. If time did not allow for at least one task derived from each spouse's list in any given therapy session, then the following session began with a task derived from the desired change list not used in the previous session.

The rationale for using conflict resolution tasks derived from the lists of desired changes was that these should represent areas that each spouse has some emotional

investment in and thus are areas which are apt to evoke characteristic patterns of behavior. There were two rationales for choosing faculty communication as intervention points. First, communication problems typically play an important role in marital difficulties. Thus, communication training can be helpful to the clients in the resolution of their difficulties. Second, the focus on communication was helpful to the experimenter as a means of control for what transpired in a session. That is, it helped standardize the treatment across sessions and subjects.

The trainer's role in the pretherapy sessions was to make the couple aware of faulty or destructive communication patterns, and to assist in the development of new, more constructive patterns. During the videotape sessions, the trainer and the couple observed the tape together. Videotape sessions were for viewing only. No training was done during these sessions. The trainer's function was simply to sit with the couple while they observed the tape. The videotape was not stopped during these replay sessions so that the entire tape could be reviewed. More standardization of the treatment procedure across sessions and subjects was assured by not stopping the videotape.

Sessions were begun one week after intake. One week following the third pretherapy-videotape session, subjects

were given the posttest which consisted of the MAI, the MCI, and the MTQ. In addition, videotapes of the first and third sessions for each couple were reviewed by two doctoral level counseling psychology interns at the Southern Illinois University Counseling Center, in order to record the number of self-attributional statements made by each subject. Reviewers were blind as to the subjects' experimental condition.

Experimental group 2. Each week for three weeks, couples in experimental group 2 (E2) received a 90-minute pretherapy session. The first half of each session was videotaped, but subjects did not observe it. As in E1, couples were given conflict resolution tasks derived from their lists of desired changes in the first 45 minutes of the session. In order to control for the number of desired change areas discussed both within and across sessions, no new content (conflict resolution tasks) was introduced during the second 45 minutes of the session. The trainer and the couples dealt only with content introduced in the first half of the session. The trainer's role in these sessions was to make the couple aware of faulty communication patterns and to assist in the development of more constructive patterns. One week following the third pretherapy session, subjects were given the posttest. Also, the frequency of self-attributional statements was recorded for sessions one and three as in E1.

Control group. Couples in the control group (C) were seen on intake and completed the pretest measures as did couples in E1 and E2. These couples were not seen for treatment or training at the Center for the next three weeks and were instructed not to be seen by any other therapist during this period. After three weeks, they were given the posttest. Following the posttest, therapy was immediately arranged for them.

### Results

In a preliminary analysis, pretest scores on all dependent measures were analyzed to determine pretreatment equivalence between groups. All analyses were nonsignificant, indicating no difference between groups on the MAI, the MCI, on self-attribution and "importance for change" measures on the MTQ, or in the frequency of self-attributional statements.

An analysis of the two couples who dropped out of the study showed that they did not differ significantly on any of the pretest measures or with regard to age or length of time married from the couples who remained. One of the couples dropped out of the videotape treatment condition with the female trainer after one session, citing that they no longer wanted treatment because they had resolved their one major conflict. The other couple dropped out of the no videotape treatment condition with

the male trainer after one session, stating that the treatment was not what they wanted.

To control for the quality of the work done by the two trainers, the videotape of the second session for each couple was examined by a counseling psychologist trained and experienced in the use of communications training. Prior to rating the videotapes in the present study, he watched a videotape of a couple in therapy while the experimenter pointed out and explained the faulty communication patterns of interest in the present study and their prescribed interventions. The rater used a copy of Appendix B to aid him in his ratings. He recorded the occurrence of each pattern, whether or not the trainer detected it, and whether the trainer implemented the prescribed intervention. His examination indicated that the minimum criterion levels for trainer intervention were met in all but one session for each trainer. In each case, the trainer was given training sufficient to reach the 90% criterion. To validate further the efficiency and standardization of the two trainers' work, analyses computed to test for trainer effects for subjects in E1, for subjects in E2, and for sex of subject were nonsignificant.

Two explanations regarding analysis of the results of the present study are, perhaps, necessary prior to the presentation of those results. First, the present study was concerned with change scores on the various dependent

measures. Change can occur in either a positive or negative direction. In that regard, algebraic differences rather than absolute differences from pre- to posttest were used in the following analyses. Second, the decision was made to analyze each group separately from pre- to posttest with a  $t$  test for matched samples. An analysis of variance was to follow significant  $t$  tests to determine significance of difference between groups. This analysis sequence was chosen because the crux of the present study was to increase self-attribution, and it would be of little value to know that groups differed significantly if none of them were effective at increasing self-attribution; that is, if none showed a significant increase in self-attribution from pre- to posttest. Hypothetically speaking, it would be possible for two of the three groups to show a change in the negative direction (i.e., decrease in self-attribution), while the third group showed no change. As a result, an analysis of variance could show that the groups differed significantly without any group showing an increase in self-attribution.

The primary objective of the present study was to determine the effect of videotape playback on attribution of responsibility for conflict in distressed couples. Dependent variables included both a subjective client self-report measure and a behavioral measure--frequency of self-attributional statements. For the self-report

measure, difference means were computed using self-attribution percentages--measures on the MTQ indicating the percentage of blame or responsibility a subject was willing to attribute to himself or herself. Specifically, differences between pre- and posttest self-attribution percentages were recorded for each of the three problem areas specified by each subject in each group. A mean of these three difference scores was computed for each subject. This served as a subject's self-attribution score. Means and standard deviations for each group are presented in Table 1. A t test for matched groups computed by the direct difference method (Spence, Underwood, Duncan & Cotton, 1968) was used to compare pre- and posttest scores for E1. The term "matched" used here and in all following instances refers to the fact that measures taken on a single group before and after experimental manipulation are to be compared. Results indicated that self-attribution had increased significantly, t (9) = 2.27, p < .05. Identical analyses for E2 and C were nonsignificant. Presented in Table 2 are the nonsignificant results of a one-way analysis of variance used to analyze differences between groups. A t test for independent samples comparing change in self-attribution scores for males and females in E1 was not significant, indicating that the effect was not sex related.



Table 1  
Means and Standard Deviations for Pre- and  
Posttest Self-Attribution Scores

Group <sup>a</sup>	Pretest		Posttest	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Videotape/Training (E1)	34.83	17.09	41.50	18.27
Training (E2)	38.30	13.38	36.67	18.98
Control (C)	41.00	13.99	39.81	15.74

<sup>a</sup>n = 10 for each group.

Table 2  
Summary of Analysis of Variance for Increase  
in Self-Attribution Scores

Source of Variation	<u>df</u>	<u>MS</u>	<u>F</u>
Between Groups	2	258.06	2.53
Within Groups	27	102.13	
Total	29		

In order to determine the effect of videotape playback on self-attributional statements (SAS), the increase in SAS for subjects in E1 and E2 from pretherapy session one to session three was recorded. Means and standard deviations are presented in Table 3. As predicted, a t test for

matched samples revealed that SAS increased significantly for subjects having the benefit of videotape playback,  $t(9) = 5.40, p < .01$ . The same analysis for E2 did not reach significance. When compared to subjects in E2, subjects in E1 showed a significantly greater increase in SAS,  $t(18) = 3.70, p < .01$ . A  $t$  test for independent samples comparing increases in SAS for males and females in E1 was not significant, indicating that the effect was not sex related. An interrater reliability coefficient of .94 was compiled by the two naive interns who rated the videotapes for SAS.

Table 3

Means and Standard Deviations for Frequency  
of Self-Attributional Statements

Group <sup>a</sup>	Session 1		Session 3	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Videotape/Training (E1)	.70	.64	3.40	1.43
Training (E2)	1.40	1.43	2.00	1.45

<sup>a</sup> $n = 10$  for each group.

It was assumed that with an increase in self-attribution there would be a concomitant increase in the perceived "importance of self-change" for resolution of marital difficulties. To determine the effect of videotape playback

on "importance of self-change," difference scores between pre- and posttest "importance of self-change" ratings were computed in the same manner as the self-attribution scores in a previous analysis, except that "importance of self-change" ratings replaced self-attribution percentages. Means and standard deviations are presented in Table 4. A t test for matched samples computed by the direct difference method used to compare pre- and posttest scores for E1 was nonsignificant, as were the same analyses for E2 and C.

Table 4  
Means and Standard Deviations for Pre- and Posttest  
"Importance of Self-Change" Ratings

Group <sup>a</sup>	Pretest		Posttest	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Videotape/Training (E1)	7.09	1.20	6.86	1.28
Training (E2)	7.58	.85	7.67	1.04
Control (C)	7.42	.66	7.15	1.00

<sup>a</sup>n = 10 for each group.

The assumption was also made that with an increase in self-attribution there would be a concomitant decrease in the perceived "importance of spouse change" for marital conflict resolution. Difference scores between pre- and

posttest "importance of spouse change" ratings were derived in the manner previously described for self-attribution and "importance of self-change" measures. Means and standard deviations are presented in Table 5. Results of  $t$  tests for matched samples used to analyze the spouse change data were not significant.

Table 5

Means and Standard Deviations for Pre- and Posttest  
"Importance of Spouse Change" Ratings

Group <sup>a</sup>	Pretest		Posttest	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Videotape/Training (E1)	7.30	.96	7.00	.89
Training (E2)	7.33	.62	7.03	1.05
Control (C)	6.55	1.67	6.88	1.40

<sup>a</sup> $n = 10$  for each group.

Although the primary objective of the present study was to determine the effect of videotape playback on causal attribution, a secondary objective was to determine videotape playback effects on marital communication and adjustment as reported by the client (subject). On the MCI, the husband is basically rating the wife's ability to communicate with him, and she is rating his ability to communicate with her. Consequently, MCI scores from

individual spouses in a couple are independent of each other. Change in communication was defined as a change in MCI scores from pre- to posttest. Means and standard deviations for the MCI are presented in Table 6. Change in communication was analyzed via t tests for matched samples comparing pre- and posttest scores for E1, E2 and C. All analyses failed to reach significance.

Table 6  
Means and Standard Deviations for Pre- and Posttest  
Marital Communication Inventory Scores

Group <sup>a</sup>	Pretest		Posttest	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Videotape/Training (E1)	88.50	18.78	90.80	16.82
Training (E2)	79.40	16.29	78.70	15.81
Control (C)	87.70	17.62	85.70	12.81

<sup>a</sup>n = 10 for each group.

Change in marital adjustment was defined in two ways. First, change in adjustment was defined by a change in Self-Evaluation scores (SE) on the MAI from pre- to posttest. SE represents the total number of problem areas or situations the individual identifies as pertaining to himself or herself. Means and standard deviations for SE

are presented in Table 7. Individual  $t$  tests for matched samples comparing pre- and posttest SE were nonsignificant.

Table 7  
Means and Standard Deviations for Pre- and  
Posttest MAI Self-Evaluation Scores

Group <sup>a</sup>	Pretest		Posttest	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Videotape/Training (E1)	8.80	6.28	5.40	3.10
Training (E2)	10.10	8.43	7.60	7.83
Control (C)	7.60	5.70	6.00	4.90

<sup>a</sup> $n = 10$  for each group.

Change in adjustment was also defined as a change in Spouse Evaluation Scores (SPE) on the MAI from pre- to posttest. SPE represents the total number of problem areas or situations an individual identifies as pertaining to his or her spouse. Means and standard deviations for SPE are presented in Table 8. A  $t$  test for matched samples computed by the direct difference method indicated that SPE had changed significantly in a positive direction from pre- to posttest for the videotape treatment group,  $t(9) = 2.91$ ,  $p < .01$ . Identical analyses for the experimental group without videotape playback and the control group were not significant.

Table 8  
Means and Standard Deviations for Pre- and  
Posttest MAI Spouse Evaluation Scores

Group <sup>a</sup>	Pretest		Posttest	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Videotape/Training (E1)	8.90	7.35	5.00	4.27
Training (E2)	15.50	10.31	13.20	12.08
Control (C)	8.00	5.48	5.90	5.45

<sup>a</sup>n = 10 for each group.

Results of a one-way analysis of variance used to analyze differences between groups on SPE are presented in Table 9. The increase in adjustment from pre- to post-test for E1 was not significantly different from changes in adjustment for E2 and C, probably due to greater variability within E2 and C and small sample size.

Table 9  
Summary of Analysis of Variance for Change  
in MAI Spouse Evaluation Scores

Source of Variation	<u>df</u>	<u>MS</u>	<u>F</u>
Between Groups	2	9.74	.29
Within Groups	27	33.48	
Total	29		

### Discussion

The results of the present study support the hypothesis that subjects who received pretherapy (communications) training plus videotape playback of that training would show a significant increase in change of blame attributed to self. However, self-attribution change scores for the group with the benefit of videotape playback were not significantly different from those of the group without videotape observation and the control group. Consequently, it is unwarranted to say with any certainty that the significant change in the videotape group resulted from the videotape procedure. The change in self-attribution may represent nothing more than capitalizing on sampling error due to small sample size. However, even with small sample size, the difference between groups approached significance ( $p < .1$ ). Also of importance is the instrument used to measure self-attribution in the present study. Although its test-retest reliability (.84) is acceptable, no validity data is available. Basically, subjects in the present study were asked to assign a percentage to the amount of blame or responsibility for conflict they were willing to accept. Some subjects may have responded to the task by making a well thought out estimate, while others possibly responded with a poorly thought out, impulsive guess.



Results of the current study support the hypothesis that subjects who received videotape playback of pretherapy training would show a significant increase in the frequency of self-attributional statements (SAS). The increase in SAS recorded by subjects in the videotape treatment was also significantly greater than that recorded by subjects who did not receive videotape playback. This latter finding may seem somewhat inconsistent with the previous one, showing no difference between groups with regard to increase in self-attribution. However, Wright and Fichten (1976) have reported that the argument of whether attributions mediate behaviors or behaviors mediate attributions has yet to be resolved, and that sometimes manipulations designed to change attributions tend to have a greater effect on behavior than on the attribute which is supposed to mediate it. It is possible that behavioral changes (increase in SAS) preceded or were greater than cognitive ones for some subjects in the videotape treatment group.

Previously discussed findings are consistent with results reported by Storms (1973) for a nonclinical sample. While the findings of the present study are also consistent with the clinical data reported by Alger and Hogan (1967, 1969), the study, itself, is methodologically superior to their work in that dependent measures were behavioral, as well as subjective, and the procedure was controlled, standardized, and employed comparison groups. The implication

of these findings for the practice of marital therapy concerns acceleration of the marital therapy process. When couples come to a mental health agency for therapy, each spouse is typically much more willing to attribute blame or responsibility for conflict to the other spouse than to himself or herself, and early therapy sessions are often characterized by a series of accusations and counteraccusations. Before therapeutic change can occur, each spouse must be willing to accept some responsibility for the marital difficulties. A pretherapy training procedure like the one presented in the current study could accelerate the therapy process through the facilitation of awareness and acceptance of responsibility for conflict.

Results of the present study did not support the hypothesis that with an increase in self-attribution there would be a concomitant increase in the "importance of self-change" and a concomitant decrease in the "importance of spouse change" for the resolution of marital difficulties. One explanation for the lack of increase in "importance of self-change" could again be the instrument designed to measure it, in that its validity is unknown. "Importance of self-change" may simply be a cognitive change not mediated by (self) attribution in a distressed spouse. Similarly, "importance of spouse change" may not be mediated by attribution. That is, an individual might increase the amount of responsibility he or she is willing to accept for

conflict without affecting his or her perception of how important change in his or her spouse is for marital conflict resolution.

Although the primary objective of the present study was to investigate the effects of videotape playback on causal attribution in distressed couples, a secondary objective was to determine videotape playback effects on marital communication and adjustment. Videotape playback apparently had no effect on communication as measured by the MCI, a self-report inventory. One explanation with numerous nuances involves the training procedures employed. Specifically, training sessions may have been too long or short, too widely or closely spaced, or simply too few in number. Or perhaps the five faulty communication patterns focused on were too narrow. A second explanation concerns a possible sensitizing effect of the training. As a result of having had communications training, couples at the post-test may have been more able to assess critically their communications skills. They may have actually become more adept at communicating by the posttest but, due to their new knowledge of communication, made a more accurate and critical assessment. The question of whether communication had improved or not could probably have been answered with more certainty through the adoption of behavioral measures, such as pre-post differences in the frequency of faulty communication patterns. Finally, with regard to the finding

of no difference between groups, it should be remembered that the group without videotape observation had three full 90-minute sessions of faulty pattern detection and constructive pattern training, whereas the videotape group had three 45-minute sessions of detection and training, followed by videotape playback of those sessions. In essence, the group without videotape observation had more direct training than the videotape group but did not report a greater increase in communication skills.

Adjustment was defined as Self-Evaluation (SE) and Spouse Evaluation (SPE) scores on the MAI. Although subjects in the videotape group did not rate their own adjustment as having improved following treatment, they did assess their spouses as having improved significantly. For SE on the MAI, the subject identifies the problems he or she is responsible for, and adjustment is inversely related to the number of problems identified. If an individual increased his or her self-attribution, he or she would probably not be expected to take responsibility for fewer problems on the MAI. Consequently, adjustment would not appear to have improved. The fact that ratings of spouse adjustment improved can be explained by Wright and Fichten's (1976) suggestion that accepting more blame for conflict may result in spouses perceiving each other in a more favorable light.

Implications for future research obviously include the need for behavioral correlates of self-attribution. Also, follow-up studies are needed in which subjects (clients) who have received videotape pretherapy training are followed through the therapy process to termination, in order to determine the videotape training effects on therapy process and outcome. Follow-up studies are also necessary to determine not only the maintenance of self-attributional changes, but also the possibility of other cognitive or behavioral changes occurring later as a result of attributional change. Or on a more general level, does attribution precede and mediate behavior or does behavior mediate attribution and cognitive change? Finally, while the present study focused on increasing self-attribution through changing a spouse's visual perspective from that of an actor to that of an observer of his or her own behavior, the discrepancy between how spouses view the same situations and behaviors might be reduced in future studies by having each spouse adopt an empathic set for the other spouse and then have them watch only the other spouse on a split screen during videotape playback. As a result, one spouse should attribute causation in a manner similar to the other spouse he or she observed and empathized with.

In summary, this study has provided support as to the usefulness of videotape playback as a means of increasing self-attribution and self-attributional behavior. In

addition, the present study provides support for Storms' (1973) hypothesis that change in visual perspective from actor to observer results in greater dispositional attribution. It further provides support for Jones and Nisbett's (1971) general proposition that observers of action tend to attribute causality dispositionally. Finally, caution should be exercised when drawing conclusions or inferences from the results due to the relatively small sample size.

## Appendix A

## MARITAL THERAPY QUESTIONNAIRE

Name of Wife: \_\_\_\_\_

Name of Husband: \_\_\_\_\_

Length of Time Married: \_\_\_\_\_

Previous Marital Therapy: Yes \_\_\_ No \_\_\_

INSTRUCTIONS: Please answer every question.

Part I: Problem Areas

1. (a) In your opinion, what is the most important problem (area) in your marriage?

(b) In your opinion, what percentage of this problem can be blamed on yourself, your spouse, and/or on other factors?

Self	_____	%
Spouse	_____	%
Other	_____	%
Total	_____	100

2. (a) In your opinion, what is the second most important problem (area) in your marriage?

(b) In your opinion, what percentage of this problem can be blamed on yourself, your spouse, and/or on other factors?

Self	_____	%
Spouse	_____	%
Other	_____	%
Total	_____	100

3. (a) In your opinion, what is the third more important problem (area) in your marriage?
- (b) In your opinion, what percentage of this problem can be blamed on yourself, your spouse, and/or on other factors?

Self		%
Spouse		%
Other		%
Total	100	

Part II: Desired Changes

1. Specify three areas in which you would like to see change in yourself. Following each area, rate how important you think change in each area is for the resolution of your marital difficulties.

Area 1: \_\_\_\_\_

Extremely Unimportant		Unim- portant		Impor- tant		Extremely Important
1	2	3	4	5	6	7 8 9

Area 2: \_\_\_\_\_

Extremely Unimportant		Unim- portant		Impor- tant		Extremely Important
1	2	3	4	5	6	7 8 9

Area 3: \_\_\_\_\_

Extremely Unimportant		Unim- portant		Impor- tant		Extremely Important
1	2	3	4	5	6	7 8 9



2. Specify three areas in which you would like to see change in your spouse. Following each area, rate how important you think change in each area is for the resolution of your marital difficulties.

Area 1: \_\_\_\_\_

Extremely Unimportant		Unim- portant				Impor- tant		Extremely Important
1	2	3	4	5	6	7	8	9

Area 2: \_\_\_\_\_

Extremely Unimportant		Unim- portant				Impor- tant		Extremely Important
1	2	3	4	5	6	7	8	9

Area 3: \_\_\_\_\_

Extremely Unimportant		Unim- portant				Impor- tant		Extremely Important
1	2	3	4	5	6	7	8	9

## Appendix B

## Faulty Communication Patterns and Prescribed Interventions

Faulty Communication	Intervention
<p>1. <u>Incongruent Communication</u> (verbal messages contradict nonverbal ones)</p> <p>Example: While smiling, the wife says, "you really hurt me when you (husband) don't talk to me."</p>	<p>1. Trainer points out the incongruence by saying, "Jane, I noticed that when you were talking about being <u>hurt</u>, you were <u>smiling</u>. That could create confusion for Jim (husband)." To facilitate change, the trainer says, "If you do get hurt in the situation you were just talking about, try telling Jim again, but this time tell him with nonverbal behavior that is consistent with what your words are saying." The client tries out this suggestion, and the trainer gives feedback as to the change in congruence between verbal and nonverbal behavior.</p>
<p>2. <u>Incomplete Communication</u> (sender does not complete sentences but relies on the receiver to fill in)</p> <p>Example: Husband says to wife, "you are very... you know."</p>	<p>2. Trainer interrupts and says to wife, "Jane, what does Jim mean when he says 'you are very' and just stops there and doesn't give any more information?" If she can give an answer, have her check it out with Jim. Regardless of whether or not she can give an answer and/or regardless of whether or not there is a discrepancy between what <u>she thought</u> he was communicating and what <u>he</u> thought he was communicating, the trainer urges both spouses to use</p>

Faulty Communication	Intervention
<p>3. <u>Generalizations</u> (use of words like <u>everyone</u>, <u>some people</u>, etc.)</p> <p>Example: Wife says, "<u>Nobody</u> really cares about <u>other people</u>--<u>they're</u> just selfish."</p>	<p>complete sentences and to be specific about <u>who</u> does <u>what</u> to <u>whom</u> in <u>which</u> circumstances.</p> <p>3. Trainer points out the wife's use of vague words like "everyone" and instructs her to replace words like "nobody," "other people," and "they" with names and/or personal pronouns. In this particular case, the trainer might instruct Jane to say, "<u>Jim</u> doesn't really care about <u>me</u>--he's just selfish." Trainer follows by saying, "Now, Jim knows that you are talking about <u>him</u> and <u>you</u>."</p>
<p>4. <u>Untested Assumptions</u> (thinking or action based on untested assumptions)</p> <p>Example: Husband says, "She (wife) wouldn't like it if I cried--she likes the macho type!" (Wife looks puzzled or exasperated)</p>	<p>4. Trainer asks Jim if he has ever cried in front of his wife. Regardless of his answer, the trainer instructs Jim to ask his wife to tell him what she would think, feel, and do if he were to cry in front of her. Regardless of Jane's answer, the trainer stresses the importance of verbally checking out assumptions.</p>
<p>5. <u>Subject Switching</u> (changing the topic at hand with or without the partner's agreement)</p> <p>Example: Husband says to wife, "You don't keep the house clean enough!" The wife responds, "Well, what about you--you never take the garbage out."</p>	<p>5. Trainer says, "Jane (wife), you did not really respond to Jim's (husband) complaint about the house--you changed the subject on him. Let's continue with Jim's complaint about the house before going on to your complaint about the garbage. Jim, make your statement again and Jane,</p>

Faulty CommunicationIntervention

respond to the content of only that statement as best you can. Subject changes make the resolution of almost any problem virtually impossible."

## Appendix C

Statement to Potential Subjects

This research is designed to shorten marital therapy through pretherapy training. If you choose to participate, you will at some point be taught communication skills in three pretherapy sessions while you are at the same time working on your problems. It is believed by many theorists that most if not all marital difficulties are a result of poor communication. Consequently, communication training could improve your relationship. It is possible that you may only need to be seen for the three pretherapy sessions. However, if you want or need to be seen after these three sessions, you may not be working with the person who trained you. In any case, you would be working with a competent Counseling Center staff member.

Your first three sessions will probably be videotaped so you may have the added benefit of observing part or all of these three sessions. The videotapes are confidential and cannot be viewed by anyone other than yourselves, your trainer/therapist, and perhaps other Counseling Center staff members. Videotapes will be erased following the three sessions.

Following the intake interview today, you may be asked to wait three weeks to begin. However, this wait is not uncharacteristic as we often have a waiting list that necessitates a waiting period of three weeks or longer. If you are one of the couples asked to wait, you will have the advantage of being certain that your trainer will also be your therapist.

In addition to the possible shortening of your marital therapy, an advantage of participating is that your pretherapy sessions are scheduled to last 90 minutes as opposed to the typical 50-60 minute therapy sessions of persons not participating.

Results from this project will be provided to you on request following the completion of the project.

Finally, participation in this project is purely voluntary. Should you decide not to participate or discontinue participation at any time, you will still receive appropriate services here at the Center. In addition to erasing videotapes, confidentiality will be maintained by coding any forms or inventories you might be asked to fill

out rather than using your name. In essence, your forms and inventories will be identifiable only by the project director.

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